STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
G McDonald		6/20/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1	F 550		

exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation interview and record review, the facility failed to provide a dignified existence for three residents (Resident #2, #11 and #24) when the facility allowed multiple residents to remain in common areas with bare skin exposed with no staff intervention. This affected 3 out of 20 sampled residents. The facility census was 53.

Review of the facility's undated Resident Rights Policy showed in part:
-The resident shall be treated with consideration and respect and full recognition of their dignity and individuality.

1. Observation on 5/27/24 at 12:22 P.M. showed:
-Multiple younger residents moving from table to table;
-Multiple residents with their abdomen showing and upper buttocks showing;
- Multiple residents yelling back an forth at each other and yelling at the kitchen;
-The geriatric residents are staying seated while the younger residents are going up to the meal window yelling at the kitchen staff.

2. Review of Resident #2's Significant Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/3/24 showed:
-Severe cognative impairment;
-No mood behavior issues;
-Maximum assist for Activities of Daily Living (ADL's -an individual's daily self-care activities such as eating, bathing, walking and transfers);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 550	Continued From page 2	F 550		

-Incontinent of bowel and bladder;
-Receives Hospice services;
-Diagnoses included Alzheimer's Disease (a disease that affects the brain causing memory problems), arthritis, and high blood pressure.

Review of the Resident's care plan dated 3/21/24, showed:
-The resident requires the assistance of two staff for ADL's and transfers;
-The resident has behaviors;
-Avoid over stimulation;
-Maintain a calm environment.

During an interview on 05/28/2, at 04:24 P.M., the Resident's responsible party said:
-It is very loud and busy at the facilty now and he/she is not sure the resident will be comfortable with the new residents;
-Several of the residents are not dressed appropriately for this age group;
-He/She had very little notice of the room change and that a group of younger, behavioral health residents would be moving into the facilty;
-He/She has concerns that the new residents came so quickly and he/she is afraid that the younger residents will not interact the resident appropriately;
-He/She has concerns that the new staff would not know how to take care of the resident;
-He/She does not feel the resident would be as safe as he/she was in the past;
-He/She is considering moving the resident because of this.

3. Review of Resident #11's Quarterly MDS, dated 4/28/24 showed:
-Moderate cognative impairment;
-Supervision for ADL's;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

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CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 550	Continued From page 3	F 550		

-Occasionally incontinent of urine;
-Diagnoses included heart failure, high blood pressure and high cholesterol.

-Review of the resident's care plan dated 4/28/24, showed:
-Provide the resident with support with ADL's;
-The resident has anxiety;
-The resident is a Do Not Resuscitate (DNR - medical order that instructs the health care provider to not no live resuscitative measures if a persons heart stops) code status.

During an interview on 05/28/24 at 03:32 P.M., the resident said:
-He/She has a lot of anxiety since the new younger residents moved in to the facilty;
-He/She hates to go to the dining room now because the new residents are loud and yelling at each other;
-The new residents need to pull their pants up and their shirts down;
-He/She does not like to see all the exposed body parts when he/she goes to the dining room;
-He/She used to keep the door to his/her room open but knows it is noisy and he/she doesn't feel safe;
-The staff know he/she is concerned but nothing gets done.

4. Review of Resident #24's Quarterly MDS, dated 4/1/24 showed:
-Moderate cognative impairment;
-Supervision for ADL's;
-Occasionally incontinent of urine;
-Diagnoses included diabetes mellitus (too much sugar in the blood), high blood pressure and high cholesterol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 -Review of the resident's care plan dated 12/28/23, showed: -Provide the resident support with ADL's; -The resident has pain; -The resident is a DNR code status. During an interview on 05/28/2, at 03:39 P.M., the resident said: -The new residents walk around with their bottoms and stomachs showing and he/she does not like that because it is disrespectful; -The staff tell them to pull their pants up but they fall back down again; -There was a fight in the dining room at supper last night:; -He/She feels like this is not his/her home anymore; -He/She sets next to a resident that talks all the time and it is upsetting and the staff will not move the resident; -He/She is nervous about leaving his/her door open because of the new residents. During an interview on 05/30/24 at 04:10 P.M., the Administrator said: -He/She expects that residents in the common areas and the dining room should be dressed appropriately; -All residents should treat each other with respect; -There should be no exposed skin.	F 550		
	MO236514			
F 559 SS=E	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the	F 559		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

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CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 559	Continued From page 5	F 559		

same facility and both spouses consent to the arrangement.

§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.

§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to follow their policy when the facility did not provide four residents a written notice regarding a room change, including the reason for the room change, before the facility moved the resident to another room (Resident # 3, Resident #2, Resident #11 and Resident #24), of the 14 sampled residents . These residents did not want to be moved and were emotionally upset about the room changes. The facility's census was 53.

Review of the facility policy, Room Change, dated 2017 showed:
-It is the policy of this facility to promote a resident's right to make choices and to promptly receive written notice of a room change or change in an assigned roommate. The facility supports the resident's right to refuse a room change made solely for the staff's convenience. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of the facility staff, the resident, family and/or resident representative must receive an explanation in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

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CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 559	Continued From page 6	F 559		

writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate and ask questions about the move. The room change or roommate assignment change notice will be issued as much as in advance as possible upon knowledge of the need for change. Documentation of the notice and response will be included in the medical record. The notice contains the reason for the room or change, the effective date of the change and the location to which the resident will be moved.

1. Review of Resident #3 Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/18/24 showed:
-Brief Interview of Mental Status (BIMS) of 15, Indicated no cognitive deficit.
-No behaviors
-Moderate to dependence of staff for activities of daily living (ADL's: tasks completed in a day to care for oneself such as bathing, toileting, personal hygiene)
-Diagnoses of Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration.), diabetes mellitus(a group of diseases that result in too much sugar in the blood) , anxiety disorder (a feeling of fear, dread, and uneasiness), and obstructive sleep apnea (occurs when the throat muscles relax and block the airway while sleeping).

Review of the resident's medical record showed:
-Nurse progress notes on 5/03/2024 at 1:16 P.M. resident's daughter and resident were notified of move/room change next week by Assistant Director of Nursing (ADON). His/her family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

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CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 559	Continued From page 7	F 559		

mentioned possibly changing to a private pay room.
-There was no written notice of room moves.

During an interview on 5/28/24 at 9:40 A.M. Resident #3 said:
- He/She had to move out of his/her room so multiple new residents could move in.
-He/She was previously on the 400 hall.
-He/She was not given written notice.
-He/She was not given a choice about moving rooms.
-He/She was told one day and moved rooms 2 days later.
-This had all been very distressing for him/her.

2. Review of Resident #2's Significant Change MDS dated 4/3/24, showed:
-Severe cognative impairment;
-No mood behavior issues;
-Maximum assist for ADL's;
-Incontinent of bowel and bladder;
-Receives Hospice services;
-Diagnoses included Alzheimer's Disease, arthritis, and high blood pressure.

Review of the resident's care plan dated 3/21/24, showed:
-The resident requires the assistance of two staff for ADL's and transfers;
-The resident has behaviors;
-Avoid over stimulation;
-Maintain a calm environment.

Review of the resident's medical record showed:
-Nurses note dated 5/3/24 showed the resident's responsible party was notified by phone of the room move;
-No written notice of the room move was found.

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	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 559	Continued From page 8	F 559		

During an interview on 05/28/24 at 04:24 P.M., the resident's responsible party said:
-The facility called on 5/3/24 and said they where moving the resident to another hall so they could keep the new residents on the same hall;
-The facilty did not give the resident a choice of rooms or to move;
-He/she did not receive a written notice;
He/she would have liked some time to talk this over more with the facilty.

3. Review of Resident #11's Quarterly MDS, dated 4/28/24 showed:
-Moderate cognative impairment;
-Supervision for ADL's;
-Occasionally incontinent of urine;
-Diagnoses included heart failure, high blood pressure and high cholesterol.

-Review of the resident's care plan dated 4/28/24, showed:
-Provide the resident with support with ADL's;
-The resident has anxiety;
-The resident is a Do Not Resuscitate (DNR - medical order that instructs the health care provider to not no live resuscitative measures if a persons heart stops) code status.

Review of the resident's medical record showed:
-Nurses note dated 5/3/24 showed he resident's family was notified by phone of the room move;
-No written notice of the room move was found.

During an interview on 05/28/24 at 03:32 P.M., the resident said:
-The Assistant Director of Nursing (ADON) called on a Friday and the facilty moved him/her to another room on a Monday;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 559	Continued From page 9	F 559		

-The facilty provided the resident with no written notice;
-His/her family was called but nothing in written was provided to either of them;
-He/she was not given a choice of a room or the choice to move;
-The facilty just said his/her new room would be a certain number;
-He/she would have like more notice before the room change.

4. Review of Resident #24's Quarterly MDS, dated 4/1/24 showed:
-Moderate cognative impairment;
-Supervision for ADL's;
-Occasionally incontinent of urine;
-Diagnoses included diabetes mellitus (too much sugar in the blood), high blood pressure and high cholesterol.

-Review of the resident's care plan dated 12/28/23, showed:
-Provide the resident with support with ADL's;
-The resident has pain;
-The resident is a DNR code status.

Review of the resident's medical record showed:
-Nurses note dated 5/3/24 showed he resident's responsible party was notified by phone of the room move;
-No written notice of the room move was found.

During an interview on 05/28/24 at 03:39 P.M., the resident said:
-The staff told him/her to get ready to move to another room and only gave us a few days notice;
-The staff did not let him/her choose a room the facilty told him/her the room he/she would be in;
-He/she did not receive a written notice of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 559	Continued From page 10 room move; During an interview on 05/30/24 at 02:25 P.M., the resident's family member said: - He/she did not receive a written notice of the facilty was going to move the resident; - He/she was verbally notified of the room move while at the facilty; - The facilty did not give the resident a choice of a room or the choice to move at all, the facilty said they were moving the resident; - He/she would have liked advanced notice in writing. During an interview on 05/30/24 at 04:10 P.M., the Administrator said: -The notification of the room moves are documented in the nurses notes of the residents that were here prior to the new residents admitting; -Residents should be provided a a written notice regarding a room change, including the reason for the room change, before the facility moved the resident to another room.	F 559		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 578	Continued From page 11	F 578		

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to clarify the status of the Resident #11's Do Not Resuscitate Order (DNR, medical order that instructs the health care provider not to do resuscitative measures if a person's heart stops) when the resident's responsible party signed the revocation provision of the DNR, with out changing the order on the resident's Physician's Order Sheet (POS) to Full Code Status. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 578	Continued From page 12	F 578		

affected one resident (Resident #11). The facilty census was 53.

Review of the facilty's Advanced Directive Policy, dated March 2015, showed:
-The social services designee will inquire of the resident and/or his/her family members about the existence of any written advanced directives information;
-Advanced directive shall be displayed prominently in the medical record under the advanced directive tab.

1. Review of the resident's DNR showed:
- 10/16/23, The resident's responsible party signed the revocation provision, revoking the resident's DNR code status.

Review of Resident #11's Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 4/28/24 showed:
-Moderate cognative impairment;
-Supervision for ADL's;
-Occasionally incontinent of urine;
-Diagnoses included heart failure, high blood pressure and high cholesterol.

-Review of the resident's care plan dated 4/28/24, showed:
-Admit date 10/16/23;
-Provide the resident with support with ADL's;
-The resident has anxiety;
-The resident is a DNR.

Review of the residents POS dated 5/1/24 showed:
-Order Start date 10/16/23: Code Status - DNR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 578	Continued From page 13 During an interview on 05/30/24 at 09:55 A.M., Administrator said: -Social Services usually takes care of this and he/she is not here today; -If the resident is a DNR there should be an order on the POS that states the resident is a DNR; -If the revocation provision is signed that means the resident is no longer a DNR but is a full code and live saving measures would be given; -He/She expects the Social Service Director to ensure any discrepancy on the DNR is clarified; -He/She expects the DNR form to be filled out correctly.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 14	F 584		

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility failed to provide a comfortable and home -like environment for four of 20 sampled residents (Resident #2, #11, #22 and #24) when they failed to ensure sound levels were not loud and uncomfortable in the dining room, when a resident was yelling and staff failed to intervene, and when the facility failed to ensure the door to the smoking area did not slam shut when residents went in and out and caused distress for one resident (resident #24). The facilty census was 53.

Review of the facility's undated Resident Rights Policy showed:
-The resident shall be treated with consideration and respect and full recognition of their dignity and individual preferences.

The facility did not provide the requested policy regarding a comfortable and homelike

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 15	F 584		

environment.

1. Observation on 5/27/24 at 12:22 P.M. showed:
-Multiple younger residents moving from table to table;
- Multiple residents yelling back an forth at each other and yelling at the kitchen staff;
-The geriatric residents stay seated while the younger residents are going up to the meal window yelling at the kitchen staff.

2. Review of Resident #2's Significant Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/3/24 showed:
-Severe cognitive impairment;
-No mood behavior issues;
-Maximum assist for Activities of Daily Living (ADL's, an individual's daily self-care activities such as eating, bathing, walking and transfers);
-Incontinent of bowel and bladder;
-Receives Hospice services;
-Diagnoses included Alzheimer's Disease (a disease of the brain that affects memory and reasoning), arthritis, and high blood pressure.

Review of the Resident's care plan dated 3/21/24, showed:
-The resident required the assistance of two staff for ADL's and transfers;
-The resident had behaviors;
-Avoid over stimulation;
-Maintain a calm environment.

During an interview on 05/28/24 at 04:24 P.M., the Resident's responsible party said:
-It is very loud and very busy at the facilty now.
- He/She has concerns that the new residents came so quickly and he/she was afraid the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 16	F 584		

younger residents will not interact with the resident appropriately;
- He/She said he/she talked to an employee and a lot of their staff are being replaced by the staff from another facilty and do not know how to take care of mental health residents;
-He/She said he/she had concerns that the people would not know how to take care of the resident;
-The resident has the right to a home like environment.

3. Review of Resident #11's Quarterly MDS, dated 4/28/24 showed:
-Moderate cognitive impairment;
-Supervision for ADL's;
-Occasionally incontinent of urine;
-Diagnoses included heart failure, high blood pressure and high cholesterol.

-Review of the Resident's care plan dated 4/28/24, showed:
-Provide the resident with support with ADL's;
-The resident has anxiety;
-The resident is a Do Not Resuscitate (DNR - medical order that instructs the health care provider to not no live resuscitative measures if a persons heart stops) code status.

During an interview on 05/28/24 at 03:32 P.M., the Resident said:
-He/She has a lot of anxiety since the new residents moved in;
-Meals are late he/she hates to go to the dining room because he/she has to set by "those people";
-He/She needs help at meals and the old staff would take the time to help him/her but the new staff said they do not have time;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 17	F 584		

-He/She used to keep the door to his/her room open but does not feel like it is safe to do so anymore;
-The door to the smoke area keeps slamming shut and he/she can hear it even with his/her door shut;
-His/Her family is going to move him/her out of the facility because he/she just can't take it.

4. Review of Resident #22's Annual MDS, dated 4/1/24 showed:
-Moderate cognative impairment;
-No mood or behavior issues;
-Maximum assist for ADL's;
-Diagnoses included Cerebral palsy (disorder of movement, muscle tone or posture) high blood pressure and anxiety.

Observation of the dining room on 5/28/24 at 1:15 P.M., showed:
-Resident #179 was pacing on 200 hall and was talking on the phone, yelling loudly and cursing;
-Residents are sitting in the dining room nearby and were looking at the resident pacing and yelling on 200 hall;
-Staff are sitting at the dining room tables assisting residents with eating;
-The staff did nothing to intervene and no staff responded to resident #179 that was yelling on 200 hall;
-Resident #22 asked to be removed from the dining room because of the noise and told staff it increased his/her anxiety and he/she did not eat.

During an interview on 5/29/24 at 11:17 A.M., Certified Nurses Aide (CNA) A said:
-He/She had no education about dealing with mental health residents;
-He/She was setting at a table when Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 18	F 584		

#179 got upset and was yelling and he/she didn't do anything because he/she didn't know what to do;
-He/She was afraid to say anything incase Resident #179 flipped out on him/her;
-It really overstimulated Resident #22 and he/she was crying and acting out then he/she yelled because he/she was so upset with the other residents yelling;
- A lot of our geriatric residents have left because of the new residents.

During an interview on 5/30/24 at 11:31 A.M., CNA B said:
-He/She was here when Resident #179 got upset and he/she did not know what to;
-He/She received no training;

5. Review of Resident #24's Quarterly MDS, dated 4/1/24 showed:
-Moderate cognative impairment;
-Supervision for ADL's;
-Occasionally incontinent of urine;
-Diagnoses included diabetes mellitus (too much sugar in the blood), high blood pressure and high cholesterol.

-Review of the resident's care plan dated 12/28/23, showed:
-Provide the resident with support with ADL's;
-The resident has pain;
-The resident is a DNR code status.

Observation of 300 hall on 5/28/24, from 1:35 P.M. to 1:46 P.M., showed:
-Resident #24 is in his/her room setting in a chair;
-Multiple residents standing in the hall near the resident's room by the smoke room door;
-Multiple residents walk out into the smoking area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 19	F 584		

and the door loudly slams shut behind them;
-1:39 P.M., a resident comes back inside from the smoke area and the door loudly slams shut;
-1:41 P.M., a resident comes back inside from the smoke area and the door loudly slams shut;
-1:42 P.M., a resident comes back inside from the smoke area and the door loudly slams shut;
-1:45 P.M., a resident comes back inside from the smoke area and the door loudly slams shut;
-1:46 P.M., a resident comes back inside from the smoke area and the door loudly slams shut.

During an interview on 05/28/24 at 03:39 P.M., the resident said:
-The resident that sets next to him/her at meals talk all the time and it upsets him/her and the staff will not move him/her.
-The big problem is out side his/hers room is the door to their smoking area and the door slams hard every time someone goes in and out;
-He/She goes to bed around 7:00 P.M. and the door is still slamming;
-The slamming door makes him/her nervous;
-He/She has told the staff about his/her concerns but nothing has been done so far.

During an interview on 05/30/24 at 10:40 A.M., the resident said:
-He/She is hearing the door close to the smoke area;
-He/She has told the staff again but doesn't not remember who;
-He/She liked things the way they were at the facility before the new residents came.

During an interview on 5/30/24 at 11:31 A.M., CNA B said:
-Some of the residents choose to stay in their rooms because of the noise and too much going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 584	Continued From page 20 on around them; -It gets pretty loud sometimes and he/she does not know how to make it any quieter or any better. During an interview on 05/30/24 at 04:10 P.M., the Administrator said: -He/She expects to have peaceful quiet areas in the facilty; -If the noise level is loud the staff ask the residents to turn down the noise level; -We try to keep the loud residents together and we cannot tell them they can't yell; -No one should be that uncomfortable in their own home.	F 584		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 636	Continued From page 21	F 636		

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

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 636	Continued From page 22	F 636		

Based on observation, interview and record review, the facility failed to assure resident Minimum Data Set assessments were completed accurately and timely for three of 14 sampled residents (Residents #177, #78 and #80). The facility census was 53.

Review of the facility provided Minimum Data Set and Care Planning Guidelines, dated 10/1/2015 included; It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, any published Interim RAI manual errata documents and applicable federal guidelines as the authoritative guide for completion of the MDS, CAAs and resident care planning.

1. Review of Resident #177's face sheet showed:
- The resident admitted to the facility on 5/9/24;
- Diagnoses included: Schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), falls, pain in the right wrist, shortness of breath, generalized abdominal pain, nausea, diarrhea, pain, depressive episodes, low back pain, cough, bipolar disorder, migraine headaches, chronic obstructive pulmonary disease (a group of diseases that affect the lungs), diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), and anxiety.

Review of the resident's medical record showed:
-No completed MDS in the resident chart.
-No care plan in his/her chart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 636	Continued From page 23	F 636		

2. Review of Resident #78 Face sheet showed:
-He/she admitted to the facility 5/7/24
-Diagnoses of Schizoaffective Disorder, Edema (swelling) , Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), Morbid Obesity (more than 80 to 100 pounds above their ideal body weight), Paranoid Personality Disorder (a mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason to be suspicious) , Pervasive Developmental disorder (characterized by delays in the development of social and communication skills) , Insulin dependent Diabetes Mellitus, Anxiety, Schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly).

Review of the resident's medical record showed:
-No completed MDS in the resident chart.
-No care plan in his/her chart.

3. Review of Resident #80 Face sheet showed:
-He/she admitted to the facility on 5/8/24
Diagnoses of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions.), difficulty walking, Cognitive Communication Deficit (difficulty understanding what is said, or inability to respond in a timely fashion), Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), seizures (a sudden, uncontrolled burst of electrical activity in the brain), dermatitis (a common condition that causes swelling and irritation of the skin) , Kidney failure (a condition in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 636	Continued From page 24 which one or both of your kidneys no longer work on their own), Schizoaffective Bipolar type (a mental disorder characterized by episodes of mania (extreme highs) and sometimes major depression (severe lows)). Review of the resident's medical record showed: -Entry tracking record completed 5/8/24 -No completed MDS in the resident chart. -No care plan in his/her chart. 4. During an interview on 05/30/24 at 10:00 A.M. the MDS Coordinator said: -Admission MDS Assessments should be completed within 14 days and submitted within 21 days. -If the MDS was started it would show in progress in the medical record. During an interview on 05/30/24 at 4:10 P.M. with the Director of Nursing and the Administrator : -The DON said admission MDS should be completed in 14 days. Residents who admitted on May 7th, 8th, or 9th should have had a completed MDS. -The administrator said residents should have had a MDS completed within 14 days of admission.	F 636		
F 656 SS=E	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	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 656	Continued From page 25	F 656		

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 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 656	Continued From page 26	F 656		

Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents, for three of 14 sampled residents (Residents #8, #78 and #80). The census was 53.

Review of the facility provided Minimum Data Set and Care Planning Guidelines, dated 10/1/2015 showed:
It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, any published Interim RAI manual errata documents and applicable federal guidelines as the authoritative guide for completion of the MDS, CAAs and resident care planning.

1. Review of Resident #8 Admission MDS 5/1/24 showed:
-Admission date of 4/24/24;
-Brief Interview of Mental Status (BIMS) of 14, indicated No cognitive deficits.
-Vision was severely impaired , he/she wore corrective lenses;
-Assist of 1-2 staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself);
-Continent of bowel and bladder;
-Diabetic foot ulcers (wounds that are caused by the diabetes disease process);
-Pressure reduction devices for the bed and chair;
-Diagnoses of Unspecified fracture of right acetabulum (broken hip), fracture of the great toe, repeated falls, Constipation, Anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 656	Continued From page 27	F 656		

to interfere with one's daily activities), depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities), chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe.), hemiplegia (muscle weakness or partial paralysis on one side of the body) and hemiparesis (inability to move on one side of the body) following cerebral infarction (stroke), hypertension, Diabetes Mellitus (A group of diseases that result in too much sugar in the blood) with diabetic neuropathy (nerve damage that can occur if you have diabetes), chronic kidney disease(CKD: gradual loss of kidney function.), atrial fibrillation (a rapid and irregular heart beat), and peripheral vascular diseases (condition in which narrowed blood vessels reduce blood flow to the limbs).

Review of the medical record showed no comprehensive care plan for Resident #8.

2. Review of Resident #78 Face sheet showed:
-He/She admitted to the facility 5/7/24;
-Diagnoses of Schizoaffective Disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), edema (swelling) , Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), morbid obesity (more than 80 to 100 pounds above their ideal body weight), paranoid personality disorder (a mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason to be suspicious) , pervasive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 656	Continued From page 28	F 656		

developmental disorder (characterized by delays in the development of social and communication skills), insulin dependent Diabetes Mellitus lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels). anxiety, schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly).

Review of the resident's medical record showed:
-No completed MDS in the resident chart.
-No care plan in his/her chart.

3. Review of Resident #80 Face sheet showed:
-He/she admitted to the facility on 5/8/24;
Diagnoses of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions.), difficulty walking, cognitive communication deficit (difficulty understanding what is said, or inability to respond in a timely fashion), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye), Parkinson's Disease, seizures (a sudden, uncontrolled burst of electrical activity in the brain), dermatitis (a common condition that causes swelling and irritation of the skin) , kidney failure (a condition in which one or both of your kidneys no longer work on their own), and schizoaffective bipolar type (a mental disorder characterized by episodes of mania (extreme highs) and sometimes major depression (severe lows)).

Review of the resident's medical record showed:
-Entry tracking record completed 5/8/24
-No completed MDS in the resident chart.
-No care plan in his/her chart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 656	Continued From page 29 During an interview on 05/30/24 at 10:00 A.M. the MDS Coordinator said: -Admission MDS Assessments should be completed within 14 days and submitted within 21 days. -If the MDS was started it would show in progress in the medical record. -Care Plans are completed after the MDS, within 7 days. During an interview on 05/30/24 at 4:10 P.M. with the Director of Nursing and the Administrator: -The DON said admission MDS should be completed in 14 days. Care plans are completed 7 days after the MDS is completed. -The administrator said residents should have had a MDS completed within 14 days of admission and a care plan within another 7 days. The process is 21 days total.	F 656		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 726	Continued From page 30	F 726		

needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to train staff to adequately care for one resident (Resident #179) with behavioral health care needs, causing Resident #22 to feel unsafe within the facility. The facility census was 53.

The facility did not provide a policy on education and competency.

Review of education records for Certified Nurse Aide (CNA) A and B for August 2023-May 2024 showed no education on psychiatric illness and interventions.

1. Review of Resident #179 medical record showed:
-Admitted on 5/17/24;
-Diagnoses of: Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Post Traumatic Stress Disorder (a mental health condition that's triggered by a terrifying event -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 726	Continued From page 31	F 726		

either experiencing it or witnessing it), Autism (developmental disorder that affects how people interact with others, communicate, learn, and behave);
-No base line care plan, no comprehensive care plan, no Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff).

2. Review of Resident #22 Annual MDS dated 2/13/24 showed:
-Brief Interview of Mental Status (BIMS) of 12, indicated slight cognitive loss;
-No behaviors;
-Maximum assistance to dependence on staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself);
-Diagnoses of Cerebral Palsy (a group of conditions that affect movement and posture; caused by damage that occurs to the developing brain, most often before birth), Anxiety (a feeling of fear, dread and uneasiness), Hypertension (high blood pressure) and spastic quadriplegia (a permanent nerve and muscle disorder causing limitations with severe involvement of the legs and arms and floppiness of the neck.);

3. Observation on 05/28/24 at 1:15 P.M. showed
-Resident #179 was pacing the 200 hall;
-He/She was yelling loudly, and cursing into the telephone;
-Multiple residents were sitting in the dining room, completing the noon meal, and watching resident #179;
-CNA A was sitting at a dining table assisting residents to eat and observed resident #179 multiple times, and did not respond;
-CNA B was sitting at a dining table assisting residents to eat and observed resident #179

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 726	Continued From page 32	F 726		

multiple times and did not respond;
-Resident #22 asked CNA B if he/she could assist him/her to his/her room.
-CNA B assisted Resident #22 to his/her room and returned to the table. He/She did not respond to resident #179 pacing, cursing and yelling.

During an interview on 5/29/24 at 9:34 A. M . Resident #22 said:
-He/She had to be taken from the dining room because it was too loud and upsetting.

During an interview on 5/29/24 at 11:04 A.M. CNA C said:
-He/She transferred to this facility from another facility;
-He/She had a quick reminder of how to use gloves and infection control prior to moving to the facility;
- He/She did not get any further training.

During an interview on 5/29/24 at 11:17 A.M. CNA A said:
-He/She has been working at the facility for the last 8 to 9 months;
-He/She was not provided any education on care of residents with psychiatric conditions;
-He/She was sitting at the middle table when Resident #179 got upset and was yelling;
-He/She did not do anything because he/she did not know what to do;
-He/She was afraid to say anything to Resident #179 in case he/she flipped out;
-It was really over stimulating. Resident #22 was crying and had to be taken to his/her room and did not finish his/her meal.

During an interview on 5/30/24 at 11:31 A.M. CNA B said:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 726	Continued From page 33 -He/She was at a dining room table when resident #179 was pacing, yelling and cursing on the phone; -He/She did not know what to do to intervene; -He/She had no training for behavior management and psychiatric conditions. During an interview on 5/30/24 at 4:10 P.M. with the Administrator and the Director of Nursing (DON): The Administrator said: - Staff absolutely need training how to deal with agitated residents and psychiatric disorders; -He/She is unsure what education staff have completed; - Registered Nurse A completes all education; -He/She and the DON will track all training; -He/She expects competency to be completed at least every 12 months, or quarterly as needed for issues. The DON said: He/She did not know what education had been completed prior to his/her arrival last week; -Competency should be completed annually.	F 726		
F 812 SS=F	MO236514 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.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 812	Continued From page 34	F 812		

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure staff stored food in a sanitary manner and failed to maintain the kitchen in a sanitary manner when floors, and vents were covered in dirt and debris, and when equipment in the kitchen was covered in dust and when the dry storage contained outdated food and hazardous chemicals and when the facilty failed to ensure the dishwasher sanitizer was checked before meal service. This could potentially impact all residents by dirt or debris coming in contact with food and food preparation areas and food being served on contaminated dishes. Additionally outdated food can be potentially hazardous due to spoilage. The facility census was 53.

Review of the facility's Safe Food Handling Policy, dated 5/20/15, showed:
-All food items should be stored and tightly sealed with an identifying label and date.

Review of the facilty's Storage of Dry Food and Supplies Policy, dated 5/20/15, showed:
-The store room must be neat and orderly;
-Store chemicals in an area separate from food storage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 812	Continued From page 35	F 812		

Review of the facilty's Dish Wash Policy, dated 5/20/15, showed:
-Check chemical dispensers for adequate supply of chemical three times a day.

The facilty did not provide the requested policy on cleaning of the vents in the kitchen.

1. Observation on 05/29/24 at 10:44 A.M., showed:
- An open package of noodles dated 2024;
-Vent by the plastic storage container with the cleaning rags was covered with dust and debris;
-Trash can between the refrigerators was open and overflowing with food particles running down the sides;
-Two empty card board boxes, a fan covered with dirt and debris, a bucket containing a black liquid with a mop standing in it next to a food storage rack;
-A vacuum cleaner and scattered papers on the floor in front of the storage rack that contained Graham crackers coffee and cocoa;
-A step ladder covered with dust setting next to the refrigerator;
-The dishwasher sanitation log had no entries on 4/7/24, 4/24/24, 4/25/24. 4/31/24 and 5/9/24 through 5/29/24.
-The floor in the dry storage room was dirty and sticky;
-The trash can in the dry storage room was overflowing:
-There was a can of unopened bleach powder and three gallons of germicidal bleach setting on a rack in the dry storage where other foods were stored;
- Storage bin with sugar dated 3/15/22 and a storage bin containing flour dated 2/22/22;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 812	Continued From page 36	F 812		

-Open package of rice with no date.

During an interview on 5/29/24 at 1:22 P.M., the Dietary Manager (DM) said:
- Maintenance is responsible for cleaning the vents in the kitchen;
-He/She puts a maintenance order either in the binder or by word of mouth and that is how it is reported;
-The vents should be cleaned at least every two or three months. He/She cleaned the vents the last time they were cleaned but could not remember when;
-There should be no sticky substances on the floors in the kitchen;
-Chemicals shouldn't be stored with food in the dry storage room;
-The trash can should not be overflowing in the kitchen or in the dry storage room and the lid to the trash can should be closed. The trash cans should be clean free of food debris and dripping debris;
-The stepladder should not be in the kitchen and if it is it should be clean;
-The vacuum, the box fan covered in dust, the brooms and debris on the floor by where the Graham crackers were stored shouldn't be in the kitchen;
-The sanitizer for the dishwasher should be checked three times a day before meal service;
-The bins with the sugar and the flour in the dry storage should not be dated older than one year.

During an interview on 5/29/24 at 1:50 P.M., the Registered Dietitian (RD) said:
-He/She expected the kitchen to be clean and free of dirt and debris;
-He/She expected the vents to be clean and free of debris and chemicals should not be stored in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 812	Continued From page 37 the dry storage room with food; -The trash should be emptied before it becomes overflowing the trash can lid should not stand open; -The dates on the sugar and flour should not be later than one year; -He/She expected the sanitizer concentration in the dishwasher to be recorded before every meal service; -The unnecessary clutter of the fan, the empty boxes and the brooms should be removed from the kitchen; -He/She expected the kitchen to be clean and sanitary. During an interview on 5/29/24 at 2:14 P.M., the maintence department said: -He/She was not sure how often the vents should to be cleaned in the kitchen; -The kitchen staff takes care of cleaning the vents in the kitchen; -Any work orders for maintence are put in a book but generally are given by word of mouth; -No work orders for cleaning the vents in the kitchen have been received. During an interview on 5/29/24 at 4:10 P.M., the Administrator said: -He/She expected the kitchen staff to keep the kitchen clean and sanitary; -He/She expected the kitchen staff to make sure the food is stored properly; -He/She expected the sanitizer in the dishwasher to be checked before meals; -The kitchen staff were responsible for reporting any repairs to maintenance.	F 812		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3)	F 838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 838	Continued From page 38	F 838		

§483.70(e) Facility assessment.
The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

(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 838	Continued From page 39	F 838		

and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to review and update their facility-wide assessment to determine what resources are necessary to care for their residents competently during day to day operations and emergencies. The facility census was 53.

The facility did not provide the requested policy regarding maintaining a facility assessment.

1. Review of the facility's 802/Matrix (a tool used by facilty staff to identify pertinent care areas for residents living in the facilty), dated 5/27/24 showed:
-32 residents with behavior health needs;
-The facilty census was 53.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 838	Continued From page 40 Review of the facility assessment, provided by the facility, showed: -The name of the administrator was incorrect; -Assessment review date with the Quality Assurance and Assessment/ Quality Assurance and Performance Improvement (QAA/QAPI) committee was 12/14/22; -Annual review date was 2/2/23; -The average daily census was 20; -Three residents with behavior health needs; -The information provided was incorrect. During an interview on 5/30/2024 at 4:10 P.M., the Administrator said: - The facility assessment has not been updated to reflect recent changes at the facility, including change of administrator; -The facility assessment should be completed within seven to fourteen days after a change; - It is the Administrator's responsibility to ensure the facility assessment is reviewed regularly and updated as needed.	F 838		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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F 880	Continued From page 41	F 880		

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
(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.

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	265706	A. BUILDING _____ B. WING _____	05/30/2024

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F 880	Continued From page 42	F 880		

§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 and interviews the facility failed to maintain infection control when two of 14 sampled resident's (Resident #177 and #178), nebulizer machines (a machine that turns liquid medication into a mist and is inhaled) and tubing were resting on the floor without a barrier. Additionally Resident #178's continuous positive airway pressure (CPAP) mask was observed resting on the floor and not on a barrier. The facility census was 53.

The facility did not provide a policy regarding placement of nebulizer machines and CPAP mask's.

1. Review of Resident #177 record showed the following:
-The resident was admitted to the facility on 5/9/24;
- Diagnoses included: Chronic obstructive pulmonary disease (COPD, a group of diseases that affects breathing), cough, and anxiety;
- No Minimum Data Set (MDS, a federally mandated assessment completed by the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 880	Continued From page 43	F 880		

staff) or care plan had been completed;
- A physicians order dated 5/21/24 for ipratropium- albuterol (a medication used to help make breathing easier and administered with a nebulizer machine) solution for nebulization 0.5 milligram (mg) -3 mg per vial. Administer 1 vial with the nebulizer machine every 6 hours as needed.

Observation on 5/28/24 at 9:43 A.M. showed the resident's nebulizer machine sitting directly on the floor. The tubing and mouthpiece were lying on the floor. There was no barrier.

During and interview and observation on 5/29/24 at 7:57 A.M. showed:
- The resident's nebulizer machine on the floor with the tubing and mouth piece on the floor;
- The resident said the nebulizer on the floor was the most convenient place for him/her because he/she did not have a table to set the nebulizer machine on;
- If he/she had a table, he/she would store it on the table.

2. Review of Resident #178's record showed the following:
- The resident was admitted to the facility on 5/16/24;
- Diagnoses included: Shortness of breath, cough and anxiety;
- The resident's baseline care plan showed the resident used a CPAP machine;
- No MDS or comprehensive care plan;
- Physician's order dated 5/26/24 for ipratropium-albuterol 0.5 mg-3 mg per vial. Give 1 vial with a nebulizer machine every 6 hours as needed;
- Physician's order dated 5/16/24 to clean the

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	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 880	Continued From page 44 CPAP weekly on Sundays, including the head gear and tubing, filter, and distilled water chamber. Observation on 5/28/24 at 9:08 A.M. showed: - The resident's nebulizer machine, tubing and mouth piece on the floor with no barrier; - The resident's CPAP mask was lying on the floor with no barrier. Observation on 5/29/24 at 10:22 A.M. showed: - The resident's CPAP mask on the floor without a barrier; - The resident's nebulizer machine and tubing was lying on the floor with no barrier. During an interview on 5/29/24 at 11:00 A.M. the resident said he/she stored the nebulizer machine and his/her CPAP mask on the floor because he/she did not have a table to store them on. 3. During an interview on 5/30/24 at 9:3.1. the Infection Preventionist said: - He/She expected all nebulizer machines with their tubing and CPAP masks to be off of the floor; - There should be an elevated surface available for the resident to store those items; - Nebulizer tubing, mouth pieces and CPAP masks should not touch the floor and should be wrapped in a disposable bag. During an interview on 5/30/24 at 4:10 P.M., the administrator and Director of Nursing (DON) said nebulizer machine, tubing and CPAP masks should be in a bag and not on the floor.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)	F 947		

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	265706	A. BUILDING _____ B. WING _____	05/30/2024

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CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 947	Continued From page 45	F 947		

§483.95(g) Required in-service training for nurse aides.
In-service training must-

§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

§483.95(g)(2) Include dementia management training and resident abuse prevention training.

§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year, failed to provide nurse aide's annual individual performance review or evaluation and competency,and failed to implement a tracking system for monitoring training hours. This effected two of two sampled nurse aides (Certified Nurse Aide; (CNA) D and CNA E) and had the potential to effect all staff and residents. The facility's census was 53.

The facility did not provide a policy on education and competency.

1. Record review of the in-service records for

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	265706	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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F 947	Continued From page 46 CNA D showed: - A hire date of 6/15/2021; -Had less than twelve hours of in-service education per year; -No annual competency for 2023. 2. Record review of the in-service records for CNA E showed: -A hire date of 11/3/2023 with a previous hire date of 4/10/2014; -Had less than twelve hours of in-service education; -No annual competency. During an interview on 05/30/24 at 4:10 P.M. with the Director of Nursing and the Administrator said: -The Administrator said she started work at this facility a week ago; -Staff absolutely need training, particularly on how to deal with psychiatric illness and behaviors; -Registered Nurse (RN) A puts out booklets for education he/she wants the staff to have; -The DON and she will track training; -Competency should be completed annually or quarterly if there was an issue; -The DON said she began working at the facility a week ago; -She was not sure what education had been provided previously; -There was no tracking system for individual staff; -Competency should be completed at least yearly or as needed.	F 947		

Missouri Department of Health and Senior Services

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	22027	A. BUILDING: _____ B. WING _____	05/30/2024

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A4026	19 CSR 30-85.042(22) In-service Training-Nursing Personnel The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs related to problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency. II/II This regulation is not met as evidenced by: Class II* The higher classification merited due to the impact when combined with other deficiencies. Please refer to F726 and F947 MO236514	A4026		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Please refer to F880	A4086		

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	22027	A. BUILDING: _____ B. WING _____	05/30/2024

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	22027	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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A4108	Continued From page 1	A4108		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to extent of the violation. Please refer to F559	A4108		
A7016	19 CSR 30-87.030(14) Food-Clean Containers, Storage, Covers Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be stored in a clean covered container except during necessary periods of preparation or service. Container covers shall be impervious and nonabsorbent except that linens or napkins may be used for lining or covering bread or roll containers. III This regulation is not met as evidenced by: Class II* *The higher classification merited due to extent of the violation. Please refer to F812	A7016		

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	22027	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL HOUSE	307 GRAND CARROLLTON, MO 64633

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A8010	Continued From page 2	A8010		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to extent of the violation. Please refer to F578	A8010		

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A8013	Continued From page 3	A8013		
A8013	19 CSR 30-88.010(13) Right to Plan Care/Refuse Treatment Each resident shall be afforded the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment and to participate in experimental research only upon his or her informed written consent. If a resident refuses treatment, this refusal shall be documented in the resident's record and the resident, his or her legally authorized representatives or designees, or both, shall be informed of possible consequences of not receiving treatment. II This regulation is not met as evidenced by: Class II 1. Refer to F656	A8013		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to extent of the violation and effect on the resident.	A8030		

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A8030	Continued From page 4 1. Please refer to F550 MO236514	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Carroll House
Street Address, City, Zip:	307 Grand Carrollton, MO 64633
Date of Survey:	Completed 05/30/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This Plan of Correction (POC) is submitted under State and Federal Law. The submission of this POC does not constitute an admission on the part of Carroll House (the facility) as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The Facility's submission of this POC does not constitute the submission of Carroll House that the findings cited are accurate, constitute a deficiency, or that the scope and severity regarding the deficiencies cited are correctly applied. The POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date listed in the POC. Compliance will be maintained as provided in the POC. Date of Alleged Compliance: July 12, 2024	07/12/2024
F 550	The facility will provide a dignified existence for all residents, including resident #11 and #24. Resident #2 has been discharged. All residents are considered at risk of the alleged deficient practice. All residents have been given information related to resident rights. The Social Service Designee (SSD) has met with the residents to discuss behaviors that might be offensive to others, cause other residents stress, anxiety or fear such as: improper fitting clothing, yelling in the dining area during mealtime at peers and staff, and acceptable parameters when in the dining area. Residents will be asked not to approach the kitchen staff during meals for their needs, instead to ask facility staff in dining area if they need something from the kitchen. The SSD has notified the resident guardians for clothing needs. All residents will be monitored daily by the charge nurse for	07/12/2024

E McDonald Administrator 6/25/24

	proper fitting clothing, maintaining acceptable noise levels and not yelling at one another or staff during meal times. If/when the residents display offensive behaviors they will meet with the Life Skills Instructor to discuss acceptable boundaries of behavior. If behavior continues without improvement the staff will initiate a care plan meeting with guardian. The SSD will meet with the residents monthly during resident council and will discuss any concerns over meal time process related to offensive behaviors. The process will be ongoing. The Administrator will ensure any concerns are immediately addressed. The SSD will provide a quarterly resident rights report to the QAA committee and will follow guidance and recommendations as given by the Medical Director and Administrator. Date of Alleged Compliance: July 12, 2024	
F 559	The facility will provide written notice regarding a room change, including the reason for the room change prior to move, for all residents including resident #3, #11 and #24. Resident #2 has been discharged. All residents are considered at risk of the alleged deficient practice. The SSD has been inserviced by the Administrator regarding the written notice for room moves requested by staff to include: written explanation in writing of why move is required given to the resident, family and/or resident representative. The notice will also include the effective date and location of new room. The residents will be provided the opportunity to see new location, meet new roommate and ask questions about the move. Documentation of the notice and resident response will be maintained in the medical record. The SSD has received the written room move notice from the Administrator and will utilize if and when the facility staff initiates a room move. The SSD will meet with the residents monthly during resident council related to resident rights being maintained related to room moves. The Administrator will ensure any concerns are immediately addressed. The SSD will provide a quarterly report to the QAA committee related to proper initiation of room moves and maintaining resident rights. The SSD will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024
F 578	The facility will ensure resident directives for Do Not Resuscitate	07/12/2024

	(DNR) are accurate as directed by resident and/or resident responsible party, for all residents, including resident #11. All residents are considered at risk of the alleged deficient practice. Resident #11 code status has been updated to reflect Full Code status. The SSD has completed an audit of all Outside Hospital Do Not Resuscitate forms, face sheets and physician order sheets to monitor for any discrepancy and to ensure 100% accuracy. If/when a resident changes their resuscitation directive the DON will ensure it is promptly changed on the face sheet and resident orders, as well as the green/red dots so staff will understand what to do in the event of resident death. The DON or designee will reconcile all resident code status directives monthly during facility end of the month paperwork changeover to ensure 100% accuracy is maintained. The SSD will provide a quarterly report to the QAA committee related to resident code status and will follow recommendations and guidance as given by the Administrator and Medical Director. Date of Alleged Compliance: July 12, 2024	
F 584	The facility will provide a comfortable and home-like environement for all residents including resident #11, #22 and #24. Resident #2 has been discharged. All residents are considered at risk of the alleged deficient practice. All residents have been given information related to resident rights. The Social Service Designee (SSD) has met with the residents to discuss behaviors that might be offensive to others, cause other residents stress, anxiety or fear such as: yelling in the dining area during mealtime at peers and staff, and maintaining acceptable parameters when in the dining area. Residents will be asked not to approach the kitchen staff during meals for their needs, instead to ask facility staff in dining area if they need something from the kitchen. The facility staff will assist the smokers when going outdoors to prevent the door from slamming shut. Resident #179 will be given a private area for phone calls. All residents will be monitored daily by the charge nurse for maintaining acceptable noise levels and refraining from yelling at peers and staff.	07/12/2024

	If/when the residents display offensive behaviors they will meet with the Life Skills Instructor to discuss acceptable boundaries of behavior. If behavior continues without improvement the staff will initiate a care plan meeting with guardian. The process will be ongoing until all residents feel comfortable with one another. The SSD will meet with the residents monthly during resident council and will discuss any concerns over meal time process, yelling in halls, doors slamming, or any other offensive behaviors. The Administrator will ensure any concerns are immediately addressed. The SSD will provide a quarterly resident rights report to the QAA committee and will follow guidance and recommendations as given by the Medical Director and Administrator. Date of Alleged Compliance: July 12, 2024	
F 636	The facility will assure resident Minimum Data Set (MDS) assessments are completed accurately and timely for all residents, including resident #177, #78 and #80. All residents are consideded at risk of the alleged deficient practice. The MDS Coordinator has been inserviced by the DON regarding timeliness of MDS completion. Resident #177, #78 and #80 MDS were completed prior to survey exit. Care plans will be kept in care plan book for staff review at any time and will be updated with change. The DON will audit MDS completion a minimum of once weekly to ensure timely completion is achieved and maintained. The MDS Coordinator will provide a quarterly MDS assessment report to the QAA committee and will follow guidance and recommendations as given by the Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024
F 656	The facility will ensure residents have complete, accurate and individualized care plans, to address specific needs of residents, for all residents, including resident #78 and #80. Resident #8 has been discharged. All residents are considered at risk of the alleged deficient practice. The MDS Coordinator has been inserviced by the DON related to timeliness of care plan completion. Resident #78 and #80 have completed care plans. The facility care plans are kept in a binder for review by the	07/12/2024

	facility staff. The DON will assist the MDS coordinator in maintaining a care plan due calendar and will ensure care plans are completed in a timely manner. The DON will monitor care plan completion a minimum of once weekly to ensure complainace is maintained. The MDS Coordinator will provide a care plan report to the QAA committee quarterly and follow recommendations as given by the Administrator. Date of Alleged Compliance: July 12, 2024	
F 726	The facility will train staff to adequately care of all residents with behavior needs, including resident #179. All residents are considered at risk of the alleged deficient practice. All direct care staff have been inserviced on caring for residents with psychiatric illnesses and interventions to care for them. Training will be upon hire, as needed and annually thereafter. Specific resident interventions will be listed in each individualized care plan. The Life Skills Instructor will establish acceptable boundaries with residents regarding their behavior in public area. Resident #179 will be given a private area to make or receive phone calls as well as strategies on how to speak to others without yelling and cursing. The Administrator will assign a department manager to monitor meals daily when scheduled to ensure the dining process is not over stimulating for any resident, to ensure compliance is achieved and maintained. If any resident is non compliant with behavioral expectations the Life Skills Instructor will set up a care plan meeting with guardian and continue working individually with each resident until behaviors are acceptable in a public area. The Life Skills Instructor will provide a quarterly report to the QAA committee related to resident behaviors and will follow recommendations and guidance as given by the Medical Director and Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024
F 812	The facility will ensure the staff stores food in a sanitary manner, maintains kitchen in a sanitary manner including maintaining clean floors and vents free of dirt and debris & equipment will remain free of dust. The dry food storage will contain no outdated items. Hazardous chemicals will not be stored with food. The dishwasher sanitizer will be checked befoe meal service. All residents are considered at risk of the alleged deficient practice.	07/12/2024

	The dietary department has been inserviced by the Administrator and Dietary Manager related to maintenance cleaning of floors, vents, equipment, storage of chemicals, monitoring for outdated food items and checking sanitizer in dish machine. The vents by plastic storage container has been cleaned and will be maintained. The trash can between the refrigerators will remain closed when not in use. The outside of trash can where food spilage is evident has been cleaned and will be maintained. The empty card board boxes have been thrown away. The fan has been cleaned and removed from the kitchen. Mop buckets will be emptied and properly stored when not being used. The vacuum cleaner has been put in housekeeping storage area. The scattered papers on floor have been discarded. The step ladder has been cleaner and will be properly stored. The floor in the storage area has been cleaned and will be maintained. The trash can in dry storage will be emptied timely. The bleach powder and germicidal bleach will be stored with other chemicals and not in the food area. The outdated sugar and flour have been discarded. The undated rice has been discarded. The Dietary Manager has created a cleaning schedule and will monitor daily when scheduled to ensure compliance is achieved and maintained. The Dietary Manager will also monitor for hazardous chemical storage, monitor for outdated food items, ensure the dish machine sanitizer is checked daily when scheduled and will monitor for housekeeping items in kitchen and remove if/when found. The Administrator will monitor the kitchen for compliance once weekly to ensure compliance is achieved and maintained. The Dietary Manager will provide a quarterly sanitation report to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: July 12, 2024	
F 838	The facility will ensure the facility-wide assessment remains up to date to ensure necessary resources are available to care for	07/12/2024

	their residents in the event of an emergency. All residents are considered at risk of the alleged deficient practice. The facility assessment has been updated to include but is not limited to: name of current administrator, change in census, annual review date, QAA/QAPI date and behavioral health needs, and will be maintained. The Administrator will ensure the facility assessment is updated once annually or with change. The facility assessment will be reviewed once quarterly at the QAA meeting and will be updated as needed and reviewed a minimum of annually. The Administrator will provide a quarterly facility assessment report during the QAA meeting and will strategize with staff to ensure all resident needs will be met in the event of an emergency. Date of Alleged Compliance: July 12, 2024	
F 880	The facility will ensure infection control practices are maintained for all residents with nebulizer and CPAP machines, including resident #177 and #178. All residents that utilize a nebulizer or CPAP are considered at risk of the alleged deficient practice. All licensed nurses and CMT's have been inserviced by the Infection Preventionist nurse related to proper cleaning and storage of nebulizer mask and tubing and CPAP mask and tubing after each use. The nurse on duty will monitor a minimum of once each shift to ensure proper storage of nebulizer and CPAP masks and tubing to ensure compliance is achieved and maintained. The nursing assistants and house keepers will be instructed to report if resident CPAP or nebulizer tubing/mask is not properly stored to the charge nurse. The Infection Preventionist nurse will make rounds a minimum of 2 times weekly thereafter to ensure compliance is maintained. The Infection Preventionist will educate the residents with CPAP and Nebulizer machines about the importance of cleaning masks and storing tubing and mask when not in use. The Infection Preventionist will provide a quarterly Infection Prevention report to the QAA committee and will follow recommendations and guidance as given by the DON and Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024

F 947	The facility will ensure nurse aide training education is 12 hours per year with performance review or evaluation and competency, with a tracking system for monitoring training hours. All residents are considered at risk for the alleged deficient practice. The DON has implemented an annual inservice training for all staff including nurse assistants which will include evaluation and competency and a tracking system for logging all training hours, which will be put into place for all existing employees and will be implemented upon hire for all new staff. The DON will ensure all nursing assistants have 12 hours of training annually. The Administrator will monitor the monthly attendance log to ensure all nurse assistants have attended the inservice to ensure compliance is maintained. Any nurse assistant that has not attended required training will be required to attend another session to maintain compliance with the regulation. The DON will provide a quarterly report on staff training to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024
K 321	The facility will ensure the area under stairwell will be remain free of hazards. Popane and lighter fluid will not be stored next to the building. All residents are considered at risk of the alleged deficient practice. The boxes have been removed from under the stairwell and the area will remain free of anything being stored there. The propane tank and lighter fluid have been properly stored in storage shed away from the building. The Maintenance Supervisor will ensure the propane tank and lighter fluid remain in the storage shed nbvcx swdcand the stairwell remains free of storage daily during facility rounds, when scheduled. Once compliance is achieved the Maintenance Supervisor will monitor areas for hazards a minimum of once weekly thereafter to ensure compliance is maintained. The Maintenance Supervisor will provide a quarterly plant maintenance report to the QAA committee and will follow guidance and recommendations as given by the Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024

K 353	The facility will ensure all sprinkler heads are free from penetrations to the attic. All residents are considered at risk of the alleged deficient practice. The missing escutcheon plates in the mechanical room next to room 108, in the mechanical room by room 311, in the mechanical room by room 310 and in the mechanical room by room 406 have all been replaced to prevent penetration to attic spaces, and will be maintained. The Maintenance Supervisor will continue to make weekly rounds to assess for any missing escutcheon plates and schedule outside maintenance to come replace if/when needed to ensure compliance is achieved and maintained. The Maintenance Supervisor will provide a quarterly plant maintenance report to the QAA committee and will follow guidance and recommendations as given by the Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024
K 511	The facility will ensure at least 36 inches of clearance in front of breaker boxes. All residents are considered at risk of the alleged deficient practice. The boxes in front of the kitchen breaker box have been removed and will be maintained. Items in front of breaker box in mechanical room by room 402 have been removed and will be maintained. The Maintenance Supervisor will continue to make weekly rounds to assess for proper breaker box clearance to ensure compliance is achieved and maintained. Non-compliance will be addressed with the staff if/when discovered. The Maintenance Supervisor will provide a quarterly plant maintenance report to the QAA committee and will follow guidance and recommendations as given by the Administrator. Date of Alleged Compliance: July 12, 2024	07/12/2024
K 741	The facility will ensure cigarette butts and not combined with trash in the self-closing container for cigarette butts/ashes. All residents are considered at risk of the alleged deficient practice. All staff have been inserviced by the Administrator regarding combustibles in cigarette butt container. The Maintenance Supervisor will monitor the cigarette containers a minimum of once daily x 2 weeks when scheduled,	07/12/2024

	to ensure compliance is achieved and 2 times weekly thereafter to ensure compliance is maintained. The Maintenance Supervisor will inform the Administrator if and when non-compliance is discovered. Retraining will occur if/when necessary. The Maintenance Supervisor will provide a quarterly plant maintenance report to the QAA committee and will follow guidance and recommendations as given by the Adminsitrator. Date of Alleged Compliance: July 12, 2024	
K 920	The facility will ensure safe electrical wiring. The facility will prohibit extension cords as permanent wiring, plugged into a surge protector, into another surge protector and plugged into medical equipment. All residents are considered at risk of the alleged deficient practice. The following items have been removed: The ten port USB hub in room 213 The power strip into the electric lift chair Te extension cord in room 302 with a lamp plugged into it The extension cord in room 300 with the DVD player plugged in The 2 surge protectors in maintenance shop plugging in power tools The Maintenance Supervisor will monitor for improper extension cords and surge protectors weekly during rounds and will replace with UL approved items if and when discovered to ensure compliance is achieved and maintained. The Maintenance Supervisor will provide a quarterly plant maintenance report to the QAA committee and will follow guidance and recommendations as given by the Administrator. Date of Alleged Compliace: July 12, 2024	07/12/2024
A 4026	See F 726 and F 947	07/12/2024
A 4086	See F 880	07/12/2024
A 4108	See F 559	07/12/2024
A 7016	See F 812	07/12/2024
A 8010	See F 578	07/12/2024
A 8013	See F 656	07/12/2024
A 8030	Refer to F 550	07/12/2024

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.