STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265294	A. BUILDING _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CARROLLTON	300 LIFE CARE LANE 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 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide acceptable a sink accommodation for one resident (Resident #14) to the hot water at his/her sink and failed to provide transfer assistance for one resident so they could eat (Resident #156). This affected two of 15 sampled residents. The facility census was 58. Review of facility policy Activities of Daily Living (ADLs), revised 2/12/24, showed: - The resident will receive assistance as needed to complete ADLs. - Any change in the ability to perform ADLs will be reported to the nurse; - Assist residents with bed repositioning as necessary to promote good body alignment; Review of facility policy Resident Rights, revised 9/10/24, showed: - 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; - The resident has the right to reside and receive services in the facility with reasonable accommodation of resident and preferences;	F 558	Please see Attached	

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

EXECUTIVE DIRECTOR 21 May 25

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

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F 558	Continued From page 1 - 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; 1. Review of Resident #14's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/18/25, showed: - Resident is cognitively intact; - Resident is dependent on a wheelchair for mobility; - Resident has limited range of motion on both sides of body for the lower and upper extremities; - Resident requires set up assistance for eating and oral hygiene; - Resident is dependent for toileting, showering and dressing; - Resident requires substantial assistance by staff for personal hygiene; -Diagnoses: Cerebral Palsy. Review of Care Plan, revised 1/9/25, showed: - Resident requires up to total assist with ADLs due to Cerebral Palsy; - Resident has his/her own teeth. Place toothpaste on his/her toothbrush and provide basin. Resident is able to brush own teeth; - Staff should encourage resident to perform tasks that he/she is able to do, such as washing own face; - Resident uses an electric wheel chair for mobility and is able to propel self; - Resident is encouraged to make his/her room as home-like as possible; - Resident has Cerebral Palsy and has multiple contractures (rigidity of joints and shortening of tendons leading to deformity);His/her room has been adapted in some way to help resident	F 558	please See Attached	

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F 558	Continued From page 2 remain as independent as possible. Staff should encourage resident to engage in activities that will help improve coordination and encourage resident to do as much for self as possible. Observation on 4/22/25 at 2:58 P.M. showed the resident's sink had an accommodation device attached to the cold-water facet of the reisdent's sink so that the resident could turn on the cold water independently. The hot water facet had no accommodation device attached that would allow the reisdent to turn on the hot water independently. During an interview on 4/25/25 at 10:13 A.M., the Resident said he/she would like to be able to use the hot water and have the choice between cold and hot like other residents. He/she is able to independently turn on the cold water because of the assistive device. He/she is unable to turn on the hot water because their is no assistance device. During an interview on 4/25/25 at 10:24 A.M., the Maintenance Supervisor said he was not aware that the resident could not utilize the hot water. Normally physical therapy will notify him if any adjustments or accommodations that need to be made for residents. He was sure he could install a device like the one installed on the cold water facet, that would allow the resident to be able to use the hot water. During an interview on 4/25/25 at 11:48 A.M., COTA (Certified Occupational Therapy Assistant) A said occupational therapy had done an assessment on the resident's room a few years ago and set them up with the accommodation to operate their cold water so the resident could	F 558	please see attached	

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F 558	Continued From page 3 brush own teeth. They never set the resident up with hot water because all they needed was cold water for teeth brushing. It would not be hard to put in another device on the sink so the resident could operate his/her hot water. Currently therapy provides care to help the resident with their arms which have restricted mobility. No assessment had been done to see if the resident can reach farther into the sink, other than to use own toothbrush. During an interview on 4/25/25 at 1:30 P.M., the Administrator and DON said: - Unless there's a safety issue involved all residents should have access to hot and cold water in their room; - Reasonable accommodations should be made so residents can operate the fixtures, drawers, and cabinets in their rooms; - Room assessments for accommodations are done by nursing staff and the therapy department; - There are no safety issues with Resident #14 that would prevent them from having hot water access in their room; 2. Review of Resident #156's Entry MDS, dated 3/31/25, showed: - No cognitive status assessment completed; - No functional abilities assessment completed; Review of resident admission record, dated 4/24/25, showed a diagnosis of Dementia and osteoarthritis (arthritis causing loss of mobility and stiffness). Review of the resident's Care Plan, dated 4/14/25, showed: - Resident chooses to eat meals in his/her room and eats independently. Staff should offer	F 558	Please See Attached	

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F 558	Continued From page 4 assistance when serving meal tray; - Resident will remain independent with transfers through next review date; - Resident has moderate cognitive impairment; - Staff should allow adequate time for resident to respond to questions. Do not rush and ask yes/no questions with simple, brief, consistent words; - Observe for physical/non-verbal indicators of discomfort or distress and follow up as needed; - Anticipate and meet resident's needs, assist with ADLs as needed; - Resident has an alteration in musculoskeletal status due to diagnoses of osteoarthritis. Observe and report complications related to arthritis such as stiffness which is usually worse on wakening, decline in mobility, or decline in self-care ability; Observation on 4/23/25 at 8:30 A.M., showed: - Resident lying on his/her back struggling to raise to a sitting position with a grimace of facial pain; - A bedside table with their breakfast tray sitting on it and out of reach for the resident; - Resident's call light is out of reach, underneath the resident's blanket which is turned down; During an interview on 4/23/25 at 8:32 A.M., the resident said: - Breakfast was delivered to his/her room about 15 minutes ago; - He/she was not provided any help getting out of bed and was very stiff and in pain; - The staff member who originally delivered his/her food came into room to check on his/her progress and said they would get help to get the resident out of bed; - The staff member did not push the call light to alert the nursing staff and exited the room; - The resident asked the surveyor for help to get	F 558	Please See attached	

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F 558	Continued From page 5 out of bed; During an interview on 4/23/25 at 8:42 A.M., CMT B said he/she would notify the nursing staff to help the resident since he/she was currently engaged in passing medications to residents in the hall. Observation on 4/23/23 at 9:02 A.M., showed CNA F entering resident's room and helping him/her out of bed. During an interview on 4/23/25 at 10:57 A.M, CMT B said within 10 minutes of being notified that the resident needed help he/she told two CNAs and the charge nurse at the nurse's station about the resident's request for help. During an interview on 4/24/25 at 8:34 A.M., the resident said he/she again struggled to get out of bed this morning but he/she was able to do it after a while. Yesterday's breakfast was completely cold by the time they got to it and no one offered to replace his/her breakfast tray or to warm it up. During an interview on 4/25/25 at 1:30 P.M., the Administrator and DON said depending on other tasks and work assignments it normally should not take more than 15 minutes for staff to help transfer a resident from their bed so they can eat breakfast in their room. MO251239	F 558	Please See Attached	
F 569 SS=E	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances.	F 569	Please See Attached	

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F 569	Continued From page 6 The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide personal funds and a final accounting within thirty days upon discharge for two residents (Resident #157, Resident #53). The facility census was 58. Review of the facility policy, Resident Trust Policy and Procedures, dated 3/10/16, showed: - Conveyance of Funds after Death of Resident: After fulfilling any other authorized payments, the facility shall provide any remaining resident funds and a final statement of the resident's fund activity to the individual or probate jurisdiction administering the resident's estate. These will be provided within thirty days of the resident's death.	F 569	Please See Attached	

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F 569	Continued From page 7 1. Review of the facility's interim aging report, dated 4/23/25, showed the following residents had money in the facility's operating account: -Resident #157 discharged on 11/28/24, with a balance of $803.00. -Resident #53 discharged on 3/9/25, with a balance of $5,618.32. Review of Request for Resident Refund invoices showed: -On 12/3/24, Business Office Manager (BOM) submitted invoice #2096-1 to corporate office to refund $803.00. -On 4/23/25, BOM submitted invoice #2890-1 to corporate office to refund $5,618.32. During an interview on 4/24/25 at 9:30 A.M., the BOM said: - Resident #157's refund has been processed in the system but the check had not been released by corporate and that will occur at the end of the month; - Resident #53's overage was due to family paying rent one month ahead of time and there was a balance at the time of discharge. Corporate should have the check issued by end of month; - She said that refunds should be processed and sent to discharged residents or family members upon resident death within 30 days of discharge; - She has been in contact with the corporate office to get these refunds processed. During an interview on 4/25/25 at 1:30 P.M., the Administrator said refunds should be provided within 30 days for deceased and discharged residents when required.	F 569	please see attached	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578	please see attached	

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F 578	Continued From page 8 §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. §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	F 578	Please See Attached	

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F 578	Continued From page 9 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 ensure the Do Not Resuscitate Order's (DNR, medical order that instructs the health care provider not to do resuscitative measures if a person's heart stops) for Resident #2 and Resident #24 were correct when the guardian's name was printed on the DNR instead of the name of the resident. This affected two of 15 sampled residents (Resident #2 and Resident #24). The facility census was 58. Review of the facility's policy titled, Advanced Directives and Advance Care Planning, dated, 09/26/24, showed: -Residents have the right to self-determination regarding their medical care; -This includes the right to direct his/her own medical treatment, including the right to execute or refuse to execute an advanced directive; -The MDS should reflect the appropriate advance directives; -This information is reviewed at least quarterly. 1. Review of the Resident #2's Quarterly Minimum Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/04/25, showed: -Moderate cognitive impairment; -Partial assist for Activities of Daily Living (ADLs); -Diagnoses included, dementia, anemia and high blood pressure. Review of care plan dated 01/09/25, showed: -ADL self care deficit related to dementia; -The resident had a DNR in place;	F 578	Please See Attached	

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F 578	Continued From page 10 -Code status will be reviewed every quarter Review of the resident's medical record showed: - On 1/26/24 a physician's order for Do Not Resuscitate; -DNR showed the name of the resident's guardian printed on the line reserved for the name of the resident; -The DNR form was signed by the resident's guardian on 11/11/22 and by the physician on 11/12/22. During an interview on 04/24/25 at 02:28 P.M., Certified Nurses Aide (CNA) A said: -The nurses or the Social Services Designee (SSD) take care of getting signatures for the DNR's; -The guardian signs the DNR if the resident is incapacitated; -The name of the resident should be printed on the line designated for the resident; -The guardian's name should not be printed on the line reserved for the resident. During an interview on 04/24/25, at 02:42 P.M., Licensed Practical Nurse (LPN) A said: -The resident does not make his/her own decisions; -The resident is a DNR code status; -The name of the resident should be printed on the line designated for the resident; -The guardian's name should not be printed on the line reserved for the resident. 2. Review of Resident #24's Annual MDS, dated 04/03/25, showed: -Severe cognitive impairment; -Dependent for ADLs and transfers; -Diagnoses included dementia, anxiety and	F 578	please see attached	

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F 578	Continued From page 11 muscle weakness. Review of the resident's care plan dated 04/10/25, showed: -ADL self care deficit related to dementia; -The resident has a DNR; -Code status will be reviewed every quarter. Review of the resident's medical record showed: - On 05/20/20 a physician's order for Do Not Resuscitate; - DNR showed the name of the resident's guardian printed on the line reserved for the name of the resident; -The DNR form was signed by the resident's guardian and physician on 05/20/22. During an interview on 04/24/25 at 03:24 P.M., CNA B said: -The name of the resident should be printed on the line designated for the resident; -The guardian's name should not be printed on the line reserved for the resident; -SSD oversees the DNR forms. During an interview on 04/24/25, at 03:45 P.M., LPN B said: -The resident is a DNR code status; -The name of the resident should be printed on the line designated for the resident; -The guardian's name should not be printed on the line reserved for the resident; -SSD reviews the DNR forms. During an interview on 04/25/25 at 11:18 A.M., the SSD said: -She reviews the resident DNRs every quarter; -Resident #2 and Resident #24 are both DNR code status;	F 578	please see attached	

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F 578	Continued From page 12 -The DNR is not correct if the guardian's name is printed where the resident's name is indicated; -The responsible party signed the DNR's for Resident #2 and Resident #24 because both residents are incapacitated; -The name of the resident should not be printed on the line designated for the resident; -The DNR for Resident #2 and Resident #24 are not correct; -The DNRs for Resident #2 and Resident #24 should be correct. During an interview on 04/25/25 at 01:16 P.M. the Director of Nursing (DON) said: -The resident's name should be printed on their DNR not the name of the responsible party; -She expects the DNRs to be correct; -SSD in charge of making sure the DNRs are correct. During an interview o 04/25/25, at 01:20 P.M., the Administrator said: - She expects the name of the guardian should not be printed on the line designated for the resident; -The DNR for Resident #2 and Resident #24 are not correct; -She expects the DNRs for Resident #2 and Resident #24 should be correct.	F 578	please see attached	
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.	F 584	please see attached	

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(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 13 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; §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: Based on observation and interview, the facility failed to maintain a clean and comfortable homelike environment. This had the potential to affect all residents. The facility census was 58.	F 584	please see attached	

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	265294	A. BUILDING _____ B. WING _____	04/25/2025

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F 584	Continued From page 14 Review of the facility policy, Housekeeping Services, dated 06/04/24 showed: -The facility will provide a safe, clean and homelike environment; -The floors will be cleaned daily. Review of the facility policy, Home Like Environment, dated 06/12/24, showed: -The facility will provide a safe, clean and homelike environment; - It is the responsibility of all staff to create a homelike environment and promptly address any cleaning needs. 1. Observation on 4/23/25 at 9:34 A.M., showed: - Housekeeping completed their morning clean up of the dining room; - Handwashing station and near the standing flag in the dining room has large amounts of dirt and food debris on the floor; - Food debris and crumbs on the floor leading to the kitchen area from the dining room; - Food debris visible on the floor behind chairs lining the wall; During an interview on 4/23/25 at 9:40 A.M., Housekeeper A said: - He/she does the sweeping and moping of the dining room floor and they don't normally sweep in the corners daily, just the main part of the floor; - Monday's are deep cleaning days and that's when they work the sides of the room; 2. Review of Resident 8's Admission MDS, dated 1/28/25, showed: - Resident is cognitively intact; - Diagnosis: Anemia, renal insufficiency (kidney impairment), diabetes, and schizophrenia;	F 584	please see attached	

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F 584	Continued From page 15 Observation on 4/24/25 at 12:45 P.M., Resident' room showed: - Loose dirt all along the closet and door entrance of resident's room; - Floor extremely worn with dented marks and embedded dirt spots throughout the room; During an interview on 4/24/25 at 12:50 P.M., the Resident said: - I would prefer my room was clean but housekeeping comes in and does the job as fast as they can so they can get the job done and get out without cleaning the floors properly. 3. Review of Resident #38's Quarterly MDS, dated 3/18/25, showed: - Resident has impaired cognition ; - Diagnosis: Coronary artery disease, anemia, diabetes, and depression; Observation of the Resident's room on 4/23/25 at 7:51 A.M., showed: - Multiple dead bugs on the floor along the baseboards in resident's room; - Bathroom floor had heavy dirt and trash debris; During an observation on 4/24/25 at 1:33 P.M., showed: - Heavy loose dirt and dust build on the floor alongside the walls of the resident's room; - Floors extremely worn with pock marks and embedded dirt spots throughout the room; During an interview on 4/24/25 at 1:36 P.M., the resident said he/she would prefer that the room was clean and dust and dirt be removed on a daily basis due to his/her medical conditions. During an interview on 4/25/25 at 9:00 A.M.,	F 584	please SP attached	

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F 584	Continued From page 16 Housekeeping Supervisor said: - Housekeeping staff service resident rooms by removing the trash, wiping down all surfaces with disinfectant, spray down the windows, sweep the floors and mop the floors with a wet disposable mop head. They sweep the whole room including corners and bathrooms. Corners can be difficult due to the mop size. During an interview on 4/25/25 at 1:30 P.M., the Administrator said housekeeping staff should sweep along the baseboards and in the corners of the rooms and the facility every time they deep clean or if the area is dirty.	F 584	Please See Attached	
F 699 SS=D	MO#251239 Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide trauma informed care for one sampled resident (Resident #37) with a diagnosis of Post-Traumatic Stress Disorder (PTSD, a mental health condition that is triggered by a terrifying event). This affected one of 15 sampled residents. The facility census was 58.	F 699	Please See Attached	

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F 699	Continued From page 17 Review of the facility policy, Trauma Informed Care, dated 09/06/24 showed: -Based on the comprehensive assessment of a resident, this facility must ensure that residents who are diagnosed with a mental disorder or who have a history of trauma/or PTSD, receive appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing; -Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma; -A trauma informed approach to care recognizes the widespread impact and signs and symptoms of trauma in residents and incorporates knowledge about trauma into care plans, and practices to avoid re-traumatization; -The facility should collaborate with the resident's family, friends and any other health care professionals to develop and implement and individualized plan of care with interventions; -In situations where a trauma survivor is reluctant to share his/her history, the facility should still attempt to identify triggers which may re-traumatize the resident and develop interventions which minimize or eliminate the effect of the trigger on the resident. 1. Review Resident #37's Quarterly Minimum Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/14/25, showed: -No cognitive impairment; -Independent for Activities of Daily Living (ADLs); -Takes antipsychotic, (a class of psychiatric drugs prescribed to treat mental health conditions), medication on a routine basis; -Diagnoses included, PTSD, schizophrenia,	F 699	please see attached	

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F 699	Continued From page 18 depression and anxiety. Review of the resident's care plan dated 02/13/25, showed: -Physically aggressive toward staff; -Refuses to take all medications; -At risk of change in mood or behavior. -There was no care plan regarding PTSD or staff interventions. Review of the resident's medical record showed: -Resident admitted on 09/29/22 with a history of adult physical abuse confirmed during a subsequent encounter; -Behavior note dated 11/11/2024, at 12:36 A.M., the resident yelled out most of the night. Resident observed yelling at the T.V. Staff attempted to talk to the resident. The resident asked staff to leave the room and not return. The staff left the room and the resident could still be heard yelling through the night; -Behavior note dated 4/24/2025 at 03:35 P.M., the resident refused to take medication this morning and refused to eat lunch. Staff went into resident's room to check on him/her. The resident wouldn't talk to the staff; -Event note dated 11/01/2025 at 03:18 P.M., the resident is hollering out. The staff went into the resident's room and the resident was setting on the floor; -Physician's Order Sheet (POS) dated April 2025, showed a diagnosis of PTSD. Observation and interview on 04/23/25 at 08:43 A.M., showed: -The resident's door was closed; -Upon entering the room the resident lay in bed in with his/her eyes open; -The resident said he/she is not from this town	F 699	please see Attached	

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F 699	Continued From page 19 and then spoke unintelligible words at a fast rate of speed. Observation and interview on 04/24/25 at 11:18 A.M., showed: -The resident's door was closed; -Upon entering the room the resident lay in bed in with his/her eyes open; -The resident would not speak; -The resident looked at the ceiling and then said leave and shut the door. During an interview on 04/24/25 at 02:28 P.M., Certified Nurse's Aide (CNA) A said: -He/She did not know the resident had a diagnosis of PTSD; -The resident yells out at times and spends a lot of time in his/her room; -The resident can be heard yelling in his/her room and when the staff check on him/her the resident tells them to leave; -Sometimes the resident will refuse lunch; -The resident has attempted to hit another resident before; -The resident's care plan should include a diagnosis of PTSD and what upsets them; -Staff should know what triggers or upsets the resident; -The staff should know how to de-escalate the resident. During an interview on 04/24/25 at 02:42 P.M., CNA B said: -There are no longer any residents at the facility with a diagnosis of PTSD; -He/She was not aware the resident had a diagnosis of PTSD; -The resident's care plan should have the trauma history and what the resident's triggers are;	F 699	please see attached	

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F 699	Continued From page 20 -He/She did not know what the resident's triggers were or how to mitigate them. During an interview on 04/25/25, at 08:56 A.M., LPN A said: -The resident stays in his/ her room most of the time; -The resident has behaviors at times; -He/She was not aware the resident had a diagnosis of PTSD; -He/She did not know what the resident's triggers were; -The resident's diagnosis of PTSD should be care planned; -The resident's triggers and any interventions should be care planned; -The care plan determines how to care for the resident; -Staff could unintentionally trigger the resident if they do not know what his/her triggers are. During an interview on 04/25/25 at 09:23 A.M., the Resident's Guardian said: -The resident had a psychiatric stay on 09/13/23 and his/her assessment identified a history of PTSD; -He/She was notified by the facility on March 2024, that the resident hit another resident; -The facility said the resident was triggered by another resident and that is why he/she lashed out; -He/She expects the resident's diagnosis of PTSD to be on the resident's care plan; -He/She expects the staff to be able to identify the resident's specific triggers; -He/She expects the staff to know what specific interventions are required to mitigate triggers for the resident and de-escalate the resident.	F 699	please see attached	

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F 699	Continued From page 21 During an interview on 04/25/25 at 1:16 P.M. the Director of Nursing (DON) said: -She was not aware of Resident #37's PTSD diagnosis; -She expects the staff to look at the resident's care plan and know what triggers Resident #37; -PTSD should be included in Resident #37's care plan along with specify interventions; -The MDS Coordinator is responsible for updating the care plans; -The nurses add parts to the care plan if needed; -At the end of the day the MDS coordinator is responsible for adding PTSD to the care plan. During an interview on 04/25/25, at 1:20 P.M., the Administrator concurred with the DON.	F 699	Please See Attached	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812	Please See Attached	

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F 812	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare and serve food in accordance with professional standards of food service safety when staff failed to date and label food items, failed to dispose of expired food items, and failed to perform temperature checks on food items after the cooking process was completed. This effected all the residents at the facility. The facility census was 58. Review of facility policy, Food Safety, revised 4/26/23, showed: - Danger Zone means temperatures above 41F and below 135F, that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Bacteria multiply rapidly in a moist environment in the danger zone. Rapid death of most bacteria occurs at 165F or above; - Food is stored a minimum of six inches off the floor; - When an item is transferred to a new container the container will be labeled with the name of the contents and date transferred. A "Use by Date" is noted on the label; - Food is labeled with the date received if not already indicated on the item; - Leftovers are dated properly and discarded after 72 hours unless otherwise indicated; - Frozen, raw meat that is placed in a cooler, is in a pan and labeled with pulled and use by dates; Dry Storage: - Opened packages of food are resealed tightly to prevent contamination of the food item and "use by date" will be used when applicable; - Food not safe for consumption or the safety of the food is in question will be removed from	F 812	Please See Attached	

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F 812	Continued From page 23 storage; Steam Tables: - Must be able to maintain hot foods at temperatures of 135F or above; - Must not be used for cooking or warming foods, only for keeping food hot; Review of facility policy, Food Temperature Control, revised 6/28/24, showed: - Food temperatures are checked at the completion of the cooking process and before being placed on the serving line; if issues are identified, they are corrected, or the food is discarded; - Hot foods are held at a minimum of 135F or per state requirements; - While foods are on the serving line, the foods will be maintained at a safe temperature; - The steam table is not used to prepare and/or reheat foods; 1. Observation of the kitchen on 4/22/25 at 8:30 A.M., showed: Freezer: - Package of frozen food opened 4/21/25 and resealed with no content label; - Package of frozen onion rings opened and resealed with no open or expiration date on package; Refrigerator: - Defrosting frozen chicken not labeled with a "use by date"; - Lettuce package opened 4/20, resealed with no expiration date; Dry Storeroom: - Raisin Bran resealed in plastic container with expiration date of 3/12/25 not discarded; - Fruit Loops resealed in plastic container with expiration date 4/18/25 not discarded;	F 812	please see attached	

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F 812	Continued From page 24 - Cheerios resealed in plastic container with expiration date 3/12/25 not discarded; - Left over gravy mix not sealed; Main Kitchen Area: - Tortilla chips with expiration date 4/21/25 not discarded; Small Refrigerator: - Bag of apples, unlabeled, unsealed, and no expiration date; - Chicken base opened and resealed, expiration date unreadable; 2. During a continuous observation of the kitchen on 4/23/25, showed: - 10:15 A.M. Green beans placed on steam line without any temperature check taken; - 10:20 A.M. Gravy placed on steam line from microwave without any temperature check taken; - 10:40 A.M. All of the puree and mechanically prepared items completed and placed on the steam line without temperature checks taken; - 11:12 A.M. Temperature checks conducted on all items on the steam line. Gravy has a temperature of 108F which is below the safe holding temperature of 135F required. - 11:16 A.M. The gravy is transferred to the stove for reheating; - 11:24 A.M. The DM (dietary manager) takes a temperature check while the gravy is still on a lit burner. The gravy now temps at 155F; Observation of the kitchen refrigerator on 4/24/25 at 2:20 P.M., showed leftover cooked sausage patties dated 4/20/25 with expiration date 4/22/25 that had not been discarded. During an interview on 4/23/25 at 11:30 A.M., the DM said: - The gravy was cooked improperly and should	F 812	please see attached	

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F 812	Continued From page 25 have been prepared on the stove instead of heated up in the microwave by one of the dietary staff; - Temperature checks are normally done on the steam line before serving the meal and not on the stove for side dishes. Main course meals like today's chicken should have temperature checks done until they reach the required temperature for cooking; During an interview on 4/23/25 at 3:28 P.M., the DM and Dietician said: - The danger zone for food bacteria growth are temperatures below 135F, 145F for fish, 155F for ground beef, and 165F for chicken. - Both staff members agreed that taking the temperatures at the steam table prior to serving was sufficient to ensure the safety of the residents and had no issues with not taking temperatures after cooking is completed at the stove; - Food items that are opened should be resealed and dated, items that are expired should be thrown away on the date of expiration; During an interview on 4/25/25 at 1:30 P.M., the Administrator said: - She would expect food items that have been opened to be resealed, dated with the open date and the new expiration date if being stored for future use; - Items that have been resealed should be clearly labeled as to the contents; - She would expect food temperature checks to be done prior to placing items on the steam table, prior to serving and prior to being served on the hall for residents; - She would not expect expired items in the refrigerator or storeroom;	F 812	Please see attached	

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F 812	Continued From page 26 - All containers should be sealed tight when being used for leftovers or future serving.	F 812		

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A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Please refer to F699	A4075		
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		
A4093	19 CSR 30-85.042(84) Bedpans, Commodes, Urinals Clean/Covered Staff shall ensure that bedpans, commodes, and urinals are covered after use, emptied promptly, and thoroughly cleaned after use. II/III This regulation is not met as evidenced by:	A4093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11500	A. BUILDING: _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CARROLLTON	300 LIFE CARE LANE CARROLLTON, MO 64633

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A4093	Continued From page 1 Class II Please refer to F880	A4093		
A4100	19 CSR 30-85.042(91) Social Service Program The facility shall designate a staff member to be responsible for the facility's social services program. The designated staff person shall be capable of identifying social and emotional needs, knowledgeable of methods or resources, or a combination of these to use to meet them and services shall be provided to residents as needed. II/III This regulation is not met as evidenced by: Class III Please refer to F699	A4100		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III Please refer to F656	A4108		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS	A7015		

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A7015	Continued From page 2 At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III Refer to F812	A7015		
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers Unless its identity is unmistakable, bulk food, such as cooking oil, syrup, salt, sugar or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by common name. III	A7019		

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A7019	Continued From page 3 This regulation is not met as evidenced by: Class III Refer to F812	A7019		
A7028	19 CSR 30-87.030(26) Hazardous Food Cooking Temperatures Potentially hazardous foods requiring cooking shall be cooked to heat all parts of the food to a temperature of at least one hundred forty degrees Fahrenheit (140°F), except that poultry, poultry stuffings, stuffed meats and stuffings containing meat shall be cooked to heat all parts of the food to at least one hundred sixty-five degrees Fahrenheit (165°F) with no interruption of the cooking process. Pork and food containing pork shall be cooked to heat all parts of the food to at least one hundred fifty degrees Fahrenheit (150°F); rare roast beef shall be cooked to an internal temperature of at least one hundred thirty degrees Fahrenheit (130°F); and rare beef steak shall be cooked to a temperature of one hundred thirty degrees Fahrenheit (130°F) unless otherwise ordered by the resident. II/III This regulation is not met as evidenced by: Class III Refer to F812	A7028		
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,	A8010		

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A8010	Continued From page 4 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 III Please refer to F578.	A8010		
A9010	19 CSR 30-88.020(10) Discharge Requirement Within 5 Days Within five (5) calendar days of the discharge of a resident, the resident, his/her designee, guardian and conservator, or conservator shall be given an up-to-date accounting of the resident ' s personal funds and the balance of the funds and all personal possessions shall be returned to the resident. This requirement shall not apply for	A9010		

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A9010	Continued From page 5 residents discharged due to death, or for residents discharged to hospitals when those residents are expected to return to the facility. The operator shall have a receipt for all funds and possessions returned to the resident, his/her designee, guardian and conservator, or conservator. II/III This regulation is not met as evidenced by: Class III Refer to F569	A9010		

PLAN OF CORRECTION

Provider/Supplier Name:	Life Care Center of Carrollton
Street Address, City, Zip:	300 Life Care Lane, Carrollton, MO 64633
Date of Survey:	04/25/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265294

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and Federal law. The admission of the plan of correction does not constitute an admission on the part of Life Care Center of Carrollton as to the accuracy of the surveyor's findings nor the conclusion drawn there from. **The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.** **The plan of correction 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 identified in the plan of correction 5/28/25. Compliance will be maintained as provided in the plan of correction. Please feel free to contact Life Care Center of Carrollton at 660-542-0155. We respectfully request a desk review for compliance review.**	
F 569	It is the practice of this facility to provide personal funds and final accounting within 30 days upon discharge to the resident or resident representative. **What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** The personal funds for Residents # 53 and # 157 were reviewed and returned to the resident and/or resident representative.	**5/28/2025**

	On 4/23/25 at the time of discovery BOM requested update and payment for refund for resident #157. Refund was issued on 4/25/25 On 4/23/25 at the time of discovery for resident #53 BOM requested update and refund for payment. Refund was issued on 4/25/25	
	How will you identify other residents having the potential to be affected by the same deficient practice: On 4/28/25 The Business Office Manager and Executive Director completed an audit of all resident funds to ensure the facility was not in possession of any other discharged resident funds beyond 30 days. No other residents were found to be affected by this deficient practice.	
	What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: On 4/28/25 The Executive Director educated BOM regarding the facility policy of Resident Trust Policy and Procedures with an emphasis on refunding funds upon discharge. The facility Business Office Manager/designee will review all discharges by the next business day to review resident accounts to ensure refunds are processed timely if applicable.	

	How the facility plans to monitor its performance to make sure that solutions are sustained: The Executive Director/designee will review resident discharges and accounts per policy to ensure compliance. This will be monitored weekly for 1 month, then monthly for 2 months. Any discrepancy noted in the audit will be addressed at that time. Results of the audits will be reviewed with the QAPI committee monthly for its review and recommendations.	
F558	It is the practice of this facility to ensure resident rights to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. **What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** After discussion with Resident # 14 an extender was added to the sink for the hot water faucet. Resident # 156: Upon discovery resident need for transfer assistance, Resident was transferred to a sitting position to assist with breakfast.	5/28/2025
	How will you identify other residents having the potential to be affected by the same deficient practice: On 4/28/25 The Director of Rehab conducted an audit of current residents to screen for needs and preferences of sink accommodations. No other residents were found to be affected by this deficient practice.	

	On 4/23/2025 at 11 am staff nurse completed a walking visual round to ensure all residents were assisted with transfer to preferred positioning for mealtime. No other residents were found to be affected by this deficient practice.	
	What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Staff Development Coordinator/ or designee will complete an educational in-service for Nursing staff regarding: Anticipating and meeting reasonable accommodation of resident needs/preferences with an emphasis on transfer assistance and adaptive equipment.	
	How the facility plans to monitor its performance to make sure that solutions are sustained: The DON/designee will conduct an audit of adaptive equipment and transfer assistance to meet the needs and preferences of all residents. This audit will take place 5 days per week, on various shifts, for 1 week then weekly, on various shifts, for 4 weeks. Any discrepancy noted during the audit will be addressed with the staff as indicated. Results of the audit will be submitted monthly to the QAPI committee for its review and recommendations	
F584	It is the practice of this facility to provide residents with a safe, clean, comfortable and homelike environment. **What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** On 4/23/25 at 1pm upon discovery the housekeeping supervisor performed a deep clean of the dining room to include the floor	5/28/2025

	and handwashing station in the dining room. This included the floor leading to the kitchen area from the dining room. The food debris that was noted behind chairs in the dining room was removed when the chairs were moved and floor cleaned. On 4/25/25 The room of Resident # 8 was deep cleaned to include the corners, baseboard and floor. 4/25/25 The room and bathroom of Resident # 38 was deep cleaned to include corners, baseboard and floor. Trash was removed and discarded	
	How will you identify other residents having the potential to be affected by the same deficient practice: On 4/28/25 the housekeeping director/designee conducted a visual audit of resident rooms and bathrooms to determine which need to have a deep cleaning completed and they will be deep cleaned on a priority basis. All residents have potential to be affected by this deficient practice. On 4/28/25 the housekeeping supervisor will educate all housekeeping staff regarding the facility policy Housekeeping Services with an emphasis on daily floor cleaning.	
	What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Housekeeping Director/designee will conduct a visual inspection of random rooms to ensure compliance with the Housekeeping Services Policy and cleanliness.	
	How the facility plans to monitor its performance to make sure that solutions are sustained: The Housekeeping director/designee will conduct an audit of resident rooms, bathrooms and the dining room to ensure that the rooms are cleaned according to facility policy and standards. This audit will include resident rooms and bathrooms and public areas daily 5 days per week for 1 week then twice a week for four weeks. Any discrepancy noted during the audits will be addressed at that time. Results of the audits will be submitted to the facility Administrator for review weekly and to the QAPI committee, monthly for its review and recommendations.	
F578		**5/28/2025**

	It is the practice of this facility to ensure that advance directive – Do Not Resuscitate (DNR) paperwork is accurate **What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** On 4/24/25 upon discovery, the DNR paperwork for Resident # 2 and #24 was reviewed for accuracy and corrected.	
	How will you identify other residents having the potential to be affected by the same deficient practice: On 5/1/25 The Health Information Management Director conducted an audit of resident advance directives (Do Not Resuscitate paperwork) to ensure that each is filled out correctly. No other residents found to be affected by this deficient practice. The Regional Director Clinical Services/designee will complete an educational review for the Nursing Management Team and Social Services staff regarding completion of DNR paperwork.	
	What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Director of Nursing/designee will conduct a review /audit of new code status' and new orders for accuracy and completion during morning meetings, 5 days per week for four weeks.	
	How the facility plans to monitor its performance to make sure that solutions are sustained:	

	The Executive Director will review audits and any discrepancy noted during the review will be addressed at that time, Results of the audit will be submitted monthly, to the QAPI meeting for its review and recommendations.	
F699	It is the practice of this facility to complete a trauma informed consent assessment on each facility resident. **What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** On 5/20/25 A trauma informed care assessment for Resident #37 was completed by Social Services Director and care plan updated to care for resident needs.	5/28/2025
	How will you identify other residents having the potential to be affected by the same deficient practice: The Assistant Director of Nursing/designee conducted an audit of trauma informed care assessments on current residents to ensure that each has the assessment was completed and if the assessment revealed a past trauma, a care plan for post traumatic event will be developed. No other residents were found to be affected.	
	What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The Executive Director will conduct an educational review for the Social Services staff and Nursing management on the facility policy on Trauma Informed Care. The Director of Nursing/designee will complete an audit of trauma informed care assessments on new admissions, readmissions and with changes in condition to verify that the assessments are completed and care plans updated 5	

	days a weeks for four weeks, then two days a week for three weeks.	
	How the facility plans to monitor its performance to make sure that solutions are sustained: The Executive Director will monitor audits, any discrepancy noted In the audit will be corrected at that time. Results of the audit will be submitted to the QAPI committee monthly for its review and recommendations.	
F812	It is the practice of this facility to store, prepare and serve food in accordance with professional standards of food service. **What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** Upon discovery of foods with no open date and no expiration date or expired in the freezer, refrigerators and dry storage were discarded. Gravy was reheated to appropriate temperature prior to serving. All residents have the potential to be affected by this deficient practice.	5/28/2025
	How will you identify other residents having the potential to be affected by the same deficient practice: The Dietary Manager completed an audit of the freezer, small refrigerator, refrigerator and dry storage rooms to ensure that there were no other items that had been outdated or not labeled correctly. Any discrepancy noted during this audit was corrected at the time. The Registered Dietician will conduct an educational review for the dietary manager and dietary staff regarding	

	facility policy on Food Safety with an emphasis on safe food temperatures.	
	What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The facility Administrator /designee will conduct an audit of food safety, preparation and storage to ensure compliance with the standard. This audit will take place 5 days per week for 1 week, then weekly to ensure compliance. It will include (1) kitchen temperature logs on food items, while being placed on the steam table (2) refrigerator and freezer audit to ensure that items are labeled and dated (3) Refrigerator/freezer and dry storage areas to ensure there are no outdated or past 'use by' items (4) all items open are resealed or placed in airtight containers. All audits will take place daily, X 5 days, for 1week, then 3 times per week for 3 weeks, then weekly x 3 weeks, then monthly x 2 months.	
	How the facility plans to monitor its performance to make sure that solutions are sustained: All Audits will be monitored by the Executive Director and Any discrepancy noted during the audit will be addressed at that time. Results of the audits will be submitted to the QAPI committee monthly for its review and recommendations.	
A4075	**Refer to F699**	
A4100	**Refer to F699**	
A4108	**Refer to F656**	
A7015	**Refer to F812**	
A7019	**Refer to F812**	

A7028	Refer to F812	
A8010	Refer to F578	
A9010	Refer to 569	

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.