STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265322	A. BUILDING _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIXA NURSING & REHAB	1104 NORTH MAIN STREET NIXA, MO 65714

(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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of possible misappropriation were reported to the State Survey Agency (Department of Health and Senior Services, DHSS) within the required 24-hour time frame when staff failed to report an allegation of misappropriation of property made by one	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Tekwe	ADMINISTRATOR	08/19/2024

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 609	Continued From page 1	F 609		

resident (Resident #122). The facility census was 65.

Review of the facility's policy titled "Reporting - Abuse Policy," undated, showed the following:

-It is the policy of the facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties;
-Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator;
-The nursing some administrator or designee will report abuse to the state agency per State and Federal requirements.

1. Review of Resident #122's face sheet (resident's information at a quick glance) showed the following information:

-Admission date of 08/25/23 with readmission date of 07/05/24;
-Diagnoses included sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age) and hyperlipidemia (high levels of fat in blood).

Review of the resident's significant change Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 04/30/24, showed the resident was cognitively intact.

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F 609	Continued From page 2 During an interview on 07/15/24, at 10:07 A.M., the resident said the following: -He/she did not want to answer any questions because he/she was upset; -An aide took his/her embroidery scissors from him/her a couple of weeks ago; -The scissors were taken by an aide that worked the night shift and the resident did not know the aides name; -The resident spoke with the Administrator and Social Service Director (SSD) this morning and they were not aware that the resident's scissors had been taken by an aide; -He/she likes to crochet and used the scissors to cut yarn; -The scissors had a yellow, plastic handle and the blades were very small and short; -The scissors were a gift from his/her family that had visited from out of state; -He/she had not been told he/she could not have scissors. During an interview on 07/16/24, at 10:30 A.M., the resident said the following: -He/she does not participate in activities and prefers to stay in his/her room and crochet; -No one has followed up with him/her about his/her scissors; -The resident had no scissors to cut his/her yarn. Review of the facility's July 2024 Grievance Log showed no grievances had been filed for the month of July 2024. During an interview on 07/16/24, at 11:40 A.M., the SSD said the resident came to the SSD on	F 609		

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F 609	Continued From page 3 07/15/24 stating that an aide had taken his/her embroidery scissors. The SSD asked the resident if he/she wanted to file a formal grievance and the resident said no. During an interview on 07/18/24, at 1:20 P.M., the Housekeeping Supervisor said the following: -The staff were told in morning meeting that the resident's scissors had been taken by an aide; -The residents aren't allowed to have regular scissors, but can have safety scissors; -The Housekeeping Supervisor gave the resident his pair of safety scissors until administration finds which aide took the resident's scissors. During an interview on 07/18/24, at 1:24 P.M., the Activities Director said the following: -The resident does not participate in group activities; -The resident crochets in his/her room; -The staff were told in morning meeting that the resident's scissors had been taken by an aide; -There was no risk associated with the resident having scissors. Review of the resident's record showed staff did not document reporting the allegation of misappropriation. Review of DHSS records showed the home did not self-report the allegation of misappropriation. During an interview on 07/23/24, at 2:00 P.M., Certified Nurse Aide (CNA) A said the following: -Misappropriation is a form of abuse and should be reported to administration;	F 609		

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F 609	Continued From page 4 -If misappropriation was reported to CNA A, he/she reported it to the charge nurse and the chain of command; -The state required allegations of abuse, neglect, and misappropriation be reported to the state within two hours. During an interview on 07/23/24, at 2:15 P.M., Certified Medical Technician (CMT) B said the following: -If a resident reported abuse, neglect, or misappropriation to him/her, CMT B would tell the charge nurse immediately; -The state required allegations of abuse, neglect, or misappropriation to be reported to the state within two hours. During an interview on 07/23/24, at 2:11 P.M., SSD said the following: -If a resident reported abuse, neglect, or misappropriation to him/her, SSD would report it to the Administrator; -The Administrator and Director of Nursing (DON) investigate allegations; -The state required allegations of misappropriation be reported to the state within 24 hours; -There have not been any allegations of misappropriation; -The resident did report to her on 07/15/24, that an aide took his/her scissors; -He/she ask the resident if he/she wanted to file a formal grievance and the resident said no; -Staff were looking for the resident's scissors; -She did not report the misappropriation allegation to the state.	F 609		

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F 609	Continued From page 5 During an interview on 07/23/24, at 3:45 P.M., the DON said the following: -The resident had been at the home for over a year; -The resident had scissors to use for crocheting; -There was no risk associated with the resident having scissors; -The SSD should document the allegations made by the resident; -The allegation of misappropriation should have been reported to the stated within 24 hours. During an interview on 07/23/24, at 3:52 P.M., the Administrator said the following: -During his morning rounds on 07/15/24, he was told by the resident that an aide had taken his/her scissors; -He referred the resident to the SSD to file a grievance; -Staff was made aware of the missing scissors in a morning meeting; -Staff would look for the scissors; -Reports of items taken by staff would be considered misappropriation and should be reported to the state within 24 hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		

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F 610	Continued From page 6 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete investigations of all allegations of misappropriation when staff failed to investigate one resident's (Resident #122) allegation of misappropriation. The facility census was 65. Review of the facility's policy titled "Investigation," undated, showed the following: -It is the policy of this facility that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated; -The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed; -The facility staff will complete an active search for missing item(s) including documentation of investigation; -The investigation will consist of at least the following: a review of the completed complaint report; an interview with the person or persons reporting the incident; interviews with any	F 610		

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witnesses to the incident; a review of the resident medical record if indicated; a search of resident room (with resident permission); an interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident;, and interviews with the resident's roommate, family members and visitors.

1. Review of Resident #122's face sheet (resident's information at a quick glance) showed the following information:

-Admission date of 08/25/23 and readmission date of 07/05/24;
-Diagnoses included sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age) and hyperlipidemia (high levels of fat in blood).

Review of the resident's significant change Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 04/30/24, showed the resident was cognitively intact.

During an interview on 07/15/24, at 10:07 A.M., the resident said the following:

-He/she did not want to answer any questions because he/she was upset;
-An aide took his/her embroidery scissors from him/her a couple of weeks ago;
-The scissors were taken by an aide that worked the night shift and the resident did not know the aides name;
-The resident spoke with the Administrator and Social Service Director (SSD) this morning and they were not aware that the resident's scissors

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F 610	Continued From page 8 had been taken by an aide; -He/she likes to crochet and used the scissors to cut yarn; -The scissors had a yellow, plastic handle and the blades were very small and short; -The scissors were a gift from his/her family that had visited from out of state; -He/she had not been told he/she could not have scissors. During an interview on 07/16/24, at 10:30 A.M., the resident said the following: -He/she does not participate in activities and prefers to stay in his/her room and crochet; -No one has followed up with him/her about his/her scissors; -The resident had no scissors to cut his/her yarn. Review of the resident's record showed staff did not document investigating the allegation of misappropriation of the resident's scissors. During an interview on 07/16/24, at 11:40 A.M., the SSD said the resident came to the SSD on 07/15/24 stating that an aide had taken his/her embroidery scissors. The SSD asked the resident if he/she wanted to file a formal grievance and the resident said no. During an interview on 07/18/24, at 1:24 P.M., the Activities Director said the following: -The resident does not participate in group activities; -The resident crochets in his/her room; -The staff were told in morning meeting that the resident's scissors had been taken by an aide; -There was no risk associated with the resident having scissors.	F 610		

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F 610	Continued From page 9 Review of the facility's July 2024 Grievance Log showed no grievances had been filed for the month of July 2024. Review of the facility records showed the facility did not provide a timely written investigation of the resident's allegation of misappropriation. During an interview on 07/23/24, at 2:00 P.M., Certified Nurse Aide (CNA) A said administration is responsible for investigating allegations of misappropriation. During an interview on 07/19/23, at 1:42 P.M., Certified Medication Tech (CMT) C said the Director of Nursing (DON) investigated allegations of misappropriation and the state would send someone to investigate. During an interview on 07/23/24, at 2:11 P.M., SSD said the administrator and Director of Nursing (DON) investigate allegations of abuse, neglect, and misappropriation. There had not been any allegations of misappropriation. The resident did report to her on 07/15/24, that an aide took his/her scissors. During an interview on 07/23/24, at 3:45 P.M., the DON said she and the Administrator were responsible for completion of investigations of abuse, neglect, exploitation, and misappropriation. The resident had been at the home for over a year and had scissors to use for crocheting. There was no risk associated with the resident having scissors. The SSD should document the allegations made by the resident. During an interview on 07/23/24, at 3:52 P.M., the	F 610		

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F 610	Continued From page 10 Administrator said the following: -The Administrator said that during his morning rounds on 07/15/24, he was told by the resident that an aide had taken his/her scissors; -The Administrator said reports of items taken by staff were considered misappropriation.	F 610		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident's choice of to receive Cardiopulmonary Resuscitation (CPR - an emergency treatment that's done when someone's breathing or heartbeat has stopped) or not was consistently and clearly documented when staff documented conflicting CPR choice information for 10 residents (Resident #11, #12, #17,#23, #26, #30, #40, #41, #46 and #58) out of a sample of 16 residents. The facility census was 65. Review of the facility's policy and procedure titled, "Advanced Directives from the Nursing Guidelines Manual," undated, showed the following: -The facility will respect advance directives in accordance with state law; -Upon admission of a resident to the facility, the	F 678		

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F 678	Continued From page 11 Social Services Designee (SSD) will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive; -Upon admission of a resident, the social services designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives; -Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record under the advance directive tab; -Advance directives include, but are not limited to, living will (a document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis) and do not resuscitate (DNR - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy or representative has directed no CPR or other life saving methods are to be used; -Inquiries concerning advance directives should be referred to the SSD. 1. Review of Resident #11's face sheet (a document that gives a resident's information at a quick glance) showed the following information: -Admission date of 10/21/22; -The resident's code status was full code (wished to receive CPR). Review of the resident's July 2024 Physician Order Sheet (POS) showed and order, dated 11/18/22, for DNR status.. Review of the resident's care plan, dated	F 678		

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F 678	Continued From page 12 01/25/23 and reviewed on 07/22/24, showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was purple DNR sheet, dated 11/10/22, which directed staff to not provide CPR. 2. Review of Resident #12's face sheet showed the following information: -Admission date of 07/14/21; -The resident's code status was full code. Review of the resident's July 2024 POS showed an order, dated 01/06/23, for DNR status. Review of the resident's care plan, dated 08/13/21 and reviewed on 07/22/24, showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -Resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated 01/05/23, which directed staff to not complete CPR. 3. Review of Resident #17's face sheet showed the following information: -Admission date of 11/16/23; -The resident's code status was full code.	F 678		

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F 678	Continued From page 13 Review of the resident's July 2024 POS showed an order, dated 12/03/23, for DNR status for the resident. Review of the resident's care plan, dated 12/07/23 and reviewed on 07/22/24, showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple (DNR) sheet, dated 11/30/23, which directed staff to not provide CPR. 4. Review of Resident #23's face sheet showed the following information: -Admission date of 05/29/24; -The resident's code status was full code. Review of the resident's July 2024 POS showed an order, dated 05/29/24, for full code status . Review of the resident's care plan, dated 12/07/23 and reviewed on 07/22/24, showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated 06/12/23, that directed staff to not provide CPR.	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265322	A. BUILDING _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIXA NURSING & REHAB	**1104 NORTH MAIN STREET NIXA, MO 65714**

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F 678	Continued From page 14 5. Review of Resident #26's face sheet showed the following information: -Admission date of 02/16/22; -The resident's code status was full code. Review of the resident July 2024 POS showed an order, dated 03/07/22, for DNR status for the resident. Review of the resident's care plan, dated 12/11/23 and reviewed on 07/23/24, showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated 03/02/22, which directed staff to not provide CPR. 6. Review of Resident #30's face sheet showed the following information: -Admission date of 10/25/23; -The resident's code status was full code. Review of the resident's July 2024 POS showed an order, dated 04/12/24, for DNR status. Review of the resident's care plan, dated 06/17/24 and reviewed on 07/22/24, showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following:	F 678		

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F 678	Continued From page 15	F 678		

-The resident's admission face sheet showed the resident was a full code;
-Behind the resident's admission face sheet was a purple DNR sheet, dated 04/11/24, that directed staff to not perform CPR.

7. Review of Resident #40's face sheet showed the following information:

-Admission date of 08/03/23;
-The resident's code status was full code.

Review of the resident's July 2024 POS showed an order, dated 08/18/23, for DNR code status.

Review of the resident's care plan, dated 08/21/23 and reviewed on 06/11/24, showed the resident chose to be a DNR code status.

Review of the facility's Code Status Book located at the nurses' desk showed the following:

-The resident's admission face sheet showed the resident was a full code;
-Behind this resident's admission face sheet was a purple DNR sheet, dated 08/07/23, which directed staff to not perform CPR.

8. Review of Resident #41's face sheet showed the following information:

-Admission date of 10/20/23;
-The resident's code status was full code.

Review of the resident's July 2024 POS showed an order, dated 06/11/24, for DNR status.

Review of the resident's care plan, dated

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	265322	A. BUILDING _____ B. WING _____	C 07/23/2024

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F 678	Continued From page 16 06/06/24 and reviewed on 07/22/24, showed the resident chose to be a DNR code status. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple (DNR) sheet, dated 02/21/24, which directed staff to not perform CPR. 9. Review of Resident #46's face sheet showed the following information: -Admission date of 09/26/22; -The resident's code status was full code. Review of the resident's July 2024 POS showed an order, dated 03/14/23, for DNR code status. Review of the resident's care plan, dated 01/25/23 and reviewed on 05/01/24, showed the resident chose to be a DNR code status. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated 12/06/22, which directed staff to not perform CPR. 10. Review of Resident #58's face sheet showed the following information: -Admission date of 04/12/24; -The resident's code status was full code.	F 678		

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F 678	Continued From page 17	F 678		

Review of the July 2024 POS showed an order, dated 06/27/24 for DNR code status.

Review of the resident's care plan, dated 06/27/24 and reviewed on 06/27/24, showed the resident chose to be a DNR code status.

Review of the facility's Code Status Book located at the nurses' desk showed the following:

-The resident's admission face sheet showed the resident was a full code;
-Behind the resident's admission face sheet was a purple DNR sheet, dated 06/06/24, which directed staff to not perform CPR.

11. During an interview on 07/23/24, at 3:00 P.M., the SSD said she was responsible for keeping each resident's code status up to date. She kept three binders with residents from A Hall, B Hall, and C Hall at the nurses' station with all residents from each of those halls code status, to include DNR or a full code status. The resident's face sheet and the purple advanced health directive sheet were placed in the book in alphabetical order. The book was up to date. The book was where the nurses would go to in case of an emergency to find code status. All residents' face sheets, POS, care plans, and purple sheets should be the same code status, either full code or DNR.

During an interview on 07/23/24, at 3:25 P.M., Licensed Practical Nurse (LPN) E said the residents' advanced health care directive and code status were on the computer, on the residents' face sheets, and on the residents' physicians orders. The face sheet, the care plan,

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F 678	Continued From page 18 the POS, and the purple sheet should all match with either DNR or full code status. There is a book at the nurses' station that has hard copies of the residents' face sheets and DNR purple sheets which tells the nurses each resident's code status. They should match to be a full code or a DNR. He/she would look on the resident's door for a green (CPR) or red dot (DNR) or in the code status book in an emergency. During an interview on 07/23/24, at 3:40 P.M., the Administrator and Director of Nursing (DON) both said code status on the residents' face sheets and DNR purple sheets should match to either a full code or a DNR status. The SSD is responsible for keeping the code status books up to date. The DON and Administrator were not aware the books were not updated. Nobody was monitoring the SSD to ensure the code status books were up to date for all residents.	F 678		

Missouri Department of Health and Senior Services

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	13840	A. BUILDING: _____ B. WING _____	C 07/23/2024

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NIXA NURSING & REHAB	1104 NORTH MAIN STREET NIXA, MO 65714

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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 1. Please review of F678.	A4075		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class III 1. Please refer to F609. 2. Please refer to F610.	A8023		

PLAN OF CORRECTION

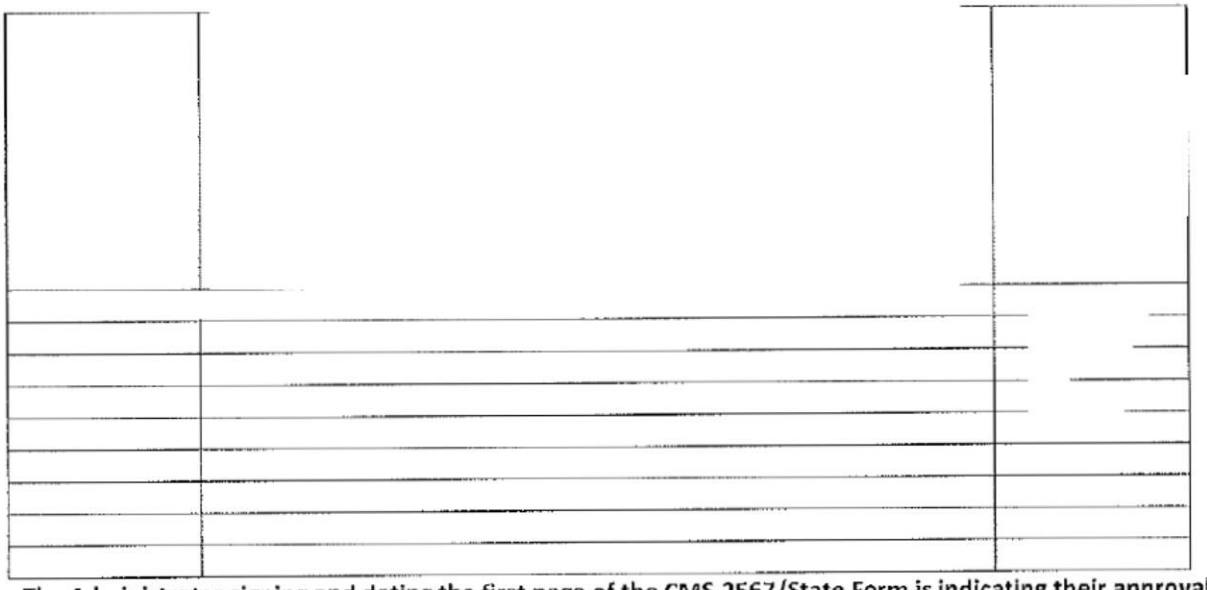
Provider/Supplier Name:	Nixa Nursing & Rehab
Street Address, City, Zip:	1104 North Main Street Nixa, Mo. 65714
Date of Survey:	7/23/2024

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 as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Nixa Nursing & Rehab. (the "Facility") as to the accuracy of the surveyors' findings, nor the conclusions drawn there from. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This 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 identified in the POC. Compliance will be maintained as provided in the Plan of Corrections on/by 9/3/24.	Completed on 9/3/24 and ongoing.
F-609	The Facility will continue to ensure all allegations of possible misappropriation are reported to the State Survey Agency within the required 24-hour time frame. 1. Resident #122's embroidery scissors were not found. The facility had the resident pick out a pair of embroidery scissors of choice and replaced the scissors of the residents' choice. 2. All current and future residents that report items missing will be considered possible misappropriation. The Facility will report to the State Survey Agency (DHSS) within 24 hours of item going missing and not found. 3. All Facility staff were in-serviced on 7/25/24and 8/26/24 by the Administrator and Director of Nursing on the reporting protocol of misappropriation of items belonging to residents. This in-service will be done at least annually and during new hire orientation. 4. The SSD will file a grievance on missing items. If items are not located the day of the grievance filed, then the SSD will report to the Administrator. The Administrator will report to DHSS within the 24-hour timeframe of reporting. 5. All grievances, to include misappropriation will be	Completed on 9/3/24 and ongoing.

	discussed during daily stand-up meeting. If misappropriation occurred, it will be reported to DHSS within the timeframe of 24-hours. 6. All findings will be discussed during QAPI meeting to ensure compliance is being met.	
F-610	The Facility will continue to ensure that an investigation is completed on all allegations of misappropriation when an allegation is reported to staff. 1. An investigation was completed by the Administrator on misappropriation of Resident #122 allegation of missing embroidery scissors. The scissors were not found. The Facility replaced the scissors of resident's choice and resident was satisfied with the outcome. 2. All current and future admitted residents will have an investigation completed timely if they report any allegations of misappropriation. 3. All Facility staff were in-serviced on 7/25/24 and 8/26/24 by the Administrator and Director of Nursing on the protocol of completing an investigation of any allegations of misappropriation. This in-service will be done at least annually and at new hire orientation. 4. All investigations of misappropriation will be discussed during daily stand-up meeting. 5. All findings of investigations will be discussed during QAPI meeting to ensure compliance is being met. 6. The above allegation and findings were discussed during the QAPI meeting on 8/8/24.	Completed on 9/3/24 and ongoing.
F-678	The Facility will continue to ensure each resident's choice of to receive CPR is consistent and clearly documented throughout the resident's medical record. 1. Resident's #11, 12, 17, 23, 26, 30, 40, 41, 46, and 58 medical records have been reviewed to ensure code status is correctly documented through out the medical record of their choice. All other residents will have medical records audited to ensure code status is correct through medical record on or before 9/3/24. 2. The Social Service Director/Designee reviewed the Code status book located at the nurses station to ensure all residents code status is correct and matches through out the medical record on 7/26/25 3. The Administrator in-serviced the SSD on ensuring the code status book and medical records were consistent with the resident preferred choice of code status. This is to be done when a change occurs with code status and new admissions. 4. The SSD will audit code status on a weekly basis to ensure the code status book, medical record and door label are consistent with resident's choice of code status. 5. The DON/Designee will review code status book weekly times 4 weeks and then monthly to ensure code status is correct for all residents. 6. All findings of code status will be discussed during QAPI to ensure compliance is being met.	Completed on 9/3/24 and ongoing
A-4075 A-8023	Refer to F-678 Refer to F-609 and F-610	Completed on 9/3/24 and

ongoing.



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.