STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265679	A. BUILDING _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VALLEY MANOR CARE CENTER	6814 SOBBIE ROAD LIBERTY, MO 64068

(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 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Missouri, Department of Health and Senior Services. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/02/24 to 09/05/24. Survey Census: 60 Sample Size: 28 No deficiencies were issued related to Intake MO00239794.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Laughon | TITLE: Administrator | (X6) DATE: 9/26/24

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

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F 584	Continued From page 1 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 observations, interviews, record review, and facility policy review, the facility failed to ensure the sit to stand mechanical lift was functioning properly before use for one of three residents (Resident (R) 5) who utilized the sit to stand lift; ensure the air conditioning unit for two of two residents (R51 and R17) was sealed to prevent pests from entering the rooms; ensure the laundry room floor was a cleanable surface; and ensure the northeast shower room was clean and safe for the residents utilizing the room of 28 sample residents. This failure had the potential to affect the 60 residents' right to reside in a safe, clean, and comfortable environment. Findings include: Review of the facility's policy titled "MECHANICAL LIFT _ MANUAL OR BATTERY OPERATED,"	F 584		

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F 584	Continued From page 2	F 584		

dated 06/24/24 and revealed the procedure as: "1. Assemble the equipment and supplies to perform the procedure. 2. Identify yourself and tell the resident what you are going to be doing. 3. Wash hands before beginning."

1. Review of R5's "Face Sheet" located under the "Resident" tab in the electronic medical record (EMR) revealed R5 was admitted 02/03/23 with diagnoses that included neuralgia and neuritis, lack of coordination, type two diabetes mellitus, anxiety disorder, and repeated falls.

Review of R5's quarterly "Minimum Data Set (MDS)" located under the "Resident Assessment Instrument (RAI)" tab of the EMR, with an Assessment Reference Date (ARD) of 08/09/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R5 was cognitively intact. The MDS revealed R5 was dependent on staff for transfers.

Review of R5's "Care Plan" located under the "RAI" tab of the EMR, updated 08/27/24, revealed "[R5] has an ADL [activity of daily living] self-care performance deficit r/t [related to] dementia ...The resident is totally dependent on x2 staff for transferring with a HOYER [mechanical] lift."

During an interview on 09/04/24 at 12:03 PM, R5 stated, "The equipment here doesn't work. It's always broken. I asked to go back to bed after the meeting (Resident Group) yesterday and the sit to stand didn't work. I was in it. I don't feel safe." R5 said the failures had been occurring for the past two months and "I tell them all the time." R5 stated, "I use the lift twice a day." R5 denied falling out of or from the lift during a transfer when the battery failed.

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During an interview on 09/04/24 at 12:05 PM, the Certified Nursing Assistant (CNA) 5, delivering R5's lunch tray to her room, stated "Yes, the sit to stand batteries don't last. One of us (staff) has to run to get another battery. The batteries have to be put on the charger."

During an interview on 09/05/24 at 12:10 PM, the Maintenance Director (MD) denied knowledge of the sit to stand lifts not working. The MD stated, "staff can tell me or write it in the maintenance book at the nurses' stations so I can check. If it's something I cannot fix, there's a phone number on the machine to call for maintenance." The MD confirmed that the batteries did need to be charged.

During an interview on 09/05/24 at 2:30 PM, the Director of Nursing (DON) provided a list of residents who utilized the Hoyer lift and those who utilized the sit to stand lift. R5 was one of three residents identified to use the sit to stand lift.

During an interview on 09/05/24 at 1:24 PM, CNA2 stated, "Yes, the batteries do run down. That happens."

During an interview on 09/05/24 at 2:10 PM, CNA 1 stated, "Yes, I'm the one who put [R5] to bed after the council meeting. I use the sit to stand with her. She was in it and the batteries ran out, we always have two people, I ran to get the other charged battery. She said her arms hurt. She always complains about that."

During an interview on 09/05/24 at 2:05 PM,

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F 584	Continued From page 4 CNA3 stated, "[R5] always complains about the lift not working, the batteries run out." During an interview on 09/05/24 at 2:15 PM, CNA7 stated, "It doesn't happen to me because I always check for the green light on the battery before I use the lift." During an interview on 09/05/24, the DON denied knowledge of the sit to stand lifts not being charged or running out of battery charge with a resident in the lift. The DON stated, "I guess I need to educate the staff about charging the batteries. I don't know why they all don't do that." 2. An environmental tour of the facility was conducted on 09/05/24 at 12:10 PM with the MD and the Housekeeping Supervisor (HSK). The following observations were made: a. R51's air conditioning unit, located in the wall under the window, was observed to have an approximate ½ inch unsealed gap which allowed one to see through the unit to the outside which allowed pests to enter the room. Both the MD and HSK confirmed the gap and the flies in the room. The casing around the window was broken with jagged edges and exposed nails. The head of R51's bed was located at the base of the window casing. The headboard had been gouged by the exposed nail. One of two window screens was located propped against the wall. The screen was severely damaged. The MD stated he was unaware of the condition of the window casing and screen. The MD said he "was going to have someone seal the air conditioning unit, but it had not yet been done." R51 was unable to be interviewed about the air conditioner, window, screen, or flies in the room.	F 584		

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F 584	Continued From page 5 b. R17's air conditioning unit, located in the wall under the window, was observed to have an approximate ½ inch unsealed gap which allowed one to see through the unit to the outside which allowed pests to enter the room. Both the MD and HSK confirmed the gap and the flies in the room. The window screen was off the window, propped against the wall. The screen was severely damaged. Flies were observed in the room along with a live black spider in the corner of the window, just above R17's headboard. R17 was unable to be interviewed about the air conditioner, window, screen, flies, or spider in the room. During an interview on 09/03/24 at 12:33 PM, Family Member (FM) 1 for R17 moved the curtain back and there was a bent window screen. The window also had exposed wood where a piece was missing and had rough edges. There was also a nail head sticking out. Also, the air conditioner had a gap at the top where the outside light could be seen. c. Observation of the Northeast shower room on 09/05/24 at 12:20 PM with the MD and the HSK revealed a soiled privacy curtain in front of the toilet stall. The HSK stated, "Oh, I'll take care of that, it should be clean." An electrical outlet, located inside the toilet stall, was falling out of the wall. d. Observation of the laundry room floor, on 09/05/24 at 12:40 PM, revealed an exposed, unsealed, concrete floor with minimal floor tiles in place. The HSK confirmed the condition of the floor and stated, "It's supposed to be retiled in two weeks, we have 30 boxes of tile.".	F 584		

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F 584	Continued From page 6 During an interview on 09/05/24 at 7:00 PM, the Administrator stated, "I was not aware of the air conditioners, that's not acceptable."	F 584		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to coordinate resident care with other health care providers who provide care for one of three residents (Resident (R) 32) with care provided by an outside health care agency of 28 sample residents. The facility's failure to provide ongoing communication with the outside health care provider places the resident at risk for inadequate or inappropriate care. Findings include: Review of the undated "Face Sheet" located in the electronic medical record (EMR) under the "Census" tab for R32 revealed an admission date of 03/11/21 with diagnosis including end-stage renal disease. Review of the admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/23/24 revealed R32 was dependent on one to two staff for activities of daily living (ADL) and a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated	F 698		

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F 698	Continued From page 7 R32 was severely cognitively impaired. Review of R32's "Care Plan" located under the "Care Plan" tab of the EMR and updated upon the resident's return from the hospital on 06/18/24, informed staff the resident was on dialysis, was served a liberalized diet and the nurse was to assess the "thrill and bruit" (the access used by dialysis) each shift. During an interview on 08/04/24 at 8:59 AM, the Certified Medication Technician (CMT) confirmed the facility did not prepare and send information regarding R32 for the dialysis treatment, nor did the dialysis center return documents with R32's information to the facility following the treatment. During an interview on 09/04/23 at 11:32 AM, the Director of Nursing (DON) confirmed the facility lacked policies and procedures for the ongoing care of R32 by the dialysis center including the sharing of pertinent clinical information, physician orders, and R32's response to the treatment. The DON stated that no documentation (including vital signs, weights, medications ordered/ administered, and other pertinent resident information) was prepared by the facility and sent to the dialysis provider for the continuing care of R34.	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		

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F 730	Continued From page 8 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure two of three Certified Nursing Assistants (CNA) 1 and CNA2 reviewed had received annual performance reviews along with 12 hours of in-service training for the last year. This deficient practice had the potential to allow CNAs to not receive the in-service training based on the outcome of the performance review. Findings include: Review of the facility's policy titled, "In-Service Training Program, Nurse Aide," revised date May 2019, revealed "Policy Statement: All nurse aide personnel participate in regularly scheduled in-service training classes. Policy Interpretation ...1. All personnel are required to attend regularly scheduled in -service training classes. 2. The facility completes a performance review of nurse aides at least every 12 months ...8. All training classes attended by employee are entered in the respective employe's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor ..." Review of CNA1's employee file revealed a hire date of 08/06/23. There was no performance review over 13 months ago. Review of CNA1's in-service training revealed the hours were not being tracked. Review of CNA2's employee file revealed a hire date of 07/21/17. The last performance review was dated 07/13/23, over 13 months ago. Review of CNA2's in-service training revealed the hours	F 730		

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F 730	Continued From page 9 were not being tracked. During an interview on 09/05/24 at 5:07 PM, the Director of Nursing (DON) was asked about the training hours. The DON stated, "We make the calendar from the state requirements. We put out January through December what training they will be. We are not tracking the training hours." The DON was asked about the performance reviews. "I get a folder monthly with the performance reviews that are due. I am behind in getting them completed."	F 730		
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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure food	F 812		

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F 812	Continued From page 10 stored in the main kitchen was labeled, dated, disposed of upon expiration, and the thermometer was properly sanitized in-between taking temperatures of the food. These failures had the potential to increase the prevalence and spread of foodborne illnesses and infection for all 60 facility residents. Findings include: Review of the facility's undated policy titled, "Handling Leftover Foods," indicated that leftover foods will be properly handled, cooled, and stored to ensure food safety. Review of the facility's undated policy titled, "Monitoring Food Temperatures," indicated that the probe should be washed, rinsed, and sanitized with an alcohol wipe and re-sanitized after each use. During an observation of the kitchen on 09/02/24 at 8:48 AM, the following items were observed in reach-in refrigerator one and verified by Dietary Aide (DA) 1 during the initial kitchen tour: -One carton of Almond Milk opened, with no open date with manufacturer's instructions (written on the carton) to use within seven days of opening. -One carton of thickened lemon water opened, with no open date with manufacturer's instructions to use within seven days. -One carton of thickened Orange Juice with an open date of 8/13 (08/13/24) with manufacturer's instructions to use within seven days. -One carton of thickened Iced Tea with an open date of 8/13 (08/13/24) with manufacturer's instructions to use within 10 days. During an observation of the kitchen on 09/02/24	F 812		

PLAN OF CORRECTION

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F584	It is the policy of the facility to ensure that a Safe/Clean/Comfortable/Homelike Environment is maintained. 1. Resident #5 – two additional batteries for the Sit to Stand and Hoyer lifts have been ordered. As this has the potential to affect all residents an Inservice to be held on 9/25/24 PT will provide training on how to use the lifts, and how to use the emergency release buttons. The staff will also be trained in placing the batteries on the charger and checking for proper charging before use. 2. a. Resident #51 – the gap around the air conditioning unit has been sealed and the casing around the window has been repaired and exposed nails have been repaired. The damaged screen will be repaired. As this has the potential to affect all residents all air conditioning units, window casings and screens will be assessed and any repairs made as needed. As this has the potential to affect all residents all air conditioning units, window casings and screens will be assessed and any repairs made as needed. Air Conditioner units, window screens and casings will be monitored monthly x 4 then quarterly and whenever an air conditioner unit has been replaced. b. Resident #17 – the gap around the air conditioning unit has been sealed and the casing around the window has been repaired and exposed nails have been repaired. The damaged screen will be repaired. As this has the potential to affect all residents all air conditioning units, window casings and screens will be assessed and any repairs made as needed. Air Conditioner units, window screens and casings will be monitored monthly x 4 then	10/18/2024

	quarterly and whenever an air conditioner unit has been replaced. c. Northeast Shower Room – the privacy curtain has been taken down and washed and reinstalled. The electrical outlet has been repaired. As this has the potential to affect all residents, shower room curtains will be taken down and washed. These will be monitored weekly x4 weeks then monthly x4, then as needed. d. Laundry Room – the tiles on the laundry room floor will be removed and the concrete floor will be sealed. The QA committee will review this plan of correction until consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee. The administrator will ensure continued compliance.	

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.

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Street Address, City, Zip:	6814 Sobbie Road Liberty Missouri 64068
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F698	It is the policy of the facility to ensure that a Dialysis professional standards are maintained. 1. Resident #32 – A Dialysis Communication Form is available through current EMR (PCC and will be utilized when resident goes out to Dialysis. The staff have been instructed on the use of the form as well as contacting Dialysis provider for follow-up information if needed. The dialysis communication form has a place for the dialysis center to record requested information (pre/post weights, medications, labs, order changes, etc.). There are not any additional residents receiving dialysis. Will monitor following dialysis beginning September 25, 2024 on dialysis days (M,W,F) x 4 weeks then weekly x4 then monthly x 4 and then as needed for continued compliance. This will be part of the new employee orientation. The QA committee will review this plan of correction until consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee. The administrator will ensure continued compliance.	10/18/2024

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

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

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F730	It is the policy of the facility to ensure that Nurse Aid Performance Reviews are complete and that 12hr/yr In-Service standards are maintained. 1. Employee performance evaluations will be completed yearly. The Human Resources director will provide each department supervisor with the evaluation form and will monitor its return. These forms need to be given to the supervisor the month prior to the due date (i.e. due in October it needs to be given to supervisor in September. Monthly audits will be done by the Administrator x 4 months and then random and ongoing to ensure continued compliance 2. An In-Service calendar will be posted with the required In-services for the remainder of 2024 and for all of 2025. There will also be ongoing online training available for staff with a posttest or return demonstration required after each online course completion. A directory of these online courses will be made to assist the staff. Each employee's attendance or completion of training will be done by the individual's name for more efficient monitoring. To ensure compliance a monthly accounting of hours will be done by DON/or designee and staff will be given a quarterly update. And in-service will be held on 9/25/24 to educate staff of the requirements. This will be part of the new employee orientation. The QA committee will review this plan of correction until consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee. The administrator will ensure continued compliance.	10/18/2024

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

PLAN OF CORRECTION

Provider/Supplier Name:	Pleasant Valley Manor Care Center
Street Address, City, Zip:	6814 Sobbie Road Liberty, MO 64068
Date of Survey:	09/05/2024

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
F812	It is the policy of the facility to ensure Food Procurement, Stor/prepare/Serve – Sanitary standards are maintained. 1. Dating of foods – a. Beverages – Upon opening these will be dated with the open date and then following the use by date on the carton date the container with the use by date. This will be monitored by the Dietary Manager or designee weekly x 4 weeks and then monthly x 4 weeks and with random and ongoing audits following. b. Removal of outdated foods – After opening foods will be labled with the date opened and the use by date. All outdated foods will be removed prior to serving in the AM. This will be monitored by the Dietary Manager or designee weekly x 4 weeks and then monthly x 4 weeks and with random and ongoing audits following. 2. Monitoring of Food Temperatures – Prior to using the thermometer's use the probe is to be cleaned with soap and water. The thermometer's probe is to be disinfected with a 70% alcohol wipe or soap and water. Time for the thermometer to return to room temperature should be allowed before testing another food. This will be monitored by the Dietary Manager or designee weekly x 4 weeks and then monthly x 4 weeks and with random and ongoing audits following. This will be part of the new employee orientation. The QA committee will review this plan of correction until consistent substantial compliance has been met as determined by the QA committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee. The administrator will ensure continued compliance.	10/18/2024

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