DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265742	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKRIDGE OF PLATTSBURG	205 E CLAY AVE, PLATTSBURG, MO 64477

(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 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/23/2024

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 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to provide a comfortable and homelike environment for all residents when they did not ensure cobwebs were cleaned from the dining room as well as the common area near the facility entrance, and failed to match the paint when repairing drywall in the dining room, or to ensure ceiling trim in the dining room was secure around attic access in the dining room. Additionally, the facility failed to maintain resident safety when they did not ensure a handrail was secure, and failed to provide a homelike environment when they did not fix or replace dining room chairs that are had tearing in the fabric. The facility census was 55. The facility did not provide a policy for regarding maintaining the facility. 1. Observation of the diningroom on 11/18/24 at 10:59 showed: -Dining room chairs vinyl was peeling off and fabric was torn. -Cobwebs near ceiling next to large upper window in dining room. -Wood trim strip around attic access panel in dining room was pulling away from the celiing with nails exposed. 2. Observation of the diningroom on 11/21/24 at 09:11 AM showed: -Cobwebs on the ceiling by the top of the TV in dining room. 3. Observation on the 100 hallway on 11/21/24 at	F 584		

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F 584	Continued From page 2 09:26 AM showed: -Handrail outside room 105 is loose. 4. Observation on 11/21/24 at 09:53 AM showed: -Cobwebs near ceiling in common area across from the nurse's station. -Dark water spots about 12 inches x 4 inches near light fixture in common area by main entrance and a large stain on ceiling near vent by main entrance. During an interview on 11/21/24 at 09:42 AM, housekeeping supervisor said twice a week housekeeping does deep cleaning tasks. Deep cleaning in common areas happens once every other week. High dusting to get cobwebs in common areas happens every other day. During an Interview on 11/21/24 at 12:52 PM, the administrator said that he would expect furnishings to be in good repair and free from peeling material and tears. He also stated that said there should not be accumulated cobwebs, and the facility should be clean at all times and housekeeping is responsible for ensuring all areas are clean. During an interview on 11/21/24 09:48 AM, the maintenance supervisor stated that they are looking into getting the dining chairs reupholstered and that there is no schedule for painting walls, however does attempt to get to painting needs as they are seen.	F 584		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

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personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility staff failed to ensure dependent residents who were unable to carry out their own activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal care, complete morning hygiene cares, offer fluids, or toilet dependent residents. These failures affected three of the 14 sampled residents (Residents #4, #34and #44). The facility census was 55.

Review of the facility's policy for peri care - female, revised 2/1/24, showed, in part:
- Purpose: To provide comfort for the resident and to prevent infection.
- (7.) Expose peri area, separate inner labia and gently wash from front to back.
- (8.) With new wipe, gently open all inner skin folds and wash inner area from front to back.
- (9.) With new wet wipe, wash the outer skin fold from front to back.
- (10.) With new wet wipe, wash inner legs and outer peri area.
- (16.) Offer resident fluids.

1. Review of Resident #4's care plan (a detailed written document created by the facility that outlines the specific needs of a resident, with the goal of maintaining their quality of life in the facility) revised 4/16/2024 showed, in part:
- Needs assistance with most ADLs
- Requires one person to assist with toilet transfers, toilet hygiene, pericare/incontinence cares and wears briefs for dignity.
- Requires one person to assist with transfers.

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- Is at risk for skin breakdown.
- Staff are to keep clean and dry as much as possible, minimize skin exposure to moisture.
- Resident #4 is cognitively intact and able to verbalize needs to staff.
- Resident #4 is hard of hearing and does not wear his/her hearing aids.

During an observation and interview on 11/20/2024 at 7:14 A.M. showed:
- CNA C, NA A, and NA B entered Resident #4's room to provide peri care/incontinence care, provide morning cares, and transfer the resident to his/her wheelchair for breakfast.
- Resident #4 kept his/her legs tightly closed throughout peri care.
- CNA C and NA A failed to expose or clean the peri area throughout peri care. With the resident on his/her back, CNA C, assisted by NA A, wiped the lower portion of Resident #4's pubic area (the lower part of the abdomen just above the external genital organs). After each wipe, staff then pushed the used wet wipes between Resident #4's tightly closed legs into the used brief beneath the resident.
- CNA C and NA A failed to expose or clean labial/vaginal folds throughout peri care. With the resident on his/her back, CNA C, assisted by NA A, wiped the outermost portion of the labia (the fleshy folds that surround the opening of the vagina) as they pushed clean wet wipes between Resident #4's tightly closed legs but never cleaned between skin folds or opened Resident #4's legs to allow access to provide complete care.
- NA A failed to remove his/her used gloves and complete hand hygiene after assisting to provide peri care to Resident #4. NA A continued Resident #4's morning cares wearing the same

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gloves he/she wore during peri care.
- NA A and NA B failed to change Resident #4's shirt while dressing him/her, leaving the resident to wear the same shirt he/she wore the previous day and had slept in.
- NA B failed to provide oral care to Resident #4 or to set up supplies for Resident #4 to complete oral care for himself/herself. NA B rinsed Resident #4's dentures with water and assisted Resident #4 to put them in.
- CNA C, NA A, and NA B failed to wash Resident #4's face, to set up supplies for Resident #4 to complete this morning care for himself/herself, or to ask the resident if this is a care he/she would like completed.
- During an interview with CNA C and NA B, both staff members reported that they had been trained to open inner perineal folds and clean this area. Neither staff member was aware that washing the resident's face was part of morning cares reporting that night shift handles that. NA B reported that he/she didn't think dentures needed to be brushed because they had been soaking overnight.

2. Review of Resident #34's care plan, revised 6/20/2024, showed, in part:
- Requires assistance with most ADLs.
- One person to assist with dressing/undressing, and mobility.
- Urinary incontinence and require assist with toileting, and incontinent brief changing.
- One person to assist with incontinence cares/pericares.
- Not able to communicate needs.
- Allow sufficient uninterrupted rest periods.
- At risk for pressure ulcers R/T decreased mobility.

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Observation on 11/20/24 from 5:56 A.M. until 12:21 P.M showed the following interactions with the resident:
- Resident #34 was seated in his/her broda chair (a specialized wheelchair) next to his/her bed, dressed in the same clothes as the day before at 5:56 A.M.
- At 7:45 A.M. Resident #34 was moved to the dining room for breakfast. Resident #34 was still wearing yesterday's clothes and had not been repositioned since this surveyor first observed the resident at 5:56 A.M.
- At 9:00 A.M. Resident #34 was observed sleeping in his/her broda chair in the T.V. room. Resident #34 was still in the same position and wearing the same clothes with no indication that he/she had been repositioned or toileted since this surveyor's first observation of the resident that day.
- At 9:52 A.M. Resident #34 was moved from the T.V. room to the activity room for bible study. The resident remained in the same position and wearing yesterday's clothes. No indication that Resident #34 had been repositioned, toileted, or allowed to rest in bed was observed.
- At 10:54 A.M. Resident #34 was moved from the activity room back to the dining room for lunch. Resident #34 remained within this surveyor's line of sight for the entirety of his/her time in the activity room. No observation of staff repositioning, toileting, or ADL care.
- At 11:51 A.M. Resident #34 was observed being fed by the activities director in the dining room.
- At 12:21 P.M. Resident #34 was taken to his/her room. Nursing staff transferred the resident into bed, and did not change the resident into clean clothes.
- Resident #34 was not interviewable, however the average person would expect to have clean

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clothes, positioning changes, and hygiene needs met.

During an interview on 11/20/24 at 12:42 P.M., NA B said:
- Residents that require a lot of help from staff are usually gotten up by the night shift and are already up when he/she arrives at work in the morning.
- He/she thinks staff is supposed to check and reposition residents every 2 hours, but he/she thinks that might depend on the resident.

During an interview on 11/20/24 at 12:46 P.M., NA A said:
- Residents should be turned and repositioned every 2 hours and that toileting residents should also happen every 2 hours or as needed.

During an interview on 11/21/24 at 12:52 P.M., the DON said:
- Residents are gotten up by staff at a time that is based on each resident's routines and preferences.
- If a resident is up a 5:55 A.M., that resident should be repositioned after breakfast.
- It is unacceptable for a resident to be up from 5:55 A.M. to 12:21 P.M. without being repositioned.

During an interview on 12/2/24 at 10:35 A.M. the DON said:
- During morning cares, "everything" should be addressed, peri care, washing face and hands, and brushing teeth.
- A resident's dentures should be brushed every morning, regardless of how long they had been soaking.
- Staff is expected to change resident's clothing

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according to their personal preference.
Non-verbal residents or resident who are not able to make their needs known should have their clothes changed daily.
- It is expected that staff anticipate the needs of non-verbal residents or residents who cannot make their needs known, and act on them accordingly.

3. Review of Resident #44's Quarterly MDS, dated 9/5/24 showed:
- Long term and short term memory problems;
- Dependent on the assistance of staff for toilet use, showers, dressing, personal hygiene and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included dementia (inability to thing), senile degeneration of the brain (a progressive decline in cognitive function that occurs with age).

Review of the resident's care plan, revised 9/13/24 showed:
- The resident needed assistance with all activities and and daily cares. Required the assistance of one staff for showering, with repositioning in bed, dressing and to propel him/her in the Broda chair (a type of reclining geri chair). The resident required the assistance of two staff for incontinent care and to assist with transfers using the mechanical lift.

Observation on 11/20/24 showed:
- At 5:55 A.M., the resident was already dressed and up in his/her Broda chair;
- At 7:45 A.M., staff propelled the resident to the dining room for breakfast and the resident's eyes were closed;
- At 8:45 A.M., staff propelled the resident from the dining room to the front lobby area by the

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nurse's station and his/her eyes were closed;
- At 8:54 A.M., staff propelled the resident to the TV room;
- At 9:42 A.M., the resident remained in the the TV room in the Broda chair;
- At 9:46 A.M., staff propelled the resident to the large activity room;
- At 10:54 A.M., staff propelled the resident from the large activity room directly to the dining room for lunch. Staff did not offer to toilet the resident or offer him/her any fluids since breakfast and he/she has not been repositioned in the Broda chair;
- At 11:41 A.M., staff sat down to assist the resident to eat;
- At 11:58 A.M., staff propelled the resident from the dining room to the front lobby area by the nurse's station;
- At 12:21 P.M., Nurse Aide (NA) A and NA B propelled the resident to his/her room and used the mechanical lift and transferred the resident from the Broda chair to his/her bed and provided incontinent care in the following manner;
- NA A and NA B turned the resident side to side in bed and removed the lift pad and pulled the resident's pants down and unfastened the incontinent brief with a strong odor of urine noted;
- NA A used the same area of the wipe and wiped down one side of the groin, across the pubic area and down the other side of the groin;
- NA A used a new wipe and wiped once down the middle perineal folds;
- NA A and NA B turned the resident onto his/her side;
- NA A wiped three times from front to back with fecal material on each wipe;
- NA A used the same area of the wipe and wiped up both sides of the buttocks, removed gloves, washed hands, applied new gloves and applied

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house barrier to the resident's red buttocks;
- NA A and NA B placed a clean incontinent brief under the resident and fastened it.

During an interview on 11/20/24 at 12:42 P.M., NA B said:
- The night shift got the resident up this morning;
- The resident was normally up when the day shift arrived to work;
- The resident had not been toileted or laid down since he/she came to work this morning;
- With one of the residents, they have to be checked every two hours but he/she thought it would depend on the resident on how often they were checked;
- He/she had started in August and was in-serviced on peri care.

During an interview on 11/20/24 at 12:46 P.M., NA A said:
- The residents should be turned and repositioned every two hours and toileted as needed or at least every one or two hours;
- The resident should have turned and repositioned every two hours;
- He/she should have separated and cleaned all areas of the skin where urine or feces had touched;
- He/she should not have used the same area of the wipe to clean different areas of the skin.

During an interview on 12/2/24 at 11:16 A.M., the DON said:
- If a resident is up at 5:55 A.M., then staff should reposition and toilet them after breakfast;
- It is not acceptable for a resident to be up from 5:55 A.M. until 12:21 P.M., before they are repositioned or toileted;
- Staff should not use the same area of the wipe

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to clean different areas of the skin;
- Staff should separate and clean all the skin folds.

Review of the facility's shower schedule showed:
- Resident #44 was scheduled to have a shower on Wednesday evening;
- The resident was listed under Hospice (end of life care) on Friday evenings.

Review of the resident's shower sheets shower sheets for August, 2024 showed:
- The resident had two showers out of nine opportunities, 8/17 and 8/14.

Review of the resident's shower sheets shower sheets for September 2024 showed:
- The resident had four showers out of eight opportunities , 9/4, 9/11, 9/18, and 9/25.

Review of the resident's shower sheets shower sheets for October 2024 showed:
- The resident had four showers out of eight opportunities, 10/2, 10/9, 10/16 and 10/23.

Review of the resident's shower sheets shower sheets for November 2024 showed:
- The resident had one shower out of six opportunities, 11/6.

Observation on 11/20/24 at 12:21 P.M., showed the resident's hair was dull and the resident had a strong odor of urine.

During an interview on 11/20/24 at 12:46 P.M., NA A said:
- They have two shower aides on days, the aides do the showers on evening shift;
- On Friday evening, they have a shower aide

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F 677	Continued From page 12 come in to do the showers; - All of the residents should get two showers a week if that's what they want; - If a resident refused their shower, the staff would try to get it made up at some point. During an interview on 12/2/24 at 11:16 A.M., the DON said: - She would expect the residents to get a shower twice a week unless their care plan had something differently.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure residents' safety and independence by pushing residents in their wheelchairs who are able to propel themselves for four of the fourteen sampled residents (residents #17, #10, #39, and #19). The facility census was 55. Review of the Accidents and Incidents policy did not show any details regarding footrest safety. 1. Review of Resident #17's Quarterly MDS (minimum data set), a federally mandated assessment tool completed by facility staff, dated,	F 689		

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F 689	Continued From page 13 9/19/24, showed: -Resident has severely impaired cognition. -Resident is able to wheel themselves in a wheelchair for 150 feet without assistance from helper. -Diagnoses included traumatic brain dysfunction, high blood pressure, anxiety, and depression. Observation on 11/18/24 at 11:29 A.M. showed: -Out of convenience, to move wheelchair traffic out of the hall more quickly. CNA A pushed resident #17 in her/his wheelchair out of dining room without footrests, The resident was instructed to hold feet up while being pushed down the hall, which poses a safety risk, and aides in promoting decline in resident's mobility. 2. Review of Resident #10's Quarterly MDS dated,10/31/24, showed: -Resident is cognitively intact. -Diagnoses included diabetes, osteoporosis, dementia, and depression. -Resident is able to independently walk 150 feet. -Resident uses a manual wheelchair. Observation on 11/19/24 04:03 P.M. showed: -Out of convenience to move wheelchair traffic out of the hall more quickly,CNA B pushed resident #10 in his/her wheelchair to his/her room without footrests. Resident was instructed to hold feet up while being pushed down the hall, which poses a safety risk, and aides in promoting decline in resident's mobility. which poses a safety risk, and aides in promoting decline in resident's mobility.	F 689		

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3. Review of Resident #39's Quarterly MDS dated 10/31/24 showed:
-Resident has moderately impaired cognition.
-Diagnoses included diabetes.
-Resident requires partial/moderate assistance to wheel themselves 150 feet.

Observation on 11/18/24 at 3:53 P.M. showed:
-Out of convenience to move wheelchair traffic out of the hall more quickly, the kitchen manager pushed resident #39 in his/her wheelchair into dining room without putting footrests down Resident was instructed to hold feet up while being pushed down the hall, which poses a safety risk, and aides in promoting decline in resident's mobility.

4. Review of Resident #19's Annual MDS dated, 8/29/24, showed:
-Resident is cognitively intact.
-Diagnoses include stroke, high blood pressure, paralysis on one side of the body, and seizure disorder.
-Resident is able to wheel themselves in a wheelchair for 150 feet without assistance from helper.

Observation 11/19/24 at 3:30 P.M. showed:
-Out of convenience to move wheelchair traffic out of the hall more quickly, the Activities director pushed resident #19's wheelchair out of the dining room without footrests, Resident was instructed to hold feet up while being pushed down the hall, which poses a safety risk, and aides in promoting decline in resident's mobility

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F 689	Continued From page 15 Residents #17, #10, #39, and #19 were not interviewable, however a reasonable person would want to propel their self if possible or have a foot rest to protect their feet. During an interview on 11/21/24 at 10:00 A.M., CNA A said there are foot pedals accessible for residents that need them. She said it is standard practice to push a resident without foot pedals if the resident can lift their feet because they don't want the resident to get hurt. During an interview on 11/20/24 at 4:11 P.M., LPN A, said that nursing staff will recommend footrests if a resident's feet are dragging. He/She said there needs to be footrests if a resident is not able to propel themselves but believes it to be ok for staff to push a resident without footrests if they are able to lift their feet up. He/She stated that it is probably a gray area because residents could get hurt. During an interview on 11/21/24 at 12:52 P.M., the DON said residents in wheelchairs should not be pushed by staff if their wheelchair does not have footrests.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		

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§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure they assessed residents for risk of entrapment from bed rails prior to installation, failed to review the risk and benefits with the resident or the resident's representative (Resident #5, #45) , failed to obtain informed consent prior to installation (Resident #5 and #45), failed to ensure the bed's dimensions were appropriate for the resident's size and weight (Resident #5 and #45), failed to obtain a physician's order prior to installation of side rails (Resident #5), and failed to complete quarterly safety assessments for residents (Resident #5, #45), and failed to care plan side rails (Resident #5). This included four of 14 residents sampled (Residents #5, #45, #17, and #42). The facility census was 55.

Review of facility policy, bed assist bar usage, revised 4/24/24, showed:
-Policy to prevent entrapment and other safety hazards associated with bed assist bar use.
-Facility leadership will be responsible for

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completing individual assist bar evaluation on a regular basis;
-Providing employees appropriate information, education, training pertaining to general risks and benefits of assist bar use;
-Education pertaining to resident-specific risks and care needs associated with bed assist bar use;
-Upon admission, readmission or change of conditions residents will be screened to determine level of independence with bed mobility, bed comfort level, if bed meets manufacturers recommendations and specifications pertaining to resident height and weight, and assess the need for special equipment and accessories (assist bars);
-Assess the resident to identify appropriate alternative prior to installing assist bars;
-Assess the resident for risk of entrapment from assist bar(s) prior to installation;
-Facility will document ongoing need for the use of an assist bar;
-Review the risks and benefits with resident and resident representative;
-Obtain informed consent;
-Obtain physician order for medical symptom assessed for need for assist bar use;
-Resident care plan will include use of assist bar(s) as assessed);
-When installing or maintaining assist bar(s), the maintenance department staff will follow the manufacturer's recommendations and specifications, or provide another bed or appropriate alternative in accordance with individual bed inspections.
-Maintenance department will conduct regular annual inspection of all bed frames, mattresses, and quarterly on assist bar(s) as part of a regular maintenance program to identify areas of

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possible entrapment;

1. Review of admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/22/24, showed:
-He/She admitted to facility on 8/12/24;
-He/She was cognitively intact;
-He/She had clear speech, clear comprehension, and ability to understand others;
-He/She had no impairment to upper or lower extremities;
-He/She was dependent on a wheelchair;
-He/She was independent with mobility, dressing toileting, and personal hygiene;
-Diagnoses included diabetes (too much sugar in the blood), heart failure, and high blood pressure.

Review of physician's orders, dated 11/18/24, showed no orders for the use of side rail or assist bars.

Review of care plan, dated 9/4/24, did not address use of side rails or assist bars.

During an interview on 11/18/24 at 2:36 P.M., resident said he/she had side rail so he/she could hold onto it to help position self in bed and assist self when he/she stood up out of his/her bed.

Observation on 11/18/24 at 2:36 P.M. showed resident had a u shaped cane rail on right side of bed.

Review of electronic medical record showed:
-He/She did not have consent for side rails;
-He/She did not have side rail assessment;

A request for the bed and assist rail maintenance inspection form for the resident was requested

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and not provided.

During an interview on 11/21/24 at 10:08 A.M., MDS Coordinator said:
-He/She did not have a side rail assessment completed on the resident;
-He/She did not have a physician's ordes for side rails for the resident;
-He/She was unsure if resident's side rails were care planned.

2. Review of Resident #45's Quarterly MDS, dated 9/19/24, showed:
-He/She was cognitively intact;
-He/She had clear speech, was able to make self-understood and clear comprehension of others;
-He/She had impairment of one side of lower extremities;
-He/She was dependent on a wheelchair;
-He/She required partial to moderate assistance with lying to sitting on side of bed, chair to bed transfers, sit to stand transfers, toilet transfers, and upper body dressing;
-He/She required substantial to maximal assistance with lower body dressing, bathing, and applying footwear;
-Diagnoses included amputation of left leg below the knee, diabetes, high blood pressure.

Review of physician's orders, dated 11/19/24, showed:
-Start dated 4/23/24, may use positioning bars for bed mobility and transfers;
-Start date 8/13/24, non weight bearing to left leg.

Review of care plan, revised 9/4/24, showed:
-Resident expressed a desire to use positioning bars to serve as an enabler to promote

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independence;
-He/She had consented to use positioning bars;
-Orders per primary care provider, may use positioning bars for bed mobility and transfers;
-Positive and negative aspects of positioning bar use have been discussed with resident and/or family and are aware of risks involved with use of positioning bars;
-Review of positioning bar use every quarter with significant status change. Remove bars if no longer appropriate;
-Resident needed assist with some activities of daily living due to left below knee amputation.

During an interview on 11/18/24 at 3:20 P.M., Resident said:
-He/She used side rails to pull self up;
-The side rails had been on bed ever since he/she had the bed.

Observation showed on 11/18/24 at 3:20 P.M. that resident had a u-shaped cane rail on both sides of his/her bed.

Review of side rails assessment showed:
-9/19/24 he/she was assessed for side rails to use to assist with transfers and bed mobility;
-6/20/24 he/she was assessed for side rails to use to assist with transfers and bed mobility.

Review of bed and assist rail maintenance inspection form showed:
-Bed assessment frequency-If assist bar(s), initally when installed, quarterly, and/or when bed frame, mattress, or other accessories replaced
-The Inspection form dated 6/5/24, showed there was no gaps of 4 and 3/4 inches inside the rail, under the rail, between the rail and the matress, or 2 and 3/8 inches between the rail and the

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headboard or footboard while resident was in his/her bed;
-The facility provided no other completed quarterly assessments.

3. Review of Resident #17's Quarterly MDS, dated 9/19/24, showed:
-Resident was rarely/never understood.
-Resident had a memory problem.
-Resident's cognitive skills for daily decision making was moderately impaired.
-Resident required partial/moderate assistance to move from lying to sitting on side of bed.
-Resident required partial/moderate assistance to move from sitting to lying on back in bed.
-Resident's diagnoses included traumatic brain dysfunction, heart disease, high blood pressure, and depression.

Observation on 11/21/24 at 11:07 A.M., showed resident has a U-shaped cane rails on both sides of the bed.

Review of care plan, dated 4/25/24, showed:
-Family had expressed a desire for me to use positioning bars to serve as an enabler to promote independence.
-Family had consented for me to use positioning bars.
-Order per my PCP, may use positioning bars for bed mobility and transfers
-Positive and negative aspects of positioning bar use have been discussed with resident and/or family and are aware of risks involved with use of positioning bars
-Review of positioning bar use every quarter and with significant status change. Remove bars if no longer appropriate.

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Review of physician orders, dated 4/23/24, showed the reisdent may use positioning bars for mobility and transfers.

Review of Bed Rail Safety Assessment, dated 5/20/24, showed the resident was assessed for bed rails.

Review of Side Rail Use Assessment Form, dated 4/24/24, showed a recommendation for side rails on both sides of the bed to help with independence.

A quarterly bedrail assessment was requested and not provided.

During an interview on 11/21/24 at 09:59 A.M., NA A said the U-shaped rails are used to assist the resident in turning in bed or to get out of bed or to grab to position while receiving cares.

During an interview on 11/20/24 04:11 PM LPN A said the U-shaped rails are for mobility.

4. Review of Resident #42's Quarterly MDS, dated 8/29/24, showed:
-Resident had severe cognitive imparment.
-Resident had no imparment in upper or lower extremity functional range of motion.
-Resident was able to roll from left to right independently.
-Resident required no assistance to move from lying to sitting on side of bed.
-Resident required no assistance to move from sitting to lying on back in bed.
-Resident's diagnoses included traumatic brain dysfunction, high blood pressure, and Alzheimer's disease.

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Observation on 11/21/24 at 11:07 A.M., showed resident has a U-shaped cane rail on left side of the bed.

Review of care plan, dated 4/25/24, showed:
-Family had consented to use positioning bars.
-Order per PCP, may use positioning bars for bed mobility and transfers
-Positive and negative aspects of positioning bar use have been discussed with resident and/or family and are aware of risks involved with use of positioning bars
-Review of positioning bar use every quarter and with significant status change. Remove bars if no longer appropriate

Review of Bed Rail Safety Assessment, dated 5/24/24, showed the resident was assessed for bed rails.

Review of Side Rail Use Assessment Form, dated 4/24/24, showed the recommendation for side rails on the left side of the bed to help with independence.

Review of care plan, dated 4/25/24, showed:
-Family has expressed a desire to use left positioning bar to serve as an enabler to promote independence.
-Family has consented to use positioning bar.
-Order per my PCP, may use positioning bar for bed mobility and transfers.
-Positive and negative aspects of positioning bar use have been discussed with resident and/or family and are aware of risks involved with use of positioning bar.
-Review of positioning bar use every quarter and with significant status change. Remove bar if no

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F 700	Continued From page 24 longer appropriate Start Date 04/25/2024 Review of physician's orders, dated 4/23/24, showed the resdient may use positioning bars for bed mobility and transfer. A request for quarterly bedrail assessment was made but not provided. During an interview on 11/21/24 at 10:53 A.M., the resident said the U-shaped rail is really handy. He/she uses it to get up. During an interview on 11/20/24 at 8:15 A.M, Director of Nursing (DON) said: -Facility did complete side rail assessments on residents; -Sometimes residents move in and side rails are already installed on the bed they move into; -Facility must obtain physician's orders prior to installing side rails; -Side rails should be care planned; -Maintenance staff has a guide for entrapment measurements; -Facility switched from side rails to only using u-shaped cane bars and did not view the cane rails as same risk for entrapment; -The Minimum Data Set (MDS) Nurse completed side rail assessments on residents. During an interview on 11/20/24 at 2:39 P.M., Maintenance said: -Facility only used mobility bars (u-shaped cane rails); -Nurse or therapy department will notify him/her to put the side rails on the bed; -He/She completed measurements with the mattresses and side rails using a guide called	F 700		

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bed and assist rail maintenance inspection form and bed rail safety assessment;
-He/She completed the entrapment assessment with the bed rail safety assessment when resident first comes into facility and with the change of mattress;
-He/She did not measure entrapment zones on a monthly basis;
-He/She completed a safety assessment monthly to ensure side rails had not come undone;
-Does not measure on a monthly basis;
-Does do safety assessments;
-Side rails will not come out if undone, all have give, there is a deal underneath the clips that go into the side of the bed, will not let you release bars.

During an interview on 11/20/24 at 3:05 P.M., Licensed Practical Nurse A said:
-Side rails are assessed upon admission of new residents;
-He/She would ask resident or family if the side rails were something they preferred or would aide them in getting around and in and out of their bed;
-If resident wanted side rails he/she would get a hold of maintenance;
-If resident had side rails on their bed they should have a physician's order;
-He/She would request a physician's order for the side rail;
-MDS coordinator completed quarterly side rail assessments for residents;
-Side rails should be included in resident's care plan.

During an interview on 11/21/24 at 10:08 A.M., MDS Coordinator said:
-Side rails are not already installed on resident's

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bed;
-Side rails are installed when and if a resident requested them;
-Facility completed assessments to determine if side rails were appropriate for the resident;
-Assessments were done quarterly;
-A physician's order for the side rails must be obtained from the physician;
-Maintenance or housekeeping would install the side rails;
-He/She obtained consents by calling the resident's representative or discussing with resident if they were their own person and obtain consent;
-Consent was included under the side rail assessment form;
-The initial side rail assessment would show the consent signature of resident or their representative;
-Maintenance staff is responsible for measuring dimensions and areas of entrapment;
-He/She assumed entrapment zones were measured quarterly but did not know for sure;
-A physician's order was required prior to installing side rails;
-He/She expected side rails to be care planned;
-He/She was responsible for writing care plans.

During an interview on 11/21/24 at 12:52 P.M., Administrator said:
-Verbal or written consent must be obtained for installation of side rails;
-Side rail consents were documented on initial side rail assessment form but were not updated with quarterly assessments;
-Entrapment assessments should be completed be completed upon initial installation and quarterly;
-He/She expected a physician's order prior to

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F 700	Continued From page 27 installation of side rails.	F 700		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure staff administered medications with a medication rate of less than five percent (%). Staff made 6 medication errors out of 31 opportunities for error, which resulted in an error rate of 19.35%. This affected 4 of the 14 sampled residents, (Residents #5, #29, #49, and #50). The facility census was 55. Review of the facility's policy for preparation and administration of oral medications, revised 2/1/24 showed, in part: To ensure the resident receives prescribed medications as ordered by Doctor utilizing the most current nursing practice. Review and verify medication administration records/medication cards with Doctor's order according to facility policy. Check medication record/card and remove the container of medication from the bin. LIQUIDS - Shake liquid (unless medication is not to be shaken) holding label to palm and pour into calibrated cup at eye level. Check the medication record/card and label again. Physician Order to be followed completely. This	F 759		

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includes completing medication as ordered.

Review of the facility's policy for administration of eye medications, revised 1/31/2024 showed, in part:
- POLICY: To ensure resident receives the prescribed medication as ordered by the Doctor utilizing the most current acceptable nursing practice.
- (2.) Check the treatment record with the medication label.
- (11.) Do not let the dropper tip touch the eye, eyelid, or finger.
- (15.) Read label of medication again.

1. Review of Resident #29's Physician order sheet (POS), dated 10/20/2024 - 11/20/2024 showed:
- Start date: 10/17/2019 - Artificial Tears (polyvin alc) (polyvinyl alcohol) [OTC] drops; 1.4%; amt: 2 drops each eye; ophthalmic (eye) Three Times A Day; AM 06:00 - 10:00, MD 13:00 - 16:00, PM 19:00 - 22:00.

Review of the Resident #29's medication administration record (MAR), dated 11/01/2024 - 11/20/2024 showed:
- Artificial Tears (polyvin alc) (polyvinyl alcohol) [OTC] drops; 1.4%; Amount to Administer: 2 drops each eye; ophthalmic (eye)
- Documentation shows it was administered three times per day for the past 19 days;

Observation and interview on 11/20/24 at 6:06 A.M., showed:
- LPN C administered eye drops that were labeled with a different resident's patient sticker. LPN C retrieved a box of artificial tears from the med cart. The box had Resident #29's name written in

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black marker across the front. The patient sticker on the bottom of the box was labeled with the name of a different resident. LPN C used the bottle of artificial tears from the mislabeled box for administration.
- LPN C failed to keep the tip of the applicator bottle from touching the resident's eye lashes during administration.
- LPN C reported during interview that the facility regularly has in-service and education related to medications and medication administration.
- LPN C stated she was unaware that the sticker on the bottom of the box had another resident's name on it.

During an interview with the Director of Nursing (DON) on 11/21/24 at 12:52 P.M. the DON said:
- the tip of the eye dropper should not touch the eyelid or eye lashes when administering eye drops.

2. Review of Resident #50's Physician order sheet (POS), dated 10/19/2024 - 11/19/2024 showed:
- Start date: 01/22/2024 - House Supplement 120 mL BID for weight loss, advanced age Twice a day; AM 06:00 - 10:00, PM 15:00 - 18:00

Review of Resident #50's medication administration record (MAR), dated 11/01/2024 - 11/19/2024 showed:
- House Supplement 120 mL BID d/t weight loss, advanced age.
- Documentation shows it was administered twice per day for the past 19 days.

Observation and interview on 11/20/24 at 6:24 A.M., showed:
- LPN C failed to follow the provider's orders

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when he/she administered an unknown dose of House Supplement. LPN C retrieved the bottle of House Supplement from the med cart and proceeded to fill a small plastic cup without measuring it and administered the liquid to Resident #50.
- LPN C said, that he/she was unaware of how many milliliters (mL) the cup held.

During an interview with the DON on 12/2/24 at 10:45 A.M., the DON said:
- When preparing liquid medications, staff are expected to measure the liquid in a measuring cup at eye level.
- That all liquid medications should be measured before administration.
- To his/her knowledge there is no liquid medication used in the facility that would not need to be measured before administration.

3. Review of Resident #49's POS dated November, 2024 showed an order start date for 2/29/24 for Olopatadine drops 0.1 % one drop daily in each affected eye for dry eyes.

Review of the resident's MAR dated November, 2024 showed an order for Olopatadine drops 0.1 % one drop daily in each affected eye for dry eyes.

Observation on 11/20/24 at 6:45 A.M., showed:
- CMT A placed one drop in the resident's left eye and the tip of the eye dropper touched the resident's eye lid and eye lashes and applied lacrimal pressure for 13 seconds;
- CMT A placed one drop in the resident's right eye and the tip of the eye dropper touched the resident's eye lid and eye lashes and applied lacrimal pressure for 14 seconds.

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During an interview on 11/21/24 at 10:21 A.M., CMT A said:
- The tip of the eye dropper should not touch the resident's eye lid or eye lashes;
- Should apply lacrimal pressure for five to ten seconds.

During an interview on 11/21/24 at 12:52 P.M., the DON said:
- The tip of the eye dropper should not touch the resident's eye lid or eye lashes;
- Staff should apply lacrimal pressure for one minute.

4. Review of the facility's policy for nasal medication administration revised 2/1/24, showed, in part:
- To ensure resident receives nasal medication per physician's orders according to approved procedures;
- Position resident: sitting up for nasal sprays;
- Give the resident a tissue and instruct to blow nose to clear nasal passage;
- Instruct resident to use finger to close nostril opposite of nostril receiving medication;
- Administer the dosage: insert spray nozzle gently into nose and spray;
- Wipe away excess medication with tissue;
- Instruct resident not to blow nose for a few minutes.

Review of the package leaflet for Flonase nasal spray, revised March 2016, showed, in part:
- Shake the bottle gently;
- Blow your nose to clear the nostrils;
- Close one side of the nostril. Tilt your head forward slightly and carefully insert the nasal applicator into the other nostril;
- Start to breathe in through your nose, and while

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F 759	Continued From page 32 breathing in press firmly and quickly down one time on the applicator to release the spray; - Repeat in the other nostril; - Wipe the nasal applicator with a clean tissue and replace the cap. Review of Resident #5's POS dated November, 2024 showed: - Start date: 11/11/24 - Fluticasone (Flonase) propionate spray, 50 micrograms (mgs.) two sprays in both nostrils daily for chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing). Review of the residents's MAR, dated November, 2024 showed: - Fluticasone (Flonase) propionate spray, 50 mgs., two sprays in both nostrils daily for COPD. Observation on 11/20/24 at 7:16 A.M., showed: - CMT A did not shake the Flonase bottle; - CMT A did not have the resident blow his/her nose; - CMT A administered two sprays in the resident's right nostril and gave two sprays in the left nostril and did not occlude either side of the nostril. During an interview on 11/21/24 at 10:21 A.M., CMT A said: - He/she should follow the manufacturer's guidelines for administration of Flonase. During an interview on 11/21/24 at 12:52 P.M., the DON said; - She would expect the staff to follow the manufacturer's guidelines for the administration of Flonase.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 33 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 observation, record review, and interviews, the facility failed to prepare and serve food in accordance with professional standards for food service safety when staff failed to utilize proper thawing techniques, failed to ensure garbage cans were kept covered when not in use, failed to properly sanitize all food preparation surfaces in kitchen, failed to store dishes in an inverted position, failed to implement proper hand washing techniques, and failed to ensure proper storage and labeling of foods. The facility census was 55. 1. Review of facility policy, waste disposal, dated April 2011, showed: -All waste must be placed in lined garbage and	F 812		

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trash cans and kept covered when not in use.

Observation on 11/18/24 9:07 A.M., showed there was no lids on two large trash cans, one in dishwashing area and one towards back of kitchen.

Observation on 11/20/24 at 9:21 A.M. showed no lids were on the trash cans in the kitchen.

During an interview on 11/20/24 at 2:49 P.M., Cook A said:
-Trash cans in the kitchen should have lids on them at all times.

During an interview on 11/20/24 at 4:02 P.M., Registered Dietician said:
-Trash cans in kitchen should have lid.

During an interview on 11/21/24 at 8:51 A.M., Cook B said:
-Trash cans in kitchen should have lids on them.

During an interview on 11/21/24 at 9:00 A.M., Dietary Aide A said:
-Trash cans in kitchen should be covered;
-The trash cans in the kitchen were not covered.

During an interview on 11/21/24 at 9:09 A.M., Dietary Manager said:
-He/She expected trash cans in kitchen to be covered at all times unless they are being used.

During an interview on 11/21/24 at 12:52 P.M., Administrator said:
-He/She expected trash cans in the kitchen to be covered.

2. Review of facility policy, hand washing and

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glove use dining services, posted 9/5/11, showed:
-All residents and staff should be free from contamination by improper hand washing and glove use.
-Wash hands after every activity such as eating, drinking, using the restroom, touching a resident or wheelchair, picking up trash, taking out the trash, touching face or hair, bussing tables;
-Wash hands before and after glove use;
-Wash hands following the instructions located at every hand sink.

Review of facility policy, untitled, revised 7/22/14, showed:
-Use proper hand washing techniques often and when necessary (hand washing should be done after any activity, such as eating, drinking, using the restroom, smoking, cleaning, touching anything contaminated, and before and after glove use)

Review of facility policy, dishwashing, dated April 2011, showed:
-Sanitize hands properly before pulling racks from the clean side of the dish machine;
-Allow items to thoroughly dry before unloading racks or storing items.

During a continuous observation on 11/20/24 from 9:21 A.M.-11:35 A.M., showed:
-9:29 A.M., Cook B washed his/her hands and then turned faucet off with his/her paper towel, and continued to use same paper towel to dry his/her hands;
-9:36 A.M. Cook B went from dirty dishes of dishwasher to clean side of dishwasher. He/She removed items from clean side of dishwasher without washing his/her hands;
-9:45 A.M., Dietary Aide B washed his/her hands

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and used bare hands to shut off water faucet handles. He/She then dried hands with paper towel;
-10:10 A.M., Dietary Aide B washed his/her hands and used bare hands to turn off faucet handles;
-10:23 A.M., Dietary Aide B washed his/her hands and used bare hands to turn off faucet handles;
-10:51 A.M., Cook B washed his/her hands, used paper towel to turn off faucet, then used same paper towel to dry his/her hands;
-11:09 A.M., Dietary Aide B washed his/her hands and used bare hands to turn off faucet handles.

Review of facility policy, dishwashing, dated April 2011, showed:
-Sanitize hands properly before pulling racks from the clean side of the dish machine.

During an interview on 11/20/24 at 2:49 P.M., Cook A said:
-He/She must wash hands any time changing tasks, entering kitchen, and any time he/she contaminates his/her hands;
-It was not sanitary to wash his/her hands and then use his/her bare hands to shut off faucet;
-It was not sanitary to wash his/her hands, turn off faucet handles with paper towel, and then use same paper towel to dry his/her hands.
-He/She should wash hands after loading dirty dishes into dishwasher and before taking clean dishes out of dishwasher.

During an interview on 11/20/24 at 4:02 P.M., Registered Dietician said:
-He/She expected frequent hand washing with anytime changing tasks, leave kitchen and returning to kitchen;
-It was not sanitary for staff to wash hands and turn faucet off with bare hands;

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F 812	Continued From page 37 -He/She expected staff to use a different paper towel to shut off faucet after washing hands and should not use same paper towel to dry his/her hands; -He/She expected staff to wash hands between loading dirty dishes and removing items from clean side of dishwasher. During an interview on 11/21/24 at 8:51 A.M., Cook B said: -He/She had to wash hands if went to bathroom, took out trash, wipe off carts, touch his/her face, brush his/her hands, or when entered kitchen; -It was not sanitary for him/her to shut off faucet handles with bare hands after washing his/her hands; -It was not sanitary for him/her to shut off faucet handles with paper towel and use same paper towel to dry his/her hands. -He/She did not know if he/she should wash his/her hands before removing clean dishes from dishwasher During an interview on 11/21/24 at 9:00 A.M., Dietary Aide A said: -He/She should wash hands by running water for 20 seconds, putting on soap, rubbing nails and stuff, rinsing hands off, pull paper towels down, turn off water with paper towel; -It was not sanitary to use his/her bare hand to shut off water faucet; -It was not sanitary to use paper towel to shut off water faucet and then use same paper towel to dry his/her hands. During an interview on 11/21/24 at 9:09 A.M., Dietary Manager said: -He/She expected staff to wash their hands between going to bathroom, smoking, when in	F 812		

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and out of the kitchen;
-He/She expected staff to turn off faucet handles after washing their hands with a towel;
-He/She expected staff to wash their hands before going to clean side of dishwasher and putting dishes away.

During an interview on 11/21/24 at 12:52 P.M., Administrator said:
-He/She expected dietary staff to wash hands frequently;
-He/She expected staff to wash hands and turn faucet off with a paper towel;
-He/She did not expect staff to turn off faucet handles with bare hands or use the same paper towel to turn off faucet handles and then dry their hands with same paper towel but expected them to use new paper towel.

3. Review of facilitys food policy, untitled, revised 8/26/11, showed:
-Leftovers will be stored and discarded properly;
-Put leftovers in appropriate containers;
-Label, date, and initial the containers;
-Place containers in cooler or freezer.
-Max storage for leftovers is 7 days for canned fruits, vegetables, etc. and 3 days for foods prepared with mayor or cooked meats.

Review of facility policy, receiving and storage of food, dated April 2011, showed:
-Keep all foods in clean, undamaged wrappers or packages;

Observation on 11/18/24 at 8:57 A.M. of the walk in cooler in kitchen showed:
-Opened, unsealed, and undated bag of soft shell tortillas;
-Opened and undated 5 lb shredded Monterey

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jack cheese;
-Opened and undated 5 lb pimento spread;
-Three sections of opened and undated American cheese wrapped in clear plastic wrap;
-Opened and undated bag of hard boiled eggs;
-Opened and undated dough;

Observation on 11/18/24 at 9:03 A.M. of dry storage showed:
-Undated and opened 5lb egg noodles;
-Undated and unsealed 10 oz bag of spaghetti noodles;
-Undated bag of mini marshmallows;

Observation on 11/18/24 at 9:07 A.M. of spice rack showed:
-Outdated 16 oz ground clove, dated 10/11/22
-Opened and undated 16oz chives;
-Opened and undated garlic powder had no date;
-Opened and undated Italian seasoning;
-Opened and undated lemon pepper 20oz;
-Opened and undated basil leaves 20 oz;
-Opened and undated celery salt 20 oz;
-Opened and outdated dill weed, dated 1/10/22;
-Opened and outdated rubbed sage 60z dated 10/11/22;
-Opened and undated Hungarian paprika 18oz;
-Opened and undated 20 oz onion powder;
-Opened and undated beef flavor soup base 16 oz;
-Opened and undated chicken flavor soup base 16 oz;
-Opened and undated iodized table salt 26 oz;
-Opened and undated season salt 16 oz;
-Opened and undated corn starch 16oz;
-Opened and undated cinnamon, 16 oz;
-Opened and undated nutmeg 16oz;
-Opened and outdated ground ginger 14oz dated 1/17/22.

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F 812	Continued From page 40 Observation on 11/18/24 at 9:12 A.M. of food preparation table: -Opened and undated sliced white bread; During an interview on 11/20/24 at 2:49 P.M., Cook A said: -Food should be dated when opened with date opened and three days following; -Spices should be dated; -Spices could be maintained thirty days to one year after opening; -Spices should be thrown out after one year During an interview on 11/20/24 at 4:02 P.M., Registered Dietician said: -He/She expected a date and label on anything left over from being cooked or that was taken out of a can; -Leftovers could be kept for three days; -He/She expected condiments such as salad dressing to have a written opened date and a disposal date one month after that open date; -Spices should be dated when opened; -Spices should be disposed one year after opened date; -He/She expected staff to dispose of spices after 1 year. During an interview on 11/21/24 at 8:51 A.M., Cook B said: -He/She dated food items when he/she opened them; -Bags should be sealed; -Spices should have a date on them; -He/She did not know how long spices could be maintained in kitchen from date they were opened.	F 812		

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During an interview on 11/21/24 at 9:00 A.M., Dietary Aide A said:
-He/She dated food items when they were opened;
-Items stored in fridge or freezer should be sealed;
-Spices should be dated when they were opened.

During an interview on 11/21/24 at 9:09 A.M., Dietary Manager said:
-He/She expected spices to have dates written on the bottle after they were opened;
-Spices could be kept for 1 year after they were opened;
-Food items that are opened should have a date on them;
-Food items should not be exposed to air;
-Everything store should be sealed.

During an interview on 11/21/24 at 12:52 P.M., Administrator said:
-He/She expected food in kitchen to be dated when opened;
-He/She expected opened food to be stored in sealed containers;
-He/She expected spices dated 2022 to be discarded.

4. Facility did not provide a policy on storage of dishware.

Observation on 11/18/24 at 9:01 A.M. showed bowls and plates are stored upright.

Observation on 11/18/24 at 9:18 A.M. showed 17 metal bake pans were stored upright, three bowls sat on top of microwave not in use stored upright;

Observation on 11/20/24 at 9:21 A.M. showed

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plates and bowls were stored face up on counter. Bowls located on top of the microwave were stored up right.

Observation on 11/20/24 at 11:08 A.M. showed under the steam table shelf had plastic containers, bowls, with lids were all stored upright.

During an interview on 11/20/24 at 2:49 P.M., Cook A said:
-Bowls, plates, cups, pans, pitchers should be stored inverted;

During an interview on 11/20/24 at 4:02 P.M., Registered Dietician said:
-Anything that could be stored inverted should be including plates, bowls, pitchers, and bakeware.

During an interview on 11/21/24 at 8:51 A.M., Cook B said:
-They always stored plates, dishes, bowls upright in the kitchen.

During an interview on 11/21/24 at 9:09 A.M., Dietary Manager said:
-He/She expected plates when stored at the end of the day to be covered with a blanket and stored up right;
-Items that have contact with food should be covered or stored upside down;
-Pitchers and bowls should be stored inverted if they were not covered.

5. Facility did not provide a policy on proper unthawaing techniques.

Observation on 11/18/24 at 8:57 A.M. of the walk in cooler showed a 5 lb roll of hamburger was

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unthawing on top of a cardboard box on the bottom shelf;

During an interview on 11/20/24 at 2:49 P.M., Cook A said:
-Meat should be unthawed in fridge prior to when need it;
-Hamburger should not be unthawing on top of card board box;

During an interview on 11/20/24 at 4:02 P.M., Registered Dietician said:
-He/She expected meat to be unthawed overnight in the refrigerator in a separate container.
-Meat could be unthawed under running water below 70 degrees in a pinch, but he/she preferred meat be unthawed in advance.

During an interview on 11/21/24 at 9:09 A.M., Dietary Manager said:
-Meat should be unthawed in refrigerator or during cooking process;

6. During a continuous observation on 11/20/24 from 9:21 A.M.-11:35 A.M., showed:
-9:21 A.M., towels and Dawn dish soap out on counter, Cook B used a wash cloth to wipe off food prep surfaces that was not in sanitizer water.
-9:24 A.M., Cook B tested sanitizer water showed appropriate parts per million (PPM), stated he/she set up the sanitizer water when he/she came into shift that morning;
-9:40 A.M., Dietary Aide A used a green towel that was in a gray pale bucket next to dawn dish soap to wipe off 3 tiered cart.

During an interview on 11/20/24 at 2:49 P.M., Cook A said:
Surfaces in kitchen should be sanitized with water

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we make from our sanitizer out of the machine or 409.

During an interview on 11/20/24 at 4:02 P.M., Registered Dietician said:
-He/She expected kitchen surfaces to be sanitized with sanitizer solution.

During an interview on 11/21/24 at 8:51 A.M., Cook B said:
-He/She sometimes used dish soap to wash off surfaces in the kitchen;
-He/She at times would use dish soap and sanitizer on kitchen surfaces in the kitchen;
-He/She did not always use both dish soap and sanitizer and sometimes only sanitized surfaces with dish soap.

During an interview on 11/21/24 at 9:00 A.M., Dietary Aide A said:
-He/She was using soapy dish water in gray container to wash off kitchen carts;
-He/She did not use sanitizer on the 3 tiered carts;
-He/She would use towels to dry off coffee cups and silverware;
-He/She used dish soap to sanitize surfaces in the kitchen;
-He/She also used sanitizer that comes from dishwasher to sanitize surfaces in the kitchen.

During an interview on 11/21/24 at 9:09 A.M., Dietary Manager said:
-Kitchen prep surfaces should be scrubbed with dish detergent, then expected staff to use 409;
-He/She expected sanitizer to be used on food prep surface areas;
-Towels were not supposed to be used to dry things and should only be used for carts and stuff;

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F 812	Continued From page 45 -He/She expected dish soap and sanitizer to be used on carts; During an interview on 11/21/24 at 12:52 P.M., Administrator said: -He/She expected surfaces in kitchen to be cleaned with sanitizer solution and then allowed to dry.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record

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review, the facility failed to follow acceptable infection control practices to reduce the development and spread of infections for three of the 14 sampled residents (Resident #18, #24, and #53), and failed to ensure the urinary catheter drainage bag for Resident #53 did not touch contaminated surfaces. The facility additionally failed to place residents with wounds (Resident #18 and Resident #24) and with urinary catheters (Resident #18 and #53) on enhanced barrier precautions (EBP). The facility census was 55.

Review of the facility's Enhanced Barrier Precautions policy, dated August 2022, showed:
- EPBs are utilized to prevent the spread multi drug resistant organisms (MDRO) to residents;
- EPBs employ targeted gown and glove use during high resident care activities when contact precautions do not otherwise apply;
- Gloves and gowns are applied prior to performing the high contact resident care activity;
- Examples of high contact resident care activities that require the use of gown and gloves are;
- Catheter care or use;
- Wound care;
- EPBs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling device;
-Signs are posted on the door or on the wall outside the resident's room indicating the type of precautions and personal protective equipment (PPE) required.

Review of the facility's Catheter Emptying, Urinary Drainage Bag, revised 1/31/24, showed:
-Keep the drainage bag and tubing off the floor at all times to prevent contamination.

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1. Review of Resident #53's Admission Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 10/30/24, showed:
-No cognitive impairment;
-Substantial assistance with showers;
-Partial assistance with toileting;
-The resident has indwelling urinary catheter;
-Frequently incontinent of bowel;
-Diagnoses included, kidney failure, and thyroid dysfunction.

Review of the resident's care plan dated 11/1/24, showed:
-The resident requires the assistance of one staff for Activities of Daily Living (ADLs);
-The resident has an indwelling urinary catheter;
- Do not allow tubing or any part of the drainage system to touch the floor.

Observation on 11/21/24, at 9:36 A.M., showed:
-There was a yellow gown for PPE hanging on the back of the resident's door;
-Certified Nurses Aide (CNA) D washed his/her hands and applied gloves;
-CNA D removed the residents brief;
-CNA D lowered catheter drainage bag to the floor by the catheter tubing;
-The resident's catheter drainage bag came in contact with the floor;
-CNA D drained the urine from the top of the catheter tubing into the drainage bag and hung it on the bed;
-CNA D removed the drainage bag from the bed and drained the urine out of the catheter tubing again;
-The drainage the bag came in contact with the floor again and with top of the trash can beside the resident's bed;

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F 880	Continued From page 49 -CNA D failed to keep the catheter drainage bag off the floor; -CNA D failed to keep the catheter drainage bag from touching the trash can; -CNA D did not apply the yellow isolation gown hanging on the back of the resident's door before starting cares on the resident; -No signs were posted on the door or on the wall outside the resident's room indicating the resident was on EBP. During an interview on 11/21/24 at 9:48 A.M., CNA D said: -The catheter drainage bag or tubing should not touch the floor; -The catheter drainage bag or tubing should not touch the trash can; -He/she was not aware that the resident was on EBP. During an interview on 11/21/24 at 9:57 A.M., Registered Nurse (RN) A said: -The catheter drainage bag or tubing should not touch the floor; -The catheter drainage bag or tubing should not touch the trash can; -If a resident has a catheter they should be on EBP; -The resident should have a sign on the door or the wall indicating EBP should be used; -The yellow gown on the back of the residents door is used for EBP. During an interview on 11/21/24 at 12:52 P.M., the Director of Nursing (DON) said: -He/she expects the staff to use EBP when the resident has a catheter or a wound; -He/she expects staff to keep catheter drainage bags from touching the floor or other	F 880		

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contaminated surfaces.
2. Review of Resident #18's Admission MDS, dated 11/7/24 showed:
- Cognitive skills intact;
- Upper and lower extremities impaired on both sides;
- Dependent on the assistance of staff for toilet use, showers, dressing and transfers;
- Had a urinary catheter (sterile tube inserted into the bladder to drain urine);
- Always incontinent of bowel
- Diagnoses included anxiety, multiple sclerosis (a disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain, optic nerve and spinal cord, called the myelin sheath), and neuromuscular dysfunction of the bladder (a condition that occurs when the nerves, spinal cord, or brain that control bladder function are damaged).

Review of the resident's care plan, revised 11/8/24 showed:
- The resident required enhanced barrier precautions related to Suprapubic catheter (a catheter which enters the bladder through the lower abdomen);
- Clean hands before entering and when leaving the room;
- Do not wear the same gown and gloves for the care of more than one person;
- Wear gloves and a gown for the following high-contact resident care activities: dressing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, central line, urinary catheter, feeding tube, tracheostomy (an artificial opening into the wind pipe to aid breathing) and wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265742	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKRIDGE OF PLATTSBURG	205 E CLAY AVE, PLATTSBURG, MO 64477

(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 880	Continued From page 51	F 880		

Review of the resident's physician order sheet (POS) dated November 2024 showed:
- Start date: 7/17/24 - Catheter change as needed related to non-function;
- Start date: 11/18/24 - Cleanse wound with normal saline, pat dry. Apply skin prep to area where foam dressing will be applied, apply saline moistened prisma (a sterile, freeze-dried wound dressing that's used to help manage wounds and promote healing) to ulcer base and cover with hydrofera blue (a moist antibacterial foam dressing used to treat a variety of wounds) over ulcer and secure with 3 x 3 quadrilobe allevyn foam dressing (a hydrocellular foam dressing with a quadrilobe shape and wide border that's designed to conform to the body's contours) to the area. Change daily every two days or when 3/4 saturated with drainage.

Observation on 11/20/24 at 10:36 A.M., showed:
- There was a sign outside the resident's room which indicated staff should use enhanced barrier precautions;
- There were two reusable gowns hanging on the back of the resident's door;
- The resident's drainage bag hung on the side of the resident's bed and did not have a dignity cover over it;
- The resident declined to have the surveyor observe catheter care;
- Licensed Practical Nurse (LPN) A and LPN B entered the resident's room, washed their hands and applied gloves;
- LPN A and LPN B did not apply any gown during the wound care process;
- LPN B provided wound care to the resident's right gluteal fold (the horizontal crease that separates the upper thigh from the buttocks), covered the resident with a blanket and placed

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	265742	A. BUILDING _____ B. WING _____	11/21/2024

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OAKRIDGE OF PLATTSBURG	205 E CLAY AVE, PLATTSBURG, MO 64477

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F 880	Continued From page 52	F 880		

the resident's call light in reach;
- LPN A and LPN B removed gloves, washed hands and left the room.

During an interview on 11/20/24 at 11:03 A.M., LPN B said:
- He/she should have worn the gown on the back of the resident's door for EBP;
- The drainage bag should have a dignity cover over it.

3. Review of Resident #24's undated care plan showed:
- Resident required Enhanced Barrier Precautions (EBP) related to urinary catheter and wounds.
- Staff is expected to wear gloves and gown for the following high-contact resident care activities: Dressing, Bathing/showering, transfering, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care: central line, urinary catheter, feeding tube, tracheostomy; wound care.
- Resident was admitted to the facility with stage III pressure ulcers (wounds caused by prolonged pressure on the skin) to his/her back and coccyx (the small, triangular bone at the base of the spine).
- Staff is expected to keep linens clean and dry.
- Requires help with all ADLs.

Review of Physician orders for October 2024., showed:
- Wound Care start date: 10/04/2024 Cleanse wounds with wound cleanser, dry. Apply lidocaine 5%/bupivocaine 2%/metronidazole 20% (pixie dust), calcium alginate, and super absorbant dressings to sacral and spinal wounds daily.

An observation on 11/18/24 at 2:18 P.M. showed:

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	265742	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKRIDGE OF PLATTSBURG	205 E CLAY AVE, PLATTSBURG, MO 64477

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F 880	Continued From page 53 - Multiple dime-sized dried blood droplets on the Resident's sheet. - A fist-sized blood stain on the bottom sheet under the resident. During an observation and interview on 11/19/24 at 10:08 A.M., showed: - LPN A and LPN D entered Resident's room for wound care. - Staff failed to apply gowns prior to care. - Blood stained top sheet and draw sheet remained untouched on Resident #24's bed. -There was no EHB signage on the door or outside the resident's room. - Two washable EBP gowns were hung on the back of Resident #24's door for staff use. - LPN D said that a resident with a catheter and wounds would require EBP. - LPN D said that they both should have donned gowns prior to wound care. During an interview on 11/21/24 at 12:52 P.M., the DON said staff are expected to wear gowns and gloves during wound care for all residents requiring EBP.	F 880		

Missouri Department of Health and Senior Services

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	05994	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKRIDGE OF PLATTSBURG	205 E CLAY AVE, PLATTSBURG, MO 64477

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A1067	19 CSR 30-85.012(67) Handrails Handrails shall be provided on both sides of all corridors and aisles used by residents. Corridor handrails shall have ends return to the wall. III This regulation is not met as evidenced by: Class III 1. Please refer to F584.	A1067		
A4060	19 CSR 30-85.042(51) Medication Errors/Adverse Reactions Reported All medication errors and adverse reactions shall be reported immediately to the nursing supervisor and the resident's physician and, if there was a dispensing error, to the issuing pharmacist. II/III This regulation is not met as evidenced by: Class II 1. Please refer to F759 * Higher classification merited due to the extent of the violation.	A4060		
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. Refer to F677	A4075		

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	05994	A. BUILDING: _____ B. WING _____	11/21/2024

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A4078	Continued From page 1	A4078		
A4078	19 CSR 30-85.042(69) Reposition Every 2 hr/Maintain Body Alignment Residents who are physically or mentally incapable, or both, of changing their own positions shall have their positions changed at least every two (2) hours and shall be provided supportive devices to maintain good body alignment. I/II This regulation is not met as evidenced by: Class II 1. Refer to F677	A4078		
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 1. Please refer to F880	A4086		
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean Walls and ceilings, including doors, windows and skylights, shall be clean and maintained in good	A6015		

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	05994	A. BUILDING: _____ B. WING _____	11/21/2024

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A6015	Continued From page 2 repair. III This regulation is not met as evidenced by: Class III 1. Please refer to F584.	A6015		
A6031	19 CSR 30-87.020(31) Kitchen Waste Containers Covered Waste containers used in food-preparation and utensil-washing areas shall be kept covered when not in actual use. III This regulation is not met as evidenced by: Class III 1. Please see F812	A6031		
A7088	19 CSR 30-87.030(86) Store Equip/Utensils to Prevent Contamination Cleaned and sanitized utensils and equipment shall be stored above the floor in a clean, dry location in a way that protects them from contamination by splash, dust and other means. The food-contact surfaces of fixed equipment shall also be protected from contamination. III This regulation is not met as evidenced by: Class III 1. Please see F812	A7088		

PLAN OF CORRECTION

Provider/Supplier Name:	OAKRIDGE OF PLATTSBURG
Street Address, City, Zip:	205 E. CLAY AVE, PO BOX 247 PLATTSBURG, MO 64477
Date of Survey:	Completed November 21, 2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265742

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 Oakridge of Plattsburg (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, or 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.	
F 584	**Corrections will include:** Dining room chairs repaired on 12/16/24. All ceiling and walls in dining room dusted to remove any cobwebs on 12/2/24. All ceiling and walls in front living room dusted to remove any cobwebs on 12/2/24. Attic access panel in dining room repaired on 12/19/24. Handrail outside room 105 repaired on 12/17/24. Ceiling in front living room repaired and painted on 12/16/24. Dining room walls to be repainted by 1/5/25. All residents who reside in our home will be considered at risk for this alleged deficient practice.	1/5/2025

	The following measures will be put into place to ensure the deficient practice does not recur: All Staff In-Serviced on 12/5/24 and will be again on 1/2/25 on proper reporting of housekeeping and maintenance items in department specific binders. Safety Committee Meeting on 12/2/24 discussed housekeeping and maintenance deficiencies to assist in monitoring and reporting of proper housekeeping and maintenance issues in our home. Housekeeping Department will be in-serviced on proper cleaning of walls, fixtures, and ceilings to include removal of cobwebs by Administrator on 12/19/24. Maintenance Director will be in-serviced on proper identification, repair, and maintenance of our home to include furniture, fixtures, walls, handrails, and painting by Administrator on 12/19/24. All new hires will be educated on identification and proper reporting of housekeeping and maintenance issues during orientation by Administrator and/or designee. **How the facility plans to monitor its performance to make sure the solutions are sustained:** Housekeeping Director will monitor proper cleaning of walls, fixtures, and ceilings to include removal of cobwebs by observing no less than 3 episodes of entire room cleaning weekly for 1 month, then bi-weekly for 1 month and then monthly to ensure proper policy and procedures are followed. Administrator will monitor proper identification, repair, and maintenance of our home to include furniture, fixtures, walls, handrails, and painting by conducting entire building walkthrough no less than 3 times weekly for 1 month, then bi-weekly for 1 month and then monthly to ensure proper policy and procedures are followed. Administrator and/or designee will check for compliance during weekly status meeting. Any issues will be discussed during quarterly Safety and QA & A meetings.	
F 677	**Corrections will include:** Residents #4, #34, and #44 will receive proper complete perineal, incontinence, morning hygiene, and bathing cares as well as offering of fluids and proper repositioning. All Nursing Staff In-Serviced on 12/5/24 and will be again on 12/19/24 and 1/2/25 on proper complete perineal/ incontinence care, proper complete morning hygiene cares to include washing face and hands, offering hydration, and changing clothes, proper repositioning, proper oral and	1/5/2025

	to propel themselves in wheelchairs and if staff requested to push resident as a courtesy, wheelchair foot pedals will be properly used for safety. All residents in wheelchairs will be considered at risk for this alleged deficient practice. **The following measures will be put into place to ensure the deficient practice does not recur:** All Staff in-serviced on 12/26/24 and will be again on 1/2/25 on proper use of wheelchair foot pedals if pushing resident in wheelchair as requested by resident only and not out of our convenience as to promote independence. All Staff will successfully complete competency with return demonstration on proper use of wheelchair foot pedals when pushing resident as requested by 1/5/25. All new hires will be educated on promotion of independence for residents in wheelchairs but utilizing foot pedals if providing courtesy push as requested by resident during orientation by Administrator and/or designee. **How the facility plans to monitor its performance to make sure the solutions are sustained:** The Administrator will address these identified issues with Safety Committee on 12/26/24 so they can monitor, identify and notify Administrator during their building rounds. Administrator and/or designee will check for compliance during weekly status meeting. Any issues will be discussed during quarterly QA & A meeting.	
F 700	**Corrections will include:** Resident #5 will receive proper assessment, education, physician order, resident consent, care plan, and proper maintenance bed and equipment assessment for bed assist rail. Resident #45 will receive proper care plan for bed assist rail. Residents #17 and #42 will receive proper maintenance quarterly bedrail assessment. All residents who have bed assist rail to increase bed mobility and independence will be considered at risk for this alleged deficient practice. **The following measures will be put into place to ensure the deficient practice does not recur:** All Nursing Staff In-Serviced on 12/5/24 and will be again on 12/19/24 and 1/2/25 on proper resident request for bed assist bar placement for proper evaluation and assessment.	1/5/2025

	MDS/ Care Plan Coordinator, Director of Nursing, and Maintenance Director in-serviced on 12/19/24 and will be again on 1/2/25 on proper resident assessment, education, physician order, resident consent, care plan, and proper maintenance bed and equipment assessment for bed assist rail placement by Administrator. **How the facility plans to monitor its performance to make sure the solutions are sustained:** Safety Committee Meeting on 12/2/24 and will again on 12/26/24 to discuss bed assist rails to ensure that proper bed assist rails policies and procedures are followed. The Administrator and/or designee are responsible for ensuring the facility bed assist bar usage policies and procedures are being followed during weekly status meetings. The system will be reviewed quarterly during QA & A meetings to ensure compliance.	
F 759	**Corrections will include:** Resident #5 will receive proper nasal medication administration. Residents #29 and #49 will receive proper eye medication administration and Resident #50 will receive proper liquid medication administration per physician's order. All residents will be considered at risk for this alleged deficient practice. **The following measures will be put into place to ensure the deficient practice does not recur:** All Certified Medication Technicians and Licensed Nursing Staff in-serviced on 12/5/24 and will be again on 12/19/24 and 1/2/25 on proper medication administration to include nasal medication administration, eye medication administration and proper liquid medication administration per physician's order. Director of Nursing will monitor this on all shifts by observing no less than 3 episodes of proper medication administration weekly for 2 months, then bi-weekly for 1 month and then monthly to ensure proper medication administration are being followed and completed. All Licensed Nurses and Certified Medication Technician new hires will receive proper training on proper medication administration to include nasal medication administration, eye medication administration and liquid medication administration.	1/5/2025

	How the facility plans to monitor its performance to make sure the solutions are sustained: Director of Nursing and/or designee will monitor this during daily action rounds and ensure proper medication administration is conducted. Administrator and/or designee will check for compliance during weekly status meeting. Any issues will be discussed during quarterly QA & A meeting.	
F 812	**Corrections will include:** Our home will prepare and serve food in accordance with professional standards for food safety for all residents. All residents will be considered at risk for this alleged deficient practice. **The following measures will be put into place to ensure the deficient practice does not recur:** Dietary staff in-serviced 12/6/24 on proper food safety and hand washing by Dietician. Dietary staff in-serviced 12/20/24 and will be again on 12/26/24 and 1/2/25 on professional standards for food safety to include properly covering garbage cans, proper sanitization of all food preparation surfaces in kitchen, and proper handwashing by Administrator. Dietary staff in-serviced 12/20/24 and will be again on 12/26/24 and 1/2/25 on professional standards for food safety to include proper food thawing techniques, proper dish storage, and proper storage and labeling of foods by Administrator. All Dietary new hires will receive training on professional standards for food safety to include properly covering garbage cans, proper sanitization of all food preparation surfaces in kitchen, proper hand washing, proper food thawing techniques, proper dish storage, and proper storage and labeling of foods during new employee orientation by Administrator and/or designee. **How the facility plans to monitor its performance to make sure the solutions are sustained:** Dietary Manager will monitor professional standards for food safety to include properly covering garbage cans, proper sanitization of all food preparation surfaces in kitchen, and proper hand washing by observing no less than 3 competencies a week during daily action rounds for 4 weeks then bimonthly for 1 month and then monthly. Dietary Manager will monitor professional standards for food safety to include proper food thawing techniques, proper	1/5/2025

	dish storage, and proper storage and labeling of foods proper storage of food, labeling and dating food for storage during daily action rounds. Administrator and/or designee will check for compliance during weekly status meeting. Any issues will be discussed during quarterly QA & A meeting.	
F 880	**Corrections will include:** Our home will follow acceptable infection control practices to reduce the development and spread of infections. Resident #53 will receive proper urinary catheter bag placement. Resident #18 will receive proper urinary drainage bag dignity cover. Residents #18, #24, and #53 have been placed on proper enhanced barrier precautions. All Nursing Staff In-Serviced on 12/5/24 and will be again on 12/19/24 and 1/2/25 on proper placement of catheter drainage bag dignity cover and drainage bag placement to ensure does not touch contaminated surfaces. All Staff In-Serviced on 12/5/24 and will be again on 12/19/24 and 1/2/25 on proper identification, placement, and following of enhanced barrier precautions. All residents will be considered at risk for this alleged deficient practice. **The following measures will be put into place to ensure the deficient practice does not recur:** All Nursing Staff will successfully complete competency with return demonstration on proper placement of catheter drainage bag and dignity bag cover by 1/3/25. All Nursing Staff will successfully complete competency with return demonstration on proper use of personal protective equipment for residents with enhanced barrier precautions by 1/3/25. All Housekeeping Staff will successfully complete competency with return demonstration on proper use of personal protective equipment for residents with enhanced barrier precautions by 1/3/25. All Nursing new hires will be given facility policy and procedures on proper placement of urinary drainage bag and dignity bag cover during orientation by Administrator and/or designee.	1/5/2025

	All new hires will be given the facility policy and procedures on proper use of personal protective equipment for residents with enhanced barrier precautions during orientation by Administrator and/or designee. **How the facility plans to monitor its performance to make sure the solutions are sustained:** Director of Nursing will monitor for proper urinary drainage bag placement and dignity bag cover on all shifts by observing no less than 3 episodes of proper urinary drainage bag placement and dignity bag cover, weekly for 1 month, then bi-weekly for 1 month and then monthly to ensure proper policy and procedures are followed. Director of Nursing will monitor for proper use of personal protective equipment for residents with enhanced barrier precautions on all shifts by observing no less than 3 episodes of proper use of personal protective equipment, weekly for 1 month, then bi-weekly for 1 month and then monthly to ensure proper policy and procedures are followed. Director of Nursing will monitor this during daily action rounds to ensure proper resident cares are being completed. Administrator and/or designee will check for compliance during weekly status meeting. Any issues will be discussed during quarterly QA & A meetings.	

A1067	Refer to F 584	
A4060	Refer to F 759	
A4075	Refer to F 677	
A4078	Refer to F 677	
A4086	Refer to F 880	
A6015	Refer to F 584	
A6031	Refer to F 812	
A7089	Refer to F 812	

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.