STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265738	A. BUILDING _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR HEALTH & REHABILITATION	1630 RADIO HILL ROAD BOONVILLE, MO 65233

(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 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Reviewed AT Based on interview and record review, the facility failed to have adequate nursing staff available to meet the needs of the residents as determined by their facility assessment and extended call light wait times. The facility census was 45.	F 725		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____, LNHA/PSA | TITLE Administrator | (X6) DATE 1/31/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...lowing 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 725	Continued From page 1	F 725		

1. Review of the facility policy titled, "Answering the Call Light", undated, showed the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Staff are directed:

-If the resident needs assistance, indicate the approximate time it will take for you to respond;
-If the resident's task is something you can fulfill, complete the task within five minutes if possible;
-If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.

2. Review of the Facility Assessment Tool, dated 07/26/2024, showed staff documented:

-Average census of 43 residents;
-Direct care staff needed for each shift (day, evening, night):
-Day shift: Five Certified Nurse Aides (CNA);
-Evening Shift: four CNAs;
-Night shift: three CNAs.
-Total CNAs needed for a 24 hour period is 12.

3. Review of the employee monthly schedule, dated 01/10/25 through 01/15/25, showed:

- On Friday 01/10/25: A total of nine CNAs.
- Saturday 01/11/25: A total of seven CNAs.
- Sunday 01/12/25: A total of eight CNAs.
- Monday 01/13/25: A total of nine CNAs.
- Wednesday 01/15/25: A total of 11 CNAs.

4. Review of the facility's wireless call light report, dated 01/10/25 through 01/11/25 at 4:36 P.M., showed:

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F 725	Continued From page 2 - Room 100 call light response times of 39 minutes; 37 minutes; 37 minutes; and 53 minutes; - Room 105 call light response times of one hour 24 minutes; and 33 minutes; - Room 106 call light response times of two hours 48 minutes; and 44 minutes; - Room 107 call light response times of 56 minutes, one hour three minutes; three hours 47 minutes; one hour 38 minutes; and two hours 23 minutes; - Room 108 call light response time of one hour 44 minutes; - Room 109 call light response time of 47 minutes; - Room 200 call light response times of one hour 43 minutes; and one hours and 21 min; - Room 201 call light response time of one hour 35 minutes; - Room 203 call light response time of one hour 3 minutes; - Room 205 call light response times of 42 minutes; 33 minutes; and one hour three minutes; - Room 206 call light response times of two hour 31 minutes; one hour 24 minutes; one hour 18 minutes; one hour; one hour eight minutes; one hour 10 minutes; and 44 minutes; - Room 207 call light response times of 37 minutes; 37 minutes; one hour two minutes; 37 minutes; and 52 minutes; - Room 300 call light response times of one hour three minutes; and 39 minutes; - Room 303 call light response time of 44 minutes. 4. Review of the facility's wireless call light report, dated 01/13/25 at 4:35 P.M., showed:	F 725		

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F 725	Continued From page 3 - Room 105 call light response times of 36 minutes, and 35 minutes; - Room 106 call light response times of 58 minutes; - Room 200 call light response times of 40 minutes; one hour nine minutes; and 32 minutes; - Room 201 call light response time of 34 minutes; - Room 202 call light response times of 32 minutes; and 44 minutes; - Room 206 call light response times of 31 minutes; 36 minutes; and 43 minutes; - Room 207 call light response time of 52 minutes. 5. During an interview on 01/12/25 at 3:48 P.M., Resident #2 said staff does not usually get him/her out of bed until 10:00 or 11:00 A.M., even though he/she wants to get up around 8:00 or 9:00 A.M. The resident said he/she puts the call light on and it can take several hours for someone to answer it. He/she said he/she does not like sitting in his/her wet clothes or brief, and if he/she needs to be turned it hurts if he/she does not get repositioned timely. The resident said it takes three to four staff to provide cares for him/her, so often times it is almost 2:00 P.M. before he/she gets changed after lunch, because they need more staff to help him/her. During an interview on 01/13/25 at 8:43 A.M., Resident #8 said call lights are a problem, and if you fall asleep staff will come in and turn it off or say they will be right back and they do not come back. The resident said he/she does not like sitting in his/her wet clothes or brief, or if he/she needs to be repositioned it can take too long. The resident said usually it is the nursing aides that	F 725		

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F 725	Continued From page 4 are short staffed. During an interview on 01/13/2025 at 9:01 A.M., Resident #43 said it usually takes 30 minutes or more for call lights to be answered at any time. During an interview on 01/15/25 at 8:43 A.M., Resident #20 said he/she has to wait a long time for staff to answer his/her call light, sometimes over an hour. The resident said it is hard to get any help, and there are too few staff to take care of so many residents. The resident said he/she has incontinence and sometimes he/she is left wet for long periods of time. The resident said it does not feel good. The resident said he/she wears briefs and has been sitting wet for a couple of hours. The resident said he/she had pushed his/her call lights several times. During an interview on 01/15/25 at 8:50 A.M., Resident #23 said staff leave him/her wet for long periods time, and it takes hours for staff to answer his/her call lights. During an interview on 01/15/25 at 8:55 A.M., Resident #1 said it "seems" like it takes a long time for staff to answer his/her call light. The resident said it takes over 30 minutes for staff to answer his/her call light. During an interview on 01/15/25 at 9:02 A.M., Resident #37 said staff take over an hour to answer his/her call light at times. The resident said staff leave him/her laying in wet clothes or a brief in his/her bed for 30 minutes to an hour. The resident said it makes him/her feel bad, laying in a cold wet bed. During an interview on 01/15/2025 at 10:04 A.M.,	F 725		

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Resident #43 said when it takes a long time for the call light to be acknowledged it makes him/her very anxious.

During an interview on 01/15/25 at 10:13 A.M., Certified Nurse Aide (CNA) G said certain residents take more time than others. He/She said one resident takes 45 minutes to an hour each time they go in the room, and the resident requires two staff to provide cares.

During an interview on 01/15/25 at 10:14 A.M., the Director of Nursing (DON) said the facility could use more CNAs.

During an interview on 01/15/25 at 10:31 A.M., LPN C said on the evening shift the facility is short staffed. The LPN said staff are pulled away from their halls to other halls. The LPN said two, maybe three aides are being scheduled for a shift and the facility has several residents who require two people for cares. The LPN said the facility has one resident that pulls aides off their hall and the aides are in his/her room a minimum one to an hour and half at a time. The LPN said he/she has spoken to the DON about this numerous times. The LPN said it takes at least three if not four staff at a time to move a resident.

During an interview on 01/15/25 at 11:22 A.M., the DON said he/she does not know why call lights are not answered timely. The DON said there is no way to tell if a CNA answered a call light, or who answered the call light. The DON said staff are pulled off their halls to answer call lights on other halls, and every staff member is responsible for answering call lights. The DON said the facility has a couple of residents that take a lot of time and staff for cares. The DON said the

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nurses or another staff member should answer call lights if the aides are busy. The DON said if four staff members are helping one resident the call light wait times will be longer because there is no staff answering lights on the other hall. The DON said recently, he/she has been running with minimal staff or fire code. The DON said with acuity in our facility, staffing for fire code is not appropriate. The DON said he/she has received complaints from residents about long call light wait times and one resident has complained about being left soiled for long periods of time. The DON said call light wait times get longer as the facility gets shorter staffed. The DON said he/she has not looked at the Facility Assessment. The DON said he/she has been told if he/she staffed to fire code, he/she will be alright. The DON said he/she sent emails to corporate about needing help in this building and does not even get a response.

During an interview on 01/15/25 at 1:46 P.M., The Staffing Coordinator said the facility has staffing issues, and there are a lot of call-ins. The Staffing Coordinator said the facility currently only has three aides for evening shift. The Staffing Coordinator said staffing affects the call light wait times. The Staffing Coordinator said he/she has had complaints from residents about call light times being long and residents being left soiled for long periods of time. The Staffing Coordinator said he/she passes the information along to the charge nurses. The Staffing Coordinator said he/she has not read the Facility Assessment, he/she said, "What's that?". The Staffing Coordinator said according to the DON, there is supposed to be two nurses each shift, five CNAs during the day, four CNAs in the evening and three CNAs on the overnight shift. The Staffing

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F 725	Continued From page 7 Coordinator said the facility is not meeting those numbers. The Staffing Coordinator said it takes three sometimes four aides to care for one of the residents. The Staffing Coordinator said during the evening when three to four staff care for one resident, there is no other staff to watch the residents for the rest of the building. The Staffing Coordinator said it takes 45 minutes to an hour for the three to four staff to provide care for the one resident. During an interview on 01/15/25 at 2:07 P.M., the administrator said there is a lot of holes in staffing. The administrator said typically the facility has three CNAs on the floor, one nurse and sometimes a CMT. The administrator said he/she did not know the facility did not have three CNAs and a nurse at times. The administrator said he/she looked at the Facility Assessment today and the facility is not staffing to the acuity shown in the Facility Assessment. The administrator said he/she has been made aware of the resident who takes three to four staff for care and is aware the staff are in the room for an hour. The administrator said nobody is providing care for the residents in the rest of building during the care for the one resident on evening shifts, "It hurts me to say". The administrator said the care for one resident and staffing, absolutely has an impact on call light times. The administrator said corporate has been made aware of the staffing needs of the building.	F 725		
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	F 880		

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F 880	Continued From page 8 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 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	F 880		

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F 880	Continued From page 9 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: Reviewed AT Based on interview and record review, facility staff failed to ensure the two-step purified protein derivative (PPD) (skin test for Tuberculosis (TB)) was completed for four employees (Staffing coordinator, Dietary Assistant L, Minimum Data Set (MDS) Coordinator, and Licensed practical nurse (LPN) K,) out of ten sampled employees. The facility census was 45. 1. Review of the facility's policy titled "Tuberculosis (TB) Employee Screening", not dated, showed all employees are screened for	F 880		

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F 880	Continued From page 10 Latent Tuberculosis Infection (LTBI) and active TB disease using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment. Each newly hired employee is screened for LTBI and active TB disease after an employment offer has been made but prior to the employee's duty assignment. Review of the Facility's Tuberculosis (TB) Testing Requirements, not dated, showed: -Upon hire or re-hire; -Step one: administer first TST following protocol; -Review result in 48-72 hours; -Negative induration is less than 10 millimeters (mm). Retest in 1-3 weeks after first test result date; -Document result in millimeters on TB screening record; -Step two: administer second TST; -Review result in 48-72 hours; -Document result in mm on TB screening record. Review of the Center for Disease Control and Prevention's, Clinical Testing Guidance for TB Skin Tests, dated May 14, 2024, showed: -Two-Step testing; -If the first skin test is negative, a second TB skin test should be done one to three weeks later; -The skin test reaction should be read between 48-72 hours after administration by a health care worker trained to read TB skin results. 2. Review of the staff coordinator's employee file showed a hire date of 09/05/24. Review showed the employee file did not contain documentation the second step PPD had been completed.	F 880		

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F 880	Continued From page 11 3. Review of Dietary Assistant L's employee file showed a hire date of 09/11/24. Review showed the employee file did not contain documentation the second step PPD had been completed. 4. Review of the MDS Coordinator's employee file showed a hire date of 10/24/24. Review showed the employee file did not contain documentation the second step PPD had been completed. 5. Review of LPN K's employee file showed a hire date of 11/27/24. Review showed the employees file did not contain documentation the two step PPD had been completed. 6. During an interview on 01/13/25 at 11:06 A.M., the business office manager said he/she is responsible for new employee screenings and the Director of nursing (DON) is responsible for ensuring the two step TBs are completed. He/She said he/she is not sure why the TBs were not completed timely and he/she believes it was an oversight. During an interview on 01/13/25 at 11:11 A.M., the DON said he/she was not aware there were employees whose two step TBs were not completed. He/She said it is the employee's responsibility to come back for their second step TB. He/She said he/she is not sure who is responsible for ensuring they are completed timely. During an interview on 01/13/25 at 02:19 P.M., the administer said it is the responsibility of both the business office manager and DON to ensure two step TBs are completed on new hires. He/She said he/she just started in December and	F 880		

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F 880	Continued From page 12 did not know there were issues with TB's not being completed. He/She said he/she was made aware today and he/she believes there are issues with follow through in the current process.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Reviewed AT Based on observation, interview, and record review, facility staff failed to ensure four residents (Residents #1, #30, #15 and #17) of 18 sampled residents, wheelchairs were maintained in good repair. The facility census was 45. 1. Review of the facility policy titled, "Maintenance Request Policy", undated, showed: -Mainenance forms are located at the nursing desk, staff are to fill out and place on clipboard; -The request is reviewed and repairs are done; -Maintenance staff performs the work and notes repairs in the TELS Electronic Maintenance Request program. Review of the facility policy titled, "TELS Wheelchair Cleaning", undated, showed; -Night shift staff will do the inspections of each residents wheelchair and clean as necessary; -Staff will inform maintenance of any issues via the TELS program or logbook at the nursing	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265738	A. BUILDING _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR HEALTH & REHABILITATION	1630 RADIO HILL ROAD BOONVILLE, MO 65233

(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 921	Continued From page 13 station. 3. Review of the facility's maintenance requests and TELS program for the last 30 days did not contain a request for torn wheelchair armrests. 4. Review of the facility form titled, "Director of Nursing (DON) Rounds", undated, showed the DON will complete rounds for observations of wheelchairs. 5. Observation on 01/12/25 at 3:45 P.M., showed Resident #1's wheelchair armrest with multiple cracks and the vinyl peeled away. The cracked vinyl had sharp edges. During an interview on 01/12/25 at 3:46 P.M., the resident said the armrest on his/her wheelchair is cracked. The resident said staff has been made aware of his/her armrest. During an interview on 01/15/25 at 9:57 A.M., Certified Nurse Aide (CNA) E said he/she noticed the left arm rest of the resident's wheelchair cracked and peeling. The CNA said he/she filled out a maintenance for back in July, and it has not been fixed. The CNA said he/she told the charge nurse it still hasn't been fixed. The CNA said the overnight CNAs should put in maintenance request when cleaning wheelchairs. During an interview on 01/15/25 at 10:13 A.M., CNA G said he/she did not notice the damage to the resident's wheelchair. The CNA said, "Obviously I should notice, I put the resident in the wheelchair". The CNA said the damaged arm rest could cause breakdown on the resident's arm, because the resident's skin is so thin.	F 921		

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	265738	A. BUILDING _____ B. WING _____	01/15/2025

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ASHLEY MANOR HEALTH & REHABILITATION	1630 RADIO HILL ROAD BOONVILLE, MO 65233

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F 921	Continued From page 14 6. Observation on 01/15/25 at 9:21 A.M., showed Resident #30's wheelchair armrests cracked with the vinyl peeled back and exposed foam. During an interview on 01/15/25 at 9:57 A.M., CNA E said he/she has not noticed the resident's armrest. The CNA said he/she had not filled out a maintenance request for the resident's wheelchair. 7. Observation on 01/15/25 at 9:28 A.M., showed Resident #15's wheelchair with the left arm rest vinyl cover torn and in disrepair. During an interview on 01/15/25 at 10:13 A.M., CNA G said he/she did notice the damage to the resident's wheelchair but did not submit a maintenance request. He/Shee said he.she did not submit a request because overnight shift aides clean the wheelchairs and submit maintenance request if they see something that needs fixed. During an interview on 01/15/25 at 10:31 A.M., Licensed Practical Nurse (LPN) C said the resident's wheelchair armrest has been reported to the DON and they were looking into it, but that has been months ago. During an interview on 01/15/25 at 10:31 A.M., LPN C said the therapy department and the maintenance director maintain the resident wheelchairs. The LPN said if he/she has an issue with the wheelchairs he/she tells therapy or the maintenance director. The LPN said there is a form staff are supposed to fill out for maintenance. The LPN said he/she had not noticed any issues with resident wheelchairs and staff have not reported any issues. The LPN said	F 921		

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	265738	A. BUILDING _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR HEALTH & REHABILITATION	1630 RADIO HILL ROAD BOONVILLE, MO 65233

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F 921	Continued From page 15 if staff reported a wheelchair issue to him/her, he/she would make a report in the TELS system. The LPN said the night shift staff clean the wheelchairs and report any issues. The LPN said if the wheelchair armrests are broken, cracked or peeling it could cause skin tears. 8. Observation on 01/15/25 at 9:35 A.M., showed Resident #17's wheelchair armrest vinyl covers torn and in poor condition. During an interview on 01/15/25 at 10:13 A.M., CNA G said he/she did notice the damage to the resident's wheelchair armrest, but did not submit a maintenance request. He/She said the wheelchair armrest have been like that since she started and thought staff had already submitted a request for it. X. During an interview on 01/15/25 at 10:13 A.M., CNA G said the maintenance director maintains resident wheelchairs. The CNA said there is a clipboard behind the desk at the Nurse's Station. The CNA said staff are supposed to write requests on the clipboard and the maintenance director checks the clip board. During an interview on 01/15/25 at 10:53 A.M., the therapy director said staff should notify the therapy department using the clipboard at the nurses station if a wheelchair requires maintenance. He/She said staff have not reported any issues with any residents armrest. He/She said the therapy department has extra armrest and can change them out. He/She said he/she wouldn't want the torn vinyl to puncture the resident's skin and cause a skin tear.	F 921		

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	265738	A. BUILDING _____ B. WING _____	01/15/2025

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F 921	Continued From page 16 During an interview on 01/15/25 at 11:08 A.M., the maintenance director said he/she maintains the wheelchairs as well as the therapy department. If something needs fixed staff should write it on a maintenance request form that he/she keeps at the nurses' station. He/She said he/she has not received any requests in the TELS system for wheelchair repair. During an interview on 01/15/25 at 11:22 A.M., The DON said therapy and maintenance maintain the resident wheelchairs. Staff should fill out a maintenance sheet so the maintenance department knows a wheelchair needs to be fixed. The DON said there are a lot of cracked and peeling armrests in the facility. The DON said he/she did not report it to anyone because he/she did not know maintenance fixed the armrests. He/She said he/she did not know if staff knew how to report broken armrests. He/She said the cracked armrests could cause skin tears, or infection due to harboring bacteria. He/She said staff should report the damages to someone. During an interview on 01/15/25 at 2:06 P.M., the administrator said the night shift CNAs maintain and care for the wheelchairs. He/She said if it is a structural problem then maintenance must maintain it. Staff should fill out a maintenance request form for damage to wheelchair arm rests and he/she does not know why staff are not reporting the issues. The administrator said a cracked and peeling arm rest could cause skin tears and is a comfort issue. He/She said the DON is responsible for ensuring the nursing staff are cleaning and maintaining the wheelchairs on a daily basis.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR HEALTH & REHABILITATION	1630 RADIO HILL ROAD BOONVILLE, MO 65233

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class III Refer to F921	A3038		
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II Refer to F880	A4031		
A4046	19 CSR 30-85.042(37) Nursing Staff Sufficient/Qualified All facilities shall employ nursing personnel in	A4046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR HEALTH & REHABILITATION	1630 RADIO HILL ROAD BOONVILLE, MO 65233

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A4046	Continued From page 1 sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II This regulation is not met as evidenced by: Class II Refer to F725	A4046		

PLAN OF CORRECTION

Provider/Supplier Name:	Ashley Manor Health & Rehabilitation
Street Address, City, Zip:	1630 Radio Hill Road, Boonville, MO 65233
Date of Survey:	01/12-15/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	49396

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. This submission of the POC does not constitute an admission on the part of Ashley Manor Health & Rehabilitation ("the facility") as to the accuracy of the surveyor findings, nor the conclusions drawn there from. The facility's submission of the 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 Correction.	
F 725 S/S=E	The facility will take additional measures to ensure the facility follows all state and federal guidelines for providing sufficient number of staff on a 24-hour basis to provide nursing care to all residents. **Corrections will include:** **1.** A new current year Facility Assessment and staffing will meets resident acuity needs accordingly. **2.** Residents #2, 8, 43, 20, 23, 1 & 37 have call lights answered in a timely manner for needs. **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows:** All residents have the potential to be affected. **The measures that will be put into place or systemic changes made to ensure the alleged deficient practice will not occur are as follows:** 1. Nursing staff will be in-serviced on answering call lights in a timely manner by the DON by date of compliance. And education for staff not leaving the rest of the building unattended to provide 4 staff care for an hour	2/21/2025

	for one resident. If they have to use 4 staff, they need to staff more for the building during the times of the resident's care. 2. Residents will be interviewed by Social Service Director and/or designee on their preferred time of waking and getting out of bed to coordinate cares with staff by date of compliance. Also interview on call lights weekly to ensure improvement. 3. An Audit will be completed by DON/ADON/ Nursing Administration for 1 month, then biweekly for 1 month, and then monthly thereafter to ensure proper call light responses. 4. Daily staffing will be reviewed by DON and/or designee to ensure appropriate staffing for resident cares on daily basis. 5. Facility will address staffing needs through job postings on Indeed, open interviewing events and assist from corporate HR to bring staffing numbers up in building. **The facility will monitor corrective actions to ensure the alleged deficient practice will not recur as follows:** 1. The DON/ADON/Nursing Administration will report any issues with call light timing to the Administrator and QAPI. 2. The DON/ designee will report any staffing issues to the Administrator and QAPI. 3. The QAPI committee will meet for 3 months or until compliance is met. The QAPI committee will review outcomes and make recommendations as needed.	
F880 S/S=E	The facility will take additional measures to ensure the facility follows all state and federal guidelines in the Infection Control Program. **Corrections will include:** 1. Staffing coordinator no longer employed at facility. 2. Dietary Assistant L, MDS Coordinator & Licensed Practical Nurse K will all have completed steps required for 2 step PPD testing. **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows:** All staff have the potential to be affected. **The measures that will be put into place or systemic changes made to ensure the alleged deficient practice will not occur are as follows:** 3. DON, Business Office Manager & Administrator will be in-serviced by the Regional Nurse Coordinator by date of compliance on TB testing requirements. **4.** DON and/or designee will complete audit on employee TB testing weekly for 3 months .	2/21/2025

	The facility will monitor corrective actions to ensure the alleged deficient practice will not recur as follows: 5. The DON/ADON/Nursing Administration will report any issues with TB Testing to the Administrator and QAPI. 6. The QAPI committee will meet for 3 months or until compliance is met. The QAPI committee will review outcomes and make recommendations as needed.	
F921 S/S=D	**Corrections will include:** 1. Staff in-service provided to ensure that maintenance requests and work order were properly entered into TELS system and/or documented on paper form and put in the location designated at nurse's station. Inservice also provided instructions for use of wheelchair cleaning logs and safety checklist. 2. Maintenance director and Therapy DOR replaced all wheelchair armrests that were in disrepair on 1/17/2025 and 1/18/2025. (including residents #1, #30, #15, and #17). . **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows:** All residents have the potential to be affected. **The measures that will be put into place or systemic changes made to ensure that the alleged deficient practice will not occur are as follows:** 1. Wheelchair cleaning schedule will be implemented and checked weekly x 4 weeks and monthly thereafter by DON/Administrator to ensure compliance. 2. Wheelchair maintenance checklist will be completed at time of cleaning and will be reviewed weekly x 4 weeks and monthly thereafter by DON/Admin to ensure compliance and timely repairs. 3. Any repairs needed will be relayed to maintenance director via paper form or entered in TELS system as a work order. **The facility will monitor the corrective actions to ensure that the alleged deficient practice will not recur as follows:**	2/21/2025

	1. Weekly x 4 weeks and monthly thereafter will review of wheelchair cleaning schedules to ensure completion. 2. Weekly x 4 weeks and monthly thereafter will review and follow up of wheelchair maintenance logs and work orders to ensure completion and compliance. 3. QAPI will monitor to ensure continued compliance with and the effectiveness of these corrective measures during monthly and quarterly meetings, respectively.	

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

PLAN OF CORRECTION

Provider/Supplier Name:	Ashley Manor Health & Rehabilitation
Street Address, City, Zip:	1630 Radio Hill Road, Boonville, MO 65233
Date of Survey:	1/12-15/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
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A3038	**Refer to F921**	2/21/25
A4031	Refer to F880	2/21/25
A4046	Refer to F725	2/21/25

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.