STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. BUILDING _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HEALTH CARE & REHABILITATION CENTER	1450 ASHLEY 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 880 SS=D	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 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:	F 880		

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

Administrator 1-2-25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. BUILDING _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HEALTH CARE & REHABILITATION CENTER	1450 ASHLEY 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 880	Continued From page 1 (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 review, facility staff failed to follow infection control practices and implement outbreak testing when two residents (Resident #1 and Resident #2) became symptomatic for Coronavirus Disease (COVID-19) . The facility census was 48. 1. Review of the facilty's COVID-19 - Testing Residents policy, undated, showed facility staff were directed to test residents with sign or symptoms of COVID-19 as soon as possible,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. BUILDING _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HEALTH CARE & REHABILITATION CENTER	1450 ASHLEY 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 880	Continued From page 2 regardless of vaccination status. Staff are directed residents and staff are tested for the SARS-CoV-2 virus to detect the presence of current infections (viral testing) and to help prevent the transmission of COVID-19 in the facility. Facility staff to conduct out break testing is initiated when a single new case of COVID-19 occurs among resident or staff to determine if others have been exposed, and a single new case of SARS-CoV-2 infection in any staff or resident should be evaluated to determine if others in the facility could have been exposed. 2. Review of Resident #1's change in status, Minimum data set (MDS), a federally mandated assessment tool, dated 9/27/24, showed staff assessed the resident as follows: -Cognitively intact; -Diagnoses of current Covid-19 infection, seizure disorder and depression. During an interview on 12/10/24 at 11:56 A.M., the resident said he/she had body aches, throwing up, diarrhea, mucous with blood and he/she cannot get comfortable, he/she said symptoms started last week and he/she has told multiple staff and no one has offered to test her for Covid-19. 3. Review of Resident #2's admission MDS, dated 11/5/24, showed staff assessed the resident as follows: -Cognitively intact; -Diagnoses of current Covid-19 infection, coronary artery disease, heart failure, diabetes, stroke, depression and COPD.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. BUILDING _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HEALTH CARE & REHABILITATION CENTER	1450 ASHLEY 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 880	Continued From page 3 During an interview on 12/10/24 at 12:00 P.M., the resident said he/she has not felt well for a few days and his/her roommate, Resident #1, has been sick too. Resident #2 said he/she has a runny nose, sore throat, cough and body aches. Resident #2 said he/she has had symptoms for two to three days and he/she wondered why no staff had tested him/her because he/she knew some residents in the building had covid. 4. During an interview on 12/10/24 at 10:30 A.M., the Director of Nursing (DON) said the facility has four known positives and have not started out break testing. The DON said he/she is being advised by corporate office to not test any other residents because it had to be reported to state. He/She said there are multiple residents that are symptomatic that he/she believes should be tested. During an interview on 12/10/24 at 11:15 A.M., He/She said if a resident has symptoms they can be tested but asymptomatic residents are not tested. During an interview on 12/10/24 at 11:16 A.M., the infection preventionist said he/she has not been instructed that someone with symptoms can not be tested, staff should question residents if they feel okay and tests them if not, but asymptomatic residents are not tested per the policy. During an interview on 12/10/24 at 11:33 A.M., the DON said eleven residents have symptoms headaches, body aches, cough and fatigue, none of them have been tested because they were advised not to test the residents by their corporate office.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. BUILDING _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HEALTH CARE & REHABILITATION CENTER	1450 ASHLEY 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 880	Continued From page 4 During an interview on 12/10/24 at 11:46 A.M., Registered Nurse B said he/she rounded with the physician today and got standing orders for residents who have symptoms to be tested. RN B said he/she does not know if the facility administration have denied testing but the physician ordered it and he/she will follow physician orders. MO00246246	F 880		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01602	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW HEALTH CARE & REHABILITATION	1450 ASHLEY 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) COMPLETE DATE
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: CLASS II. Please see 880.	A4086		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1-2-25

PLAN OF CORRECTION

Provider/Supplier Name:	Lakeview Healthcare and Rehabilitation Center
Street Address, City, Zip:	1450 W Ashley Road Boonville, MO 65233
Date of Survey:	12/10/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of all the state and federal regulations and not because Lakeview Health Care & Rehabilitation Center agrees with the allegations and citations listed on the statement of deficiencies. Lakeview Health Care & Rehabilitation Center maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Lakeview Health Care & Rehabilitation Center written credible allegation of compliance. By submitting this plan of correction, Lakeview Health Care & Rehabilitation Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish and standard of care, contract, obligation, or position, and Lakeview Health Care & Rehabilitation Center reserves all rights to raise all contentions and defenses in any civil or criminal claim, action or proceeding.	
F880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #1 and Resident #2 were tested for COVID 19 on 12/10/2024. Following positive test results Resident #1 and Resident #2 were immediately placed on isolation droplet precautions. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents can be affected by this alleged deficient practice. All Residents in the facility were tested for COVID 19 on 12/10/2024. Any Resident with positive results were placed immediately on isolation droplet precautions. Residents that tested negative on 12/10/2024 were tested again 48 hours later on 12/12/2024. All residents tested on 12/12/2024 had	01/15/2025

	negative test results. Residents were tested again 48 later on 12/14/2024. All residents tested on 12/14/2024 had negative test results **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Any resident that has signs or symptoms of COVID-19 will be tested for COVID-19. Any one positive test result will prompt testing for all residents in the facility. Education given to nursing staff on recognizing signs and symptoms for COVID-19. Including review of facility policy on testing resident for COVID-19. Any nurse that is hired after 01/15/2025 will receive education during orientation prior to the start of their first shift. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Random audits will be completed on actions rounds by the IP/Designee two times per week for two weeks. One time per week for two weeks. Monthly time one quarter to ensure sign and symptoms or being monitor correctly. Any identified concerns will be addressed immediately. Audits will be taken to Quality Assurance Performance Improvement monthly times three months and will be discussed with Interdisciplinary Team members (IDT). IDT team will determine at that time the need for continued monitoring. **Compliance Date will be 01/15/2025**	

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:	Lakeview Health Care & Rehabilitation Center
Street Address, City, Zip:	1450 W. Ashley Rd Boonville, Mo 65233
Date of Survey:	12/10/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of all the state and federal regulations and not because Lakeview Health Care & Rehabilitation Center agrees with the allegations and citations listed on the statement of deficiencies. Lakeview Health Care & Rehabilitation Center maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Lakeview Health Care & Rehabilitation Center written credible allegation of compliance. By submitting this plan of correction, Lakeview Health Care & Rehabilitation Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish and standard of care, contract, obligation, or position, and Lakeview Health Care & Rehabilitation Center reserves all rights to raise all contentions and defenses in any civil or criminal claim, action or proceeding.	
A4086	Refer to F880	01/15/2025

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.