STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265353	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RUN HEALTH CARE CENTER	1405 WEST GRAND AVE CAMERON, MO 64429

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F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandy ONeal LNHA — TITLE — (X6) DATE: 11/26/24

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

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F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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

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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exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect, when staff failed to address one resident (Resident #33) by their preferred name of choice, failed to assist one resident with eating lunch (Resident #44) and when the facility staff failed to ensure one resident (Resident #41) was dressed in clean clothing. This affected three out 24 sampled residents. The facility census was 56.

Review of the facility's undated Resident Rights Policy showed in part:
-Residents have a right to a dignified existence and self-determination;
-The facility shall protect and promote the rights of each resident;
-The facility shall care for it's residents in a manner that promotes enhancement of each resident's quality of life.

1. Review of Resident #44's Admission Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/18/24, showed:
-Severe cognitive impairment;
-Maximal assistance with showers and dressing;
-Supervision or touching assistance with transfers from chair to bed, mobility from sitting to lying;
-Frequently incontinent of urine;
-Always incontinent of bowel;
-Diagnosis included cancer, stroke, atrial fibrillation (AFib, a heart condition that causes irregular heart beat), high blood pressure and anxiety.

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Review of the resident's care plan, revised 8/29/24, showed:
-The resident has an Activities of Daily (ADL) self-care performance deficit;
-The resident has impaired cognitive function;
-The resident is dependent on staff for meeting emotional, intellectual, and physical needs;
-The resident has impaired visual function.

Observation on 11/4/24, at 12:54 P.M., showed:
- Nurse Aide (NA) A assisted the resident to the dining room;
-The resident was using a walker and NA assisted the resident into a chair that sat approximately 12 inches from the table;
-NA A did not assist the resident in moving his/her chair closer to the dining room table;
-The resident leaned forward in the dining room chair but could not move the chair closer to the table;
-The resident was still setting approximately 12 inches away from the table;
-The resident was served lunch;
-The resident picked up a fork and began eating;
-The food dropped off the fork and landed on the table and onto the resident's lap;
-Flies were landing on the food that was dropped on the table;
-The resident sat his/her fork down and started to lick the table;
-The resident licked the table and used his/her mouth to eat the food that had been dropped on the table;
-NA A was in the dining room passing trays;
-The flies were still landing on the food that was dropped on the table by the resident;
-The resident continued to use his/her mouth and tongue to eat directly off of the table;

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F 550	Continued From page 3 -No staff assisted the resident with his/her meal. 2. Review of Resident #41's Quarterly MDS dated 10/16/24, showed: -Severe cognitive impairment; -Supervision with showers and dressing; -Supervision with personal hygiene; -Frequently incontinent of urine and bowel; -Diagnosis included dementia, anxiety and bipolar disorder (a mental illness that causes extreme mood swings). Review of the resident's care plan, revised 7/10/24, showed: -Requires assistance with ADLs related to dementia; -Visually impaired; -The resident will not suffer any loss of dignity due to memory loss. Observation on 11/4/24, at 01:18 P.M., showed: -The resident walked into the dining room and sat in a chair at the table; -The resident's pants had brown stains on the back of them; -NA A gave the resident his/her meal; -Flies landed on the meal as soon as it was set on the table by NA A; -Multiple flies landed on the resident's food and the resident left the table and began opening drawers in the dining room; -The resident left the dining room and returned with a fly swatter; -Flies continued to land and crawl on the resident's food; -The resident laid the fly swatter on the table and started to eat the food after the flies had landed on it; -The resident's pants still had stains on them;	F 550		

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-Staff failed to offer the resident a new plate of food after the flies had landed on the food;
-Staff failed to offer to change the resident's stained pants.

During an interview on 11/5/24 at 10:53 A.M., NA A said:
-There should not be flies in the dining room landing on the residents' food;
-Residents should not be eating food that flies have landed on and the staff should offer them a new plate;
-Residents should be assisted closer to the table if they are dropping food on themselves or on the floor;
-Residents should not eat off the the table and should be assisted by staff;
-The staff should offer to change a resident's clothes if they look dirty or soiled;
-Residents should be treated with respect.

During an interview on 11/7/24 at 09:22 A.M., Registered Nurse (RN) A said:
-Residents should be treated with dignity;
-Residents who are having difficulty eating should be assisted by staff;
-If staff see flies on a resident's food they should be given a new plate;
-There should not be multiple flies in the dining room;
-If a resident is wearing dirty clothes the staff should offer to change them.

During an interview on 11/7/24 at 5:06 P.M., the Administrator said:
-He/she expects staff to assistance residents who need assistance with eating;
-Residents should not be eating off the table and staff should be assisting to accommodate them;

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-He/she expects staff give resident's a new plate of food if flies have landed on the food;
-He/she expects staff to change residents to who are wearing dirty clothes.

3. Review of Resident #33's care plan, reviewed 5/4/24 showed the resident did not wish to be called by his/her legal name.

Review of the resident's quarterly MDS, dated 9/25/24 showed:
- Cognitive skills intact;
- Diagnoses included depression, dementia (inability to think), psychotic disorder (mental illness characterized by psychotic symptoms, which can generally be described as a loss of contact with reality), schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and post traumatic stress disorder (PTSD, a mental health condition that can develop after a person experiences or witnesses a traumatic event).

During a group interview on 11/6/24 at 3:01 P.M., the resident said:
- He/she did not like to be called "honey", "sweetie" or "dear";
- He/she felt like it was very disrespectful for the staff to address him/her in such a manner;
- He/she would prefer to be called by his/her given name or "Ma'am/Sir".

During an interview on 11/7/24 at 10:53 A.M., Licensed Practical Nurse (LPN) D said if a resident did not want to be called "honey", "sweetie" or "dear", the staff should not call them that.

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F 550	Continued From page 6 During an interview on 11/7/24 at 2:02 P.M., Certified Nurse Aide (CNA) A said: - He/she was not aware of any resident who did not want to be called "honey", "darling", "sweetie" or "dear"; - They are not supposed to call any of the residents by any nicknames; - We should not call the residents that if they did not want to be be called that. During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said she did not expect staff to call residents by nicknames.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to maintain accommodation of needs when the facility staff did not ensure two of 14 sampled resident (Resident #46 and #39), had their call lights within reach while they were in their rooms. The facility census was 56. The facility did not provide a policy regarding call light use. 1. Review of Resident #46's Quarterly minimum data set (MDS, a federally mandated assessment completed by the facility staff) date 10/17/24 showed:	F 558		

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- The resident had a Brief Interview for Mental Status (BIMS) score of 0, indicating sever cognitive impairment;
- Diagnoses included: Dementia (a disease that affect the brain that causes memory loss and impairs reasoning), weakness and anxiety;
- The resident used a walker for mobility;
- The resident required the assistance of one staff for bed mobility, toileting, and showering.

Review of the resident's undated comprehensive care plan does not address call light use.

Observation on 11/4/24 at 9:34 A.M. showed:
The resident was in bed with the head of bed raised;
- The resident's bed was pushed with the left side of the bed against the wall;
- The residents call light was plugged into the wall and was lying on the floor behind the residents bed;
- The resident was not able to reach the call light;
- Certified Nurses Aide (CNA) D entered the resident's room, removed the resident's breakfast tray and then left the room without giving the resident his/her call light.

Observation on 11/5/24 at 10:32 A.M. showed:
- The resident was in his/her bed;
- The residents call light was lying behind the residents bed, on the floor at the foot of the bed.

Observation on 11/6/24 at 2:45 P.M. showed:
-The resident was in his/her bed;
- The bed was pushed with the left side against the wall;
- The resident call light was behind the bed, lying on the floor at the foot of the bed;
- The resident was unable to reach the call light.

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2. Review of Resident #39's Quarterly MDS, dated 10/16/24 showed:
- He/She had a BIMS score of 0, indicating severe cognitive impairment;
- Diagnoses included: Stroke, heart disease and schizophrenia (a disorder that affects a persons ability to think, feel and behave clearly).
- The resident was dependent on staff for toileting, personal hygiene, and transfers;
- The resident was incontinent of bowel and bladder.

Review of the resident's undated comprehensive care plan directed the facility staff to keep the resident's call light within arms length.

Observation on 11/4/24 at 10:11 A.M. showed:
- CNA D and Nurse Aide (NA) A enter the residents room with the resident in his/her wheel chair;
- The resident's head of bed was elevated and the resident's call light cord was draped across the frame of the head board with the call light resting on the floor;
- The staff assist the resident to bed and provided incontinent care;
- The staff covered the resident with his/her blanket, turned the light out and left the resident's room;
- The staff did not pick up the resident's call light and did not provide it to him/her.

Observation on 11/5/24 at 10:36 A.M. showed:
- The resident was in bed with the head of bed elevated;
- The resident's call light cord was draped across the bed frame at the head of the bed with the call light resident on the floor under the bed.

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F 558	Continued From page 9 During an observation on 11/6/24 at 2:43 P.M. showed: - The resident was in bed with the head of bed elevated; - The resident's call light cord was draped across the bed frame at the head of the bed with the call light resident on the floor under the bed. During an interview on 11/7/24 at 7:34 A.M. CNA D said he/she should have made sure the resident's call light was in reach at all times. During an interview on 11/7/24 at 5:06 P.M. the Director of Nurses said: - She expected the staff to ensure the resident had their call lights within reach while in their rooms and in bed; - She did not expect staff to provide cares and not provide the resident with his/her call light; - Call lights should be in reach at all times and should not be on the floor or under the bed.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		

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providing assistance and responding to written requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to consider concerns and recommendations of the resident council members concerning issues of resident care and life in the facility and failed to communicate back with the resident council regarding their concerns as reported by ten of the 11 residents who participated in a group interview. This had the potential to affect all residents in the facility. The facility census was 56.

Review of the facility's undated policy for grievances, showed, in part:
- Residents have the right to voice grievances to facility or other agency that hears grievances without discrimination or reprisal and without fear

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of discrimination or reprisal;
- Such grievances include those with respect to care and treatment which is furnished as well as that which has not been furnished, behavior of staff and other residents; and other concerns regarding their Long Term Care facility stay;
- Residents have the right to and the facility must make prompt efforts by facility to resolve grievances residents may have;
- The facility must make information on how to file a grievance or complaint available to the residents;
- The facility must establish a grievance policy to ensure prompt resolution of all grievances regarding residents' rights;
- Upon request, provider must give a copy of grievance policy to residents. Grievance policy must include: notifying resident of right to file grievances orally; contact information of grievance official; reasonable expected time frame for completing review of grievance; right to obtain written decision regarding grievance; contact information of independent entities with whom grievances may be filed;
- Identifying Grievance Official responsible for overseeing grievance process, receiving and tracking grievances through conclusion, leading investigations by facility, maintaining confidentiality of all information associated with grievances, issuing written grievance decisions to resident, and coordinating with agencies as necessary in light of specific allegations;
- Ensuring all written grievance decisions include date grievance was received, summary statement of the grievance, steps taken to investigate grievance, a summary of pertinent findings or conclusions regarding resident's concerns, a statement as to whether grievance was confirmed or not confirmed and any corrective actions taken

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or to be taken by facility as a result of grievance, and date written decision was issued.

1. Review of the resident council meeting minutes, dated 8/26/24 showed;
- Old business - laundry, call lights, trash in rooms and loud employees;
- New business - clothes missing, cold food, and trash piling up in rooms
- The form did not indicate how the issues were resolved, who was responsible or if the resolutions were satisfactory with the residents.

2. Review of the resident council meeting minutes, dated 10/1/24 showed:
- Old business - clothes missing, cold food, and trash piling up in rooms;
- New business - smell of the facility, employees being loud and swearing, dignity issues, information board, cleaner rooms, theft, dirty linens being left on the floor and wheelchairs not being washed;
- The form did not indicate how the issues were resolved, who was responsible or if the resolutions were satisfactory with the residents.

3. Review of the resident council meeting minutes, dated 10/29/24 showed:
- Old business - smell of facility, employees loud and swearing, dignity issues, information board, cleaner rooms, theft, dirty linens being left on the floor and wheelchairs not being washed;
- New business - gazebo lights not working, gazebo door needs fixed, recycle, cold food at dinner and toaster on North;
- The form did not indicate how the issues were resolved, who was responsible or if the resolutions were satisfactory with the residents.

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F 565	Continued From page 13 4. During the group meeting on 11/6/24 at 3:01 P.M., the residents said: - All 11 residents were not aware of who the Grievance Official was; - Ten of the 11 residents did not know how to file a grievance; - Ten of the 11 residents did not feel like they had any follow up from the staff about their concerns. During an interview on 11/5/24 at 12:44 P.M., the Activity Director said: - He/she had been in the current position since September; - He/she set up the resident council meetings; - They discussed the resident's concerns at the meetings. During an interview on 11/7/24 at 5:06 P.M., the Administrator said: - When residents voice concerns, the concerns should be followed up on the next month; - All grievances should be followed up on; - The residents concerns should be addressed.	F 565		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		

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requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure staff invoked (activated by verifying incapacity of the resident to make decisions) Durable Power of Attorney (DPOA) prior to allowing a resident to sign his/her Outside of Hospital Do Not Resuscitate (OHDNR) form which affected one of the 14 sampled residents, (Resident #30) and failed to obtain advance directives for code status (whether the resident wished to have cardiopulmonary resuscitation,

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CPR, if the resident's breathing stops or if the resident's heart stopped beating), which affected Resident #18. The facility census was 56.

Review of the facility's policy for advance directives, revised December 2016, showed, in part:
- Advance directives will be respected in accordance with state law and facility policy;
- Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he/she chooses to do so;
- If the resident is incapacitated and unable to receive information about his/her right to formulate an advance directive, the information may be provided to the resident's legal representative;
- Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record;
- If the resident indicates that he/she has not established advance directives, the facility staff will offer assistance in establishing advance directives. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance;
- The Attending Physician will provide information to the resident and legal representative regarding the resident's health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan;
- The plan of care for each resident will be consistent with his/her documented treatment

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preferences and/or advance directive;
- The Interdisciplinary Team will conduct ongoing review of the resident's decisions making capacity and communicate significant changes to the resident's legal representative. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (RAI);
- Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment and care plans;
- The Director of Nursing (DON) or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care;
- The Staff Development Coordinator will be responsible for scheduling advance directive training classes for newly hired staff members as well as scheduling annual Advance Directive In-Service Training Programs to ensure that our staff remain informed about the residents' rights to formulate advance directive and facility policy governing such rights.

1. Review of Resident #18's Admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/14/24 showed:
- Cognitive skills intact;
- Diagnoses included cancer, seizure disorder, anxiety, chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and congestive heart failure (CHF, accumulation of fluid in the lungs and other

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areas of the body).

Review of the resident's care plan, initiated on 10/14/24 showed the care plan did not address the resident's code status.

Review of the resident's physician order sheet (POS), dated November 2024 showed it did not address an order for the resident's code status.

Review of the resident's face sheet showed it did not address the resident's code status.

During an interview on 11/7/24 at 9:55 A.M., the MDS/Care Plan Coordinator said the resident's care plan should address the resident's code status.

During an interview on 11/7/24 at 10:53 A.M., Licensed Practical Nurse (LPN) D said:
- There should be a physician's order for a resident's code status;
- Their code status should be on the face sheet and it should be care planned.

During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said:
- There should be a physician's order for the resident's code status;
- The care plan should address the resident's code status.

During an interview on 11/7/24 at 5:06 P.M., the Regional Quality Assurance (QA) Nurse said:
- If the resident did not have a physician's order for a code status, they would automatically be a full code.

2. Review of Resident #30's Out of Hospital Do

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Not Resuscitate (OHDNR) order showed on 2/14/24, the resident had a mark to indicate his/her signature and the physician signed it on 2/14/24.

Review of the resident's Significant Change in Condition MDS, dated 2/14/24 showed:
- Cognitive skills severely impaired;
- Verbal behavior not directed at others occurred one to three days;
- Upper and lower extremities impaired on both sides;
- Dependent on the assistance of staff for eating, oral care, toilet use, dressing, personal hygiene, showers and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included dementia, anxiety, traumatic brain injury (TBI, a sudden injury that causes damage to the brain), depression and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions).

Review of the resident's care plan reviewed on 3/22/24 directed staff to not perform CPR as the resident has a DNR order.

Review of the resident's Quarterly MDS, dated 8/12/24 showed:
- The resident had short term and long term memory problems;
- Upper and lower extremities impaired on both sides;
- Dependent on the assistance of staff for eating, oral care, toilet use, dressing, personal hygiene, showers and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included dementia, anxiety, TBI,

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depression, schizophrenia and post traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).

Review of the resident's POS, dated November 2024 showed an order dated 7/31/24 - Do Not Resuscitate.

Review of the resident's face sheet showed:
- The resident's responsible party was him/herself;
- The resident's code status was Do Not Resuscitate.

During an interview on 11/5/24 at 3:34 P.M., the Social Services Designee (SSD) said:
- He/she had only been in the current position for three weeks;
- He/she has not done a lot of advance directives yet;
- On admission, he/she asked their advance directives;
- He/she did their Brief Interview for Mental Status (BIMS) assessment to determine their cognition;
- Resident #30 is not alert and oriented and is non-verbal. He/she did not think the resident should be his/her own person. The resident does not have a guardian at this time;
- If a resident's BIMS was a three, it would indicate severe cognition.

During an interview on 11/5/24 at 3:50 P.M., the Administrator said:
- If the resident had a BIMS of a three, the Interdisciplinary (IDT) team would meet and talk and see if the next of kin would want to pursue guardianship;
- Social Services would contact the family and

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F 578	Continued From page 20 see if they would be the responsible party; - Resident #30 is currently not alert and oriented; - With the resident's BIMS being a three, he/she should not have signed their OHDNR form. During an interview on 11/6/24 at 10:32 A.M., LPN B said: - Resident #30 is not alert and oriented. He/she cannot talk to you; - He/she did not feel the resident was alert and oriented enough to make legal decisions; - He/she did not feel the resident should be their own person but did not know what to do about something like that. During an interview on 11/7/24 at 10:53 A.M., LPN B said Resident #30 is not alert and oriented and he/she did not think the resident was capable of making health care decisions. During an interview on 11/7/24 at 5:06 P.M., the DON said if the resident's BIMS was a three, then the resident should not sign his/her DNR paperwork.	F 578		
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.	F 584		

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(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

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure housekeeping and maintenance services was provided to maintain a sanitary, orderly and comfortable interior throughout the facility. The facility census was 56.

Review of the facility's Floors policy, revised December 2009, showed in part:
-All floors should be cleaned daily;

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-Floor cleaning procedures are maintained by the house keeping director.

Review of the facility's undated house keeping daily cleaning duties showed:
-Pull trash;
-Dust/mop floors;
-Clean toilet;
-Dust horizontals;
-Clean shower rooms;
-Sitting and dining Rooms;
-Resident rooms 100 - 119;
-Resident rooms 120 - 139.

The facilty provided no other policies on cleaning and environment.

1. Observation on 11/04/24 at 9:02 A.M., showed:
-Room 124 with dirt and debris on the floor;
-The bathroom floor in room 124 was covered with dirt, and was sticky;
-The toilet bowl in room 124 had brown debris on the sides and will not flush.

2. Observation of the shower room on South Hall on 11/04/24 at 12:10 P.M., showed:
-The toilet bowl is covered with brown debris on the sides;
-The floor tiles around the toilet are broken and base board is coming away from the wall behind the toilet;
-The light cover above the toilet is cracked;
-The window blinds are broken by the sink.

3. Observation on 11/04/24 at 2:46 P.M., showed:
-The floor in room 134 covered with dirt and debris;
-Room 134 smelled of urine;
-The back of the stool was not in place.

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4. Observation on 11/04/24 at 2:55 P.M., showed room 138 with a brown stain on the bathroom ceiling the size of a basket ball.

5. Observation on 11/04/24 at 3:16 P.M., showed the door to the outside smoking area on South Hall with a two inch gap at the bottom and side.

6. Observation on 11/5/24 at 2:23 P.M. and 2:50 P.M., showed the showers across from the nurse's stations by rooms 111 and 139 did not have backfow preventers on the shower hoses.

During an interview on 11/6/24 at 3:50 P.M., the Maintenance Supervisor said he did not know the shower hoses needed a backflow preventer.

7. Observation on 11/5/24 starting at 2:25 P.M. showed:
- The call light cord less than two inch long in the room 101's bathroom;
- No call light cord in room 111's bathroom;
- No call light cord in room 136's bathroom;
- No call light cord in room 139's bathroom.

During an interview on 11/5/24 at 2:42 P.M., the Maintenance Supervisor said all bathroom call lights needed a cord, but some of them have been pulled out. He did not currently have any work orders for call light cords.

8. Observation on 11/6/24 at 3:27 P.M., showed the middle dining room door leading out to the corridor near the copy room would not easily open. Residents attempted to open the door but could not get it opened. The surveyor used significant force with their shoulder on the other side of the door (the door swung into the dining

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room) to push the door open. Several residents in group mentioned the door could be very difficult to open, so they don't ever use that door.

During an interview on 11/6/24 at 3:50 P.M. the Maintenance Supervisor said he did not know the door in the dining room was difficult for residents to open.

9. Observation on 11/4/24 at 9:00 A.M. showed:
- The south hall smelled like urine;
- Rooms 120, 121, 123, and 125 smelled like urine;
- The shared restroom in room 123 smelled like urine and the resident had an air freshener sitting on his/her over the bed table;
- The floor of the restroom was sticky and had black debris on it.

Observation on 11/4/24 at 10:02 A.M. showed room 129 a strong urine odor.

Observation: 11/4/24 at 10:11 A.M. showed room 122 the floor was sticky and the room had a strong urine odor.

10. Observation on 11/5/24 at 7:42 A.M.
- The South hall smells like strong urine;
- Rooms 120, 121, 123, and 125 smelled like urine.

Observation on 11/6/24 at 9:32 A.M. showed:
- The South hall smells like strong urine;
- Rooms 120, 121, 123, and 125 smelled like urine.

Observation on 11/7/24 at 7:15 A.M. showed the South hall smelled like strong urine.

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(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	Continued From page 25 During an interview on 11/07/24 at 11:35 A.M., the Maintenance Supervisor said: -He/she is in charge of making repairs in the facility which included repairs to resident rooms, resident bathrooms and shower rooms; -Staff verbally notify him/her if there is a repair that needs to be made; -He/she tries to make repairs as they are reported to him/her; -Sometimes he/she is not aware of repairs that need to be made; -The facility should be in good repair; -The door to the outside smoking area on south hall should not have a gap and should close completely. During an interview on 11/07/24 at 02:41 P.M. the Housekeeping Supervisor said: -The halls and resident rooms should not smell like urine; -He/she expects the floors to be cleaned daily and as needed; -Housekeepers should be using the daily cleaning list; -The floors should not be sticky and dingy; -The facility has had a high turnover in housekeeping staff and are trying to get back on track. During an interview on 11/7/24 at 5:06 P.M., the Administrator said: -He/she expects the facility to be clean and odor free; -He/she expects the building to be in good repair.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		

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§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her

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grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

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(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to ensure ten of eleven sampled residents who participated in a group meeting, knew who the Grievance Official was and how to file a grievance. The facility census was 56.

Review of the facility's undated policy for grievances, showed, in part:
- Residents have the right to voice grievances to facility or other agency that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal;
- Such grievances include those with respect to care and treatment which is furnished as well as that which has not been furnished, behavior of staff and other residents; and other concerns regarding their Long Term Care facility stay;
- Residents have the right to and the facility must make prompt efforts by facility to resolve grievances residents may have;
- The facility must make information on how to file a grievance or complaint available to the residents;
- The facility must establish a grievance policy to ensure prompt resolution of all grievances

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regarding residents' rights;
- Upon request, provider must give a copy of grievance policy to residents. Grievance policy must include: notifying resident of right to file grievances orally; contact information of grievance official; reasonable expected time frame for completing review of grievance; right to obtain written decision regarding grievance; contact information of independent entities with whom grievances may be filed;
- Identifying Grievance Official responsible for overseeing grievance process, receiving and tracking grievances through conclusion, leading investigations by facility, maintaining confidentiality of all information associated with grievances, issuing written grievance decisions to resident, and coordinating with agencies as necessary in light of specific allegations;
- Ensuring all written grievance decisions include date grievance was received, summary statement of the grievance, steps taken to investigate grievance, a summary of pertinent findings or conclusions regarding resident's concerns, a statement as to whether grievance was confirmed or not confirmed and any corrective actions taken or to be taken by facility as a result of grievance, and date written decision was issued.

Review of the facility's undated policy for resident rights showed, in part:
- Residents have a right to a dignified existence, self determination and communication with and access to persons and services inside and outside the facility. This facility shall protect and promote the rights of each resident which shall include the following rights:
- A resident has the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States;

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- A resident has the right to voice grievances with respect to treatment or care that is, or fails to be furnished, without discrimination or reprisal for voicing grievances and prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

1. Review of the resident council meeting minutes showed:
- 8/26/24 - the minutes did not indicate what resident rights had been reviewed or discussed or if the residents knew how to file a grievance;
- 10/1/24- the minutes did not indicate what resident rights had been reviewed or discussed or if the residents knew how to file a grievance;
- 10/29/24 - the minutes did not indicate if the resident rights had been reviewed or discussed or if the residents knew how to file a grievance.

During a group meeting on 11/6/24 at 3:01 P.M., ten of the 11 alert and oriented residents who attended said they did not know who the Grievance Official was and did not know how to file a grievance.

During an interview on 11/5/24 at 12:44 P.M., the Activity Director said:
- He/she had been in the current position since September;
- He/she set up the resident council meetings;
- They discussed the resident's concerns at the meetings.

During an interview on 11/7/24 at 5:06 P.M., the Administrator said the residents should know who the Grievance Official was and how to file a grievance.

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F 585	Continued From page 31 During an interview on 11/7/24 at 5:06 P.M., the Regional Quality Assurance (QA) Nurse said he/she addressed grievances with the residents back in April and discussed the process with them.	F 585		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility staff failed to develop a comprehensive person-centered care plan for three of 14 sampled residents (Resident #25, #18, and #49). The facility census was 56.

The facility did not provide a care plan policy.

Review of the undated Resident Right's policy showed:
- The resident had the right to participate in their person-centered care plan;
- Participate in the development of goals and outcomes of care the care plan;
- Request revisions to the person-centered care plan.

1. Review of Resident #25's Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 10/2/24 showed:
- The resident had a brief interview for mental status (BIMS) score of 12, indicating minimal

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cognitive deficit;
- Diagnoses included: Obesity, urinary incontinence and diabetes type 2 (a disease in which the body does not process blood sugar properly);
- The resident was bound to his/her wheelchair;
- The resident was incontinent of bowel and bladder;
- The resident required assistance of two staff to provide hygiene, bathing, and transfers.

Review of the resident's record showed the following:
- The resident was admitted to the facility on 6/6/2022;
- The care plan was one page in length, was dated 11/4/24 and addressed a fall the resident had;
- The resident did not have a person-centered comprehensive care plan.

2. Review of Resident #18's MDS, dated 10/14/24 showed:
- Cognitive skills intact;
- Diagnoses included cancer, seizure disorder, anxiety, chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body).

Review of the resident's care plan, initiated on 10/14/24 showed the care plan did not address the resident's code status.

Review of the resident's physician order sheet (POS), dated November 2024 showed it did not address an order for the resident's code status.

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Review of the resident's face sheet showed it did not address the resident's code status.

During an interview on 11/7/24 at 9:55 A.M., the MDS/Care Plan Coordinator said the resident's care plan should address the resident's code status.

During an interview on 11/7/24 at 10:53 A.M., LPN D said:
- There should be a physician's order for a resident's code status;
- Their code status should be on the face sheet and it should be care planned.

During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said:
- There should be a physician's order for the resident's code status;
- The care plan should address the resident's code status.

3. Review of Resident #49's care plan, reviewed on 4/24/24 showed the care plan did not address the resident going to dialysis (a procedure that removes waste products and excess fluid form the blood when the kidneys are no longer functioning properly).

Review of the resident's Quarterly MDS, dated 7/20/24 showed:
- Cognitive skills severely impaired;
- Independent with toilet use, dressing and transfers;
- Always continent of bowel and bladder;
- Diagnoses included stroke and chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and diabetes mellitus.

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F 656	Continued From page 35 During an interview on 11/7/24 at 9:55 A.M., the MDS/Care Plan Coordinator said the resident's care plan should address if the resident goes to dialysis. During an interview on 11/7/24 at 5:06 P.M., the DON said the care plans should be comprehensive and should include if the resident went to dialysis.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews the facility staff failed to review and update care plans quarterly for two of 14 sampled residents (Resident #36 and #43).The facility census was 56.

The facility did not provide a policy for care plan revisions and updates.

Review of the undated Resident Right's policy showed:
- The resident had the right to participate in their person-centered care plan;
- Participate in the development of goals and outcomes of care the care plan;
- Request revisions to the person-centered care plan.

1. Review of Resident #36's Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 8/22/24 showed:
- The resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had mild cogitative deficit;
- Diagnoses included: Alzheimer's Disease (A disease of the brain that impairs memory and reasoning), urinary incontinence and constipation;
- The resident required assistance from one staff to use the toilet, get dressed, and shower;
- The resident had verbal behaviors.

Review of the resident's care plan showed:
- The resident's care plan was last updated 5/4/24;

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- The resident's care plan did not address his/her verbal behaviors that were assessed for the MDS dated 8/22/24.

2. Review of Resident #43's care plan conference summary, dated May 2024 showed:
- Two staff attended the meeting;
- The form did not indicate if the resident was invited to the care plan meeting or if he/she attended the meeting;
- This was the only care plan conference summary provided by the facility.

Review of the resident's Quarterly MDS, dated 8/19/24 showed:
- Cognitive skills intact;
- Upper extremity impaired on one side;
- Required partial to moderate assistance of staff with toilet use, showers, and transfers;
- Frequently incontinent of bowel;
- Diagnoses included cancer, stroke, diabetes mellitus and hemiplegia (paralysis affecting one side of the body).

During an interview on 11/4/24 at 11:31 A.M., the resident said:
- He/she had not been invited to a care plan meeting and had not attended a care plan meeting.

During an interview on 11/5/24 at at 12:31 P.M., the MDS/Care Plan Coordinator said:
- He/she did the nursing component of the MDS;
- Social Services invited the residents and the responsible parties to the the care plan meetings.

During an interview on 11/5/24 at 3:34 P.M., the Social Services Designee said:
- He/she had only been in the current position for three weeks;

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F 657	Continued From page 38 - Was only able to find one care plan conference summary for the resident; - Residents and responsible parties should be invited to the meetings. During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said: - Residents and/or responsible parties should be invited to their care plan meeting; - There should be documentation to indicate who attended the care plan meetings - Care plan should be updated quarterly and as needed in coordination with the MDS assessment schedule.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure staff provided services that met professional standards of quality of care when staff failed to obtain an order for a resident to go to dialysis (a procedure that removes waste products and excess fluid form the blood when the kidneys are no longer functioning properly) which affected one of the 14 sampled residents, (Resident #49). Additionally, the facility failed to monitor the settings of the low air loss mattress (an air mattress with tiny holes that helps prevent and treat pressure wounds and regulate skin temperature and moisture levels) which affected two residents, (Resident #21 and	F 658		

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#30). The facility census was 56.

Review of the facility's policy for medication orders, dated 2001, showed:
- The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders;
- A current list of orders must be maintained in the clinical record of each resident.

1. Review of Resident #49's care plan, reviewed on 4/24/24 showed the care plan did not address the resident going to dialysis.

Review of the resident's Quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 7/20/24 showed:
- Cognitive skills severely impaired;
- Independent with toilet use, dressing and transfers;
- Always continent of bowel and bladder;
- Diagnoses included stroke and chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing) and diabetes mellitus.

Review of the resident's physician order sheet (POS) dated November 2024 showed the resident did not have a physician's order to go to dialysis.

During an interview on 11/7/24 at 9:55 A.M., the MDS/Care Plan Coordinator said the resident's care plan should address if the resident goes to dialysis.

During an interview on 11/7/24 at 10:53 A.M., Licensed Practical Nurse (LPN) D said the

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resident should have an order to go to dialysis.

During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said:
- The care plans should be comprehensive and should include if the resident went to dialysis;
- There should be a physician's order for the resident to go to dialysis.

2. Review of the undated manufacturer's guidelines for the Drive low air loss mattress showed:
- Adjust the dial to correspond to the resident's appropriate weight setting or comfort level.

Review of Resident #21's care plan, revised 5/15//24 showed:
- The resident had the potential for skin injury;
- Provide a low air loss mattress with proper functioning.

Review of the resident's Significant change in MDS, dated 8/2/24 showed:
- Cognitive skills moderately impaired;
- Upper and lower extremities impaired on both sides;
- Dependent on staff assistance for eating, oral care, showers, dressing, personal hygiene, transfers and toilet use;
- Always incontinent of bowel and bladder;
- Weight - 160 pounds. No weight gain or weight loss;
- Had one Stage III pressure ulcer (a full thickness of skin loss, exposing the subcutaneous tissues, presents as a deep crater with or without undermining adjacent tissue) on admit;
- Diagnoses included non traumatic brain dysfunction (brain damage caused by internal

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factors rather than an external physical force), congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), anxiety, cerebral palsy (CP, abnormal brain development or damage to the developing brain that affects a person's ability to control their muscles) and dementia (inability to think).

Observation on 11/4/24 at 9:23 A.M., showed the Drive low air loss mattress was set on 300 pounds.

Observation on 11/4/24 at 9:47 A.M., showed Nurse Aide (NA) B and Certified Nurse Aide (CNA) C provided incontinent care and the resident did not have a pressure ulcer on his/her buttocks.

Review of Resident #21's weight on 11/7/24 at 11:30 A.M., showed:
- 10/4/24 - 151.6;
- 11/3/24 - 147.8.

Observation on 11/7/24 at 11:36 A.M., showed the low air loss mattress was set on 280 pounds.

Review of the resident's POS, dated November 2024 showed the resident did not have a physician's order for the low air loss mattress or what the settings should be set on.

3. Review of the undated manufacturer's guidelines for the Proactive low air loss mattress, showed:
- Users can adjust air mattress to a desired firmness according to the resident's weight or the suggestion from a a health care professional.

Review of Resident #30's care plan, reviewed

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3/22/24 showed it did not address the use of the low air loss mattress or what the settings should be.

Review of the resident's Quarterly MDS, dated 8/12/24 showed:
- Short term and long term memory problems;
- Cognitive skills severely impaired;
- Upper and lower extremities impaired on both sides;
- Dependent on the assistance of staff for eating, oral care, toilet use, showers, dressing, personal hygiene and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included dementia, anxiety, traumatic brain injury (TBI, a sudden injury that causes damage to the brain), depression and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions).

Observation on 11/4/24 at 2:52 P.M., showed the low air loss mattress was set on 230 pounds.

Review of the resident's weight on 11/7/24 at 11:28 A.M., showed:
- 10/1/24 - 153.1 pounds;
- 11/2/24 - 154.4 pounds.

Observation on 11/7/24 at 11:36 A.M., showed the low air loss mattress was set on 230 pounds.

Review of the resident's POS, dated November 2024 showed the resident did not have a physician's order for the low air loss mattress or what the settings should be set on.

4. During an interview on 11/6/24 at 10:32 A.M.,

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F 658	Continued From page 43 LPN B said: - The nurses monitor the low air loss mattresses to make sure the settings are correct; - He/she just visually checks it and does not think it is documented anywhere; - Hospice (end of life care) sets up the low air loss mattresses. During an interview on 11/7/24 at 7:09 A.M., LPN A said: - The nurses check the settings each shift; - When they had paper charting, it was written in the books; - He/she just remembered what the settings should be; - Should look on the POS for the orders for the low air loss mattress and for what the settings should be set on. During an interview on 11/7/24 at 10:53 A.M., LPN D said: - The nurses monitor the settings on the low air loss mattress; - He/she did not know what settings they should be set on; - He/she did not know how often they should be checked. During an interview on 11/7/24 at 5:06 P.M., the Regional Quality Assurance (QA) nurse said: - There should be a physician's order to indicate the weight of the resident and it would be per manufacturer's guidelines; - The nurses should be checking them to ensure they are on the correct setting.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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§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 personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADL's) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal care which affected three of the 24 sampled residents, (Resident #1, #21 and #25) and failed to ensure showers or bed baths were completed for Resident #21 and #43). The facility census was 56.

Review of the undated policy for resident rights, showed, in part:
- The facility shall care for its resident's in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

The facility did not provide a policy for perineal care.

1. Review of Resident #21's Significant Change in Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/2/24 showed:
- Cognitive skills moderately impaired;
- Upper and lower extremities impaired on both sides;
- Dependent on staff assistance for eating, oral care, showers, dressing, personal hygiene, transfers and toilet use;
- Always incontinent of bowel and bladder;

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- Diagnoses included non traumatic brain dysfunction (brain damage caused by internal factors rather than an external physical force), congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), anxiety, cerebral palsy (CP, abnormal brain development or damage to the developing brain that affects a person's ability to control their muscles) and dementia (inability to think).

Review of the resident's care plan, revised 8/14/24 showed:
- The resident had bowel and bladder incontinence related to diagnosis of dementia. Provide peri care after each incontinent episode.

Observation on 11/4/24 at 9:47 A.M., showed:
- Certified Nurse Aide (CNA) C and Nurse Aide (NA) B washed their hands and applied gloves;
- CNA C wiped down each side of the groin with a different wipe each time;
- CNA C used a new wipe and with the same area of the wipe, wiped down the skin folds and did not separate and clean all areas;
- NA B applied antifungal powder (used to treat fungal or yeast infections of the skin) to the front perineal folds;
- CNA C and NA B turned the resident on his/her side and tucked the wet cloth pad;
- CNA C wiped from front to back with a smear of fecal material on the wipe;
- CNA C used a new wipe and wiped up one side of the buttocks and tucked a clean cloth pad under the resident;
- CNA C removed gloves, did not wash his/her hands and applied gloves;
- CNA C applied Thera Calazinc body shield (helps protect and relieve minor skin irritations due to rashes) to both sides of the resident's

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buttocks;
- CNA C removed gloves, sanitized and applied new gloves;
- CNA C and NA B turned the resident to the other side and removed the wet cloth pad and pulled the clean cloth pad through and repositioned the resident in bed;
- CNA C did not clean all areas of the skin where urine or feces had touched.

During an interview on 11/7/24 at 10:09 A.M., CNA C said:
- He/she should have separated and cleaned all areas of the skin where urine or feces had touched;
- Should not use the same area of the wipe to clean different areas of the skin. It should just be one swipe.

2. Review of Resident #1's care plan, reviewed 6/11/24 showed:
- The resident required the use of an indwelling catheter;
- Daily catheter care;
- Monthly catheter change performed by urology due to complications in the past.

Review of the resident's Quarterly MDS, dated 9/27/24 showed:
- Brief Interview for Mental Status was not completed;
- Dependent on the assistance of staff for toilet use, showers, dressing, personal hygiene and transfers;
- Had a catheter;
- Always incontinent of bowel;
- Diagnoses included anxiety, diabetes mellitus, schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions,

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emotional responsiveness, and social interactions) and non-traumatic brain injury (brain damage caused by internal factors, rather than an external force to the head).

Observation on 11/6/24 at 12:15 P.M., showed:
- Certified Nurse Aide (CNA) A and Nurse Aide (NA) A did not wash their hands and applied gloves;
- CNA A used the same area of the wipe and dabbed around the insertions site of the supra pubic catheter (a flexible tube that drains urine from the bladder through a small incision in the lower abdomen);
- CNA A used a new wipe and wiped down one side of the groin;
- CNA A used a new wiped and wiped down one side of the groin and with the same area of the wipe, wiped across the pubic area and down the skin folds;
- CNA A did not separate and clean all the skin folds;
- CNA A and NA A turned the resident on his/her side;
- CNA A wiped down one side of the resident's buttocks and placed a clean incontinent brief under the resident;
- CNA A and NA A turned the resident and pulled the clean incontinent brief through;
- CNA A did not anchor the catheter tubing and wiped up and down the tubing from the connection site down to the drainage bag;
- CNA A and NA A fastened the clean incontinent brief;
- CNA A wiped in the wrong direction and did not separate and clean all areas of the skin.
- CNA A and NA A removed gloves and washed hands

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During an interview on 11/7/24 at 2:02 P.M., CNA A said:
- When cleaning the supra pubic catheter should use one wipe and clean around the insertion site and use a new one to wipe down the tubing;
- They do not have to anchor the catheter tubing when cleaning it;
- Should separate and clean all areas of the skin where urine has touched;
- Should not use the same area of the wipe to clean different areas of the skin. It should be one wipe with one stroke;
- He/she always wiped in the down direction.

During an interview on 11/7/24 at 5:06 P.M., the DON said:
- Staff should not use the same area of the wipe to clean different areas of the skin;
- Staff should separate and clean all the skin folds;
- Staff should wipe from front to back and not down.

During an interview on 11/7/24 at 5:06 P.M., the Regional Quality Assurance (QA) Nurse said:
- Staff should anchor the catheter tubing and wipe down the tubing.

3. The facility did not provide a policy for showers or bed baths.

Review of Resident #43's care plan, reviewed 3/22/24 showed:
- The resident required assistance due to hemiplegia (paralysis affecting one side of the body) due to history of stroke;
- Preferred to have a shower two days a week. No preference for time or day. If resident refuses, please ask again at a later time.

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Review of the resident's Quarterly MDS, dated 8/19/24 showed:
- Cognitive skills intact;
- Upper extremity impaired on one side;
- Required partial to moderate assistance from staff for toilet use, showers, transfer and dressing the lower extremities;
- Frequently incontinent of urine;
- Diagnoses included cancer, stroke, diabetes mellitus and hemiplegia.

Observation and interview on 11/4/24 at 11:35 A.M., the resident said:
- He/she was supposed to have showers on Monday and Thursday;
- He/she has not been getting his/her showers;
- It made him/her feel terrible because he/she liked to feel clean and fresh;
- The resident's hair appeared greasy and dull.

Review of the resident's bathing self-performance on 11/6/24 at 11:34 A.M., showed:
- Preferred bathing on Monday and Thursday and as needed;
- 10/9/24- total dependence;
- 10/10/24 - the resident refused;
- 10/24/24 - total dependence;
- 10/28/24 - physical help with part of the bathing activity;
- 10/31/24 - total dependence;
- 11/5/24 - total dependence.

4. Review of Resident #21's care plan, revised 5/15/24 showed;
- The resident required staff assistance for all ADL's;
- The resident preferred to have bed baths two times per week.

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Review of the resident's Significant Change in MDS, dated 8/2/24 showed:
- Cognitive skills moderately impaired;
- Upper and lower extremities impaired on both sides;
- Dependent on staff assistance for eating, oral care, showers, dressing, personal hygiene, transfers and toilet use;
- Always incontinent of bowel and bladder;
- Diagnoses included non traumatic brain dysfunction CHF, anxiety, CP, and dementia.

Review of the resident's bathing self-performance on 11/7/24 at 12:03 P.M., showed:
- The resident wanted bed baths on Tuesday and Friday and as needed;
- 10/7/24 - total dependence;
- 10/29/24 - total dependence;
- Did not provide shower or bed bath information for November 2024.

5. During an interview on 11/6/24 at 10:32 A.M., LPN B said:
- He/she has not had any residents complain about not getting their showers;
- Do not have a dedicated shower aide;
- The aides just work the shower schedule out between themselves and fill out the shower sheets;
- The charge nurse reviews the shower sheets and signs them then puts them in the DON's box;
- If a resident refused a shower, he/she would go and talk to them and if the resident still refused, then the resident and the charge nurse would sign the shower sheet.

During an interview on 11/6/24 at 10:51 A.M., the Quality Assurance (QA) Nurse said:

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- In August, the facility switched computer programs and at that time the previous DON had the aides stop filling out shower sheets;
- The point of care in point click care will only let them look at the last 30 days of showers;
- The staff were educated and have started filling out shower sheets again.

During an interview on 11/7/24 at 10:09 A.M., CNA C said:
- On Mondays and Thursdays, the aides do the even rooms and on Tuesdays and Fridays the aides do the odd rooms;
- Typically on Mondays and Thursdays they have about 14 showers to do and on Tuesdays and Fridays they have about 17 showers to do;
- Some days they can get all the showers done and some days they only get three or four showers completed;
- The evening shift does not normally pick up any showers;
- They used to document the showers in point of care but just started filling out the shower sheets again;
- He/she has had some residents complain about not getting their showers completed.

During an interview on 11/7/24 at 10:53 A.M., LPN D said:
- He/she has had residents complain about not getting their showers done. When the resident complains, they try to get them completed that day;
- The aides are not able to get all the showers completed on one shift;
- The aides have started filling out shower sheets and he/she reviews them, signs them and turn them into the DON;
- If a resident refused a shower, he/she tried to

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document it in the resident's chart and talks to the resident. He/she did not sign the shower sheet if the resident refused.

During an interview on 11/7/24 at 5:06 P.M., the DON said the residents should have their showers twice weekly if that was their preference.

5. Review of Resident #25's quarterly MDS dated 10/2/24 showed:
- The resident had a BIMS score of 12, indicating minimal cognitive deficit;
- Diagnoses included: Obesity, urinary incontinence and diabetes type 2 (a disease in which the body does not process blood sugar properly);
- The resident was bound to his/her wheelchair;
- The resident required assistance of two staff to provide hygiene, bathing, and transfers.

Review of the resident's undated comprehensive care plan does not address the resident's incontinence needs.

Observation on 11/6/24 at 10:27 A.M. showed:
- The resident's call light was on and CNA C and CNA F entered the resident's room;
- The resident asks for incontinent care to be done;
- Both CNA's wash their hands and put on gloves;
- The resident had the blanket wrapped around his/her body;
- CNA C pulls back the resident's blanket;
- The blanket was saturated with urine and there was a strong odor of urine;
- 11/6/24 6:00 A.M. was written across the front of the resident's incontinence brief;
- CNA F rolled the resident toward him/her and CNA C unfastened the resident's brief;

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F 677	Continued From page 53 - The brief was soaked with urine though to the cloth pad, bath blanket used as a turn sheet, and the mattress below; - The bath blanket had large brown rings where the resident was lying; - CNA C pulled the residents' brief away from the resident; - The resident's bottom and left hip was dark red; - Under the resident abdominal skin fold was dark red and had an open slit on the right side above the resident's hip; - CNA C cleaned the resident's bottom with one wipe, making multiple swipes and turned the resident; - CNA F removed the dirty linens from the resident's bed and wiped the resident's right hip area with one wipe , making multiple swipes; - CNA C placed the resident on his/her back wiped the resident's pubic area with one wipe, going front to back; - CNA C wiped the resident's left and right groin with the same wipe; - CNA C did not separate the resident's groin fold to clean the resident; - CNA F applied a clean blanket over the resident and both CNA's left the room. During an interview on 11/6/24 at 10:50 A.M. CNA F said: - The resident was saturated with urine because the the staff did not clean the resident since 6:00 A.M. when night shift did it; - He/She and CNA C should have checked and cleaned the resident at 8:00 A.M.; - He/She was trained to check and provide incontinent care every two hours and as needed for residents that were not able to use the restroom.	F 677		

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F 677	Continued From page 54 During an interview on 11/6/24 at 2:45 P.M. RN A said: - He/She expected staff to check and provide incontinent care every two to three hours when the resident was not able to get to the bathroom. 6. During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said: - She expected the staff to use different wipes for each area of the skin; - Staff should separate and clean all areas of the skin where urine or feces had touched.	F 677		
F 729 SS=E	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.	F 729		

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F 729	Continued From page 55 §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure three of five sampled staff (Certified Nurse Aid (CNA) E, CNA D, CNA C) completed competencies upon hire and annually. The facility census was 56. The facility did not provide a policy for CNA competencies. 1. Review of the staff roster showed: - CNA E was hired 2/21/24; - CNA D was hired 8/21/23; - CNA C was hired 4/15/24. 2. During an interview on 11/7/24 at 1:58 P.M. the Administrator said: - She was unable to find CNA's E, D, C competencies from hire or annual; - Competencies were not being completed upon hire and annually; - She expected the CNA competencies to be completed upon hire and annually by the nurses.	F 729		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		

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§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record

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review the facility failed to minimize adverse consequences related to medication therapy to the highest extent possible when the facility failed to ensure the consultant pharmacist reviewed each resident's medication for unnecessary medications, psychoactive medication, including gradual dosage reductions, and drug irregularities monthly and additionally failed to ensure the attending physician was notified of the pharmacist's recommendations. This affected three of the 24 sampled residents (Resident #1, #4 and #51). The facility census was 56.

The facility did not provide the requested drug regimen review policy.

1. Review of Resident #4's medical record showed:
-Initial admit date 2/14/24;
-Admission date 9/3/24;
- 8/14/24 a GDR (gradual dosage reduction) was attempted for Trazodone (used to treat insomnia) 50 milligrams (mg) and Zoloft (used to treat depression) 100 mg;
-No other drug regimen reviews were found.

Review of the resident's Admission Minimum Date Sets (MDS) a federally mandated assessment tool completed by facility staff, dated 9/10/24 showed:
- Severe cognitive impairment;
- Dependent on the assistance of staff for toilet use, showers, dressing, personal hygiene;
- Frequently incontinent of bowel and bladder;
- Received antipsychotic, anti-anxiety and anti-depressant medications;
- Diagnoses included stoke, dementia and thyroid (a gland that regulates other organs in the body) disorder.

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Review of the resident's care plan dated 9/23/24, showed:
-The resident has an Activities of Daily Living (ADLs) performance deficit;
-The resident takes psychotropic medications for depression, insomnia and dementia;
-Consult with physician to perform or document against a Gradual Dose Reduction (GDR,tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) at least quarterly.

2. Review of Resident #51's medical record showed:
-Admit date 5/31/24;
-6/12/24 - pharmacist recommended Haldol (used to treat nervous, emotional, and mental conditions) 1 mg intramuscular injection, every 24 hours as needed, the order could not stand for greater that 14 days;
-6/12/24 - pharmacist recommended Haldol 1 mg by mouth every 24 hours as needed, the order could not stand for greater that 14 days;
-No response from the physician was found.

Review of the resident's care plan dated 7/4/24, showed:
-The resident is at risk for side effects from antidepressant use;
-The resident is at risk for side effects from antipsychotic use;
-Pharmacy consultant review of the resident's medication to be done monthly.

Review of the resident's Quarterly MDS dated, 9/7/24 showed:
- No cognitive impairment;

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- Independent with ADLs;
- Received antipsychotic and anti-depressant medications;
- Diagnoses included Post Traumatic Stress Disorder (PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event), dementia and depression.

3. Review of Resident #1's care plan, reviewed 6/11/24 showed:
- The resident was at risk for side effects related to psychotropic drug use. Administer medication as ordered. Observe for side effects. Monitor the resident's behavior. Pharmacy consult to review medication monthly.

Review of the resident's monthly drug regimen review between 6/12/24 through 9/11/24 showed:
- 6/12/24 - the pharmacist recommended labs to be drawn. 6/19/24 - The form was faxed to the physician and it did not indicate if the physician had responded;
- 9/11/24 - the pharmacist recommended a gradual dose reduction (GDR) of Lorazepam (used to treat anxiety), Lexapro (used to treat depression), Trazodone (used to treat depression) and Udezy (used to treat schizophrenia, a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). There was no documentation to indicate if the physician had been notified of the recommendations.

Review of the resident's Quarterly MDS, dated 9/27/24 showed:
- Brief Interview for Mental Status was not completed;
- Dependent on the assistance of staff for toilet

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F 756	Continued From page 60 use, showers, dressing, personal hygiene and transfers; - Had a catheter; - Always incontinent of bowel; - Received antipsychotic, anti-anxiety and anti-depressant medications; - Diagnoses included anxiety, diabetes mellitus, schizophrenia and non-traumatic brain injury (brain damage caused by internal factors, rather than an external force to the head). During an interview on 11/7/24 at 5:06 P.M., the Regional Quality Assurance (QA) Nurse said: - Drug regimen reviews should be done every month; - the recommendations are emailed, printed and given to the physician either in person or by fax; - It should be completed within 72 hours; - The GDRs got to the MDS Coordinator and should be reviewed at the weekly risk meeting; - The physician should sign the recommendations; - The previous Director of Nursing (DON) did not always complete the drug regimen reviews.	F 756		
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 an error rate of less than five percent (%). Staff made eight errors	F 759		

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out of 30 opportunities for error, which resulted in an error rate of 26.67%. This affected three of the 14 sampled residents, (Resident #23, #35, and #48). The facility census was 56.

The facility did not provide a policy for obtaining blood sugars, administration of insulin, administration of nasal sprays, or the administration of eye drops.

Review of the website. mayoclinic.org. for obtaining blood sugars showed:
- Wash and dry your hands and testing site thoroughly with soap and water before pricking your skin;
- Don't use hand sanitizer before testing;
- If using alcohol wipes, let the site completely dry prior to pricking the skin.

1. Review of Resident #48's physician order sheet (POS) dated November 2024 showed:
- Order date 8/2/24 - Check blood sugars before meals and at bedtime related to diabetes mellitus;
- Order date 8/14/24 - Insulin Lisper (fast acting insulin) per sliding scale. Blood sugar 151 - 200, give four units for diabetes mellitus.

Review of the resident's medication administration record (MAR) dated November 2024 showed:
- Check blood sugars before meals and at bedtime related to diabetes mellitus;
- Insulin Lispro per sliding scale. Blood sugar 151
- 200, give four units for diabetes mellitus.

Observation and interview on 11/6/24 at 12:08 P.M., showed:
- Licensed Practical Nurse (LPN) B cleaned the resident's finger tip with an alcohol wipe, let it air

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dry for seven seconds then obtained the resident's blood sugar;
- LPN B used the vial of Lispro insulin, opened 8/17/24 and was to be discarded after 9/17/24, drew up four units in the syringe and administered the insulin;
- He/she should have let the finger tip air dry before obtaining the blood sugar. He/she should not have used the insulin since it was expired.

2. Review of the website, www.webmd.com for administration of artificial tears showed:
- Tilt the head back, look up and pull down the lower eyelid to make a pouch;
- Place the dropper directly over the eye and squeeze out one or two drops as needed;
- Look down and gently close your eye for one or two minutes;
- Place one finger at the corner of the eye near the nose and apply gentle pressure. This will prevent the medication from draining away from the eye.

Review of Resident #35's POS dated November 2024 showed:
- Start date 8/9/24 - Artificial Tears ophthalmic solution, instill one drop in both eyes twice daily for dry eyes;
- Start date 8/9/24 - Glycol Powder 17 grams by mouth two times a day for constipation;
- Start date 8/9/24 - Metamucil oral powder 48.57%, give one tablespoon by mouth daily for constipation.

Review of the resident's MAR dated November 2024 showed:
- Artificial Tears ophthalmic solution, instill one drop in both eyes twice daily for dry eyes;
- GlycoLax Powder (Miralax) 17 grams by mouth

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two times a day for constipation;
- Metamucil oral powder 48.57%, give one tablespoon by mouth daily for constipation.

Observation on 11/7/24 at 7:41 A.M., showed;
- Certified Medication Technician (CMT) A placed one tablespoon of Metamucil in a five ounce blue cup. The label on the container said to mix with eight ounces of water;
- CMT A poured 17 grams of Miralax in the five ounce blue cup with the Metamucil and added four ounces of water to the blue cup and administered it to the resident;
- CMT A instilled 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 eight seconds;
- CMT A instilled 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 nine seconds.

3. 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 breath in through your nose, and while breathing in press firmly and quickly down one tine 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 #23's POS dated November 2024 showed:
- Start date 8/7/24 - Artificial Tears Ophthalmic

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solution, instill one drop in both eyes four times a day for dry eyes;
- Start date - 8/6/24 - Fluticasone (Flonase) suspension 50 micrograms (mcg.), two sprays in each nostril daily for allergies.

Review of the resident's MAR dated November 2024 showed:
- Artificial Tears Ophthalmic solution, instill one drop in both eyes four times a day for dry eyes;
- Fluticasone (Flonase) suspension 50 mcg., two sprays in each nostril daily for allergies.

Observation on 11/7/24 at 9:21 A.M., showed:
- CMT A did not shake the bottle or have the resident blow his/her nose;
- CMT A did not close either side of the resident's nostril and instilled one spray in each nostril, instead of two sprays;
- CMT A instilled one drop of Artificial Tears in left eye and touched the tip of the eye dropper to the resident's eye lid and eye lashes. CMT A applied lacrimal pressure for five seconds;
- CMT A instilled one drop of Artificial Tears in the right eye and touched the tip of the eye dropper to the resident's eye lid and eye lashes. CMT A applied lacrimal pressure for four seconds.

During an interview on 11/7/24 at 2:20 P.M., CMT A said:
- He/she should have followed the manufacturer's guidelines for the administration of Flonase. Should have shook the bottle, had the resident blow their nose, and close one side of the nostril;
- He/she should have administered two nasal sprays instead of one nasal spray;
- The tip of the eye dropper should not touch the resident's eye lid or eye lashes;
- He/she should have applied lacrimal pressure

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F 759	Continued From page 65 for one minute; - He/she was not for sure how much water to use with Miralax or with the Metamucil; - He/she thought it was alright to put the MIralax and the Metamucil in the same cup. During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said: - Staff should let the finger tip dry before obtaining the blood sugar; - Staff should check the insulin vial for expiration and should not use it if it was expired; - Staff should follow the manufacturer's guidelines for the administration of the Felons and should administer the correct dose; - Staff should not touch the tip of the eye dropper to the resident's eye lid or eye lashes and should apply lacrimal pressure for one minute; - Metamucil should be mixed in eight ounces of water and should mix the Miralax in four to eight ounces of water; - Staff should not mix the Metamucil and the Miralax together in the same cup.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff provided a safe and effective medication administration system that was free of significant medication errors when staff used insulin that was expired which affected one of the 14 sampled residents, (Resident #48). The facility census was 56.	F 760		

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F 760	Continued From page 66 The facility did not provide a policy for administration of insulin. 1. Review of Resident #48's physician order sheet (POS) dated November 2024 showed: - Order date 8/14/24 - Insulin Lisper (fast acting insulin) per sliding scale. Blood sugar 151 - 200, give four units for diabetes mellitus for a blood sugar of 189. Review of the resident's medication administration record (MAR) dated November 2024 showed: - Insulin Lispro per sliding scale. Blood sugar 151 - 200, give four units for diabetes mellitus. Observation and interview on 11/6/24 at 12:08 P.M., showed: - Licensed Practical Nurse (LPN) B used the vial of Lispro insulin, opened 8/17/24 and discard after 9/17/24, and drew up four units in the syringe and administered the insulin; - He/she should not have used the insulin since it was expired. During an interview on 11/7/24 at 5:06 P.M., the Director of Nursing (DON) said staff should check the insulin vial for an expiration date and should not use it if expired.	F 760		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments,	F 801		

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individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

This includes:
§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other

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clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure the Dietary Manager (DM) had the appropriate competencies and skills sets to carry out the functions of the

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food and nutrition service. The facility census was 56.

The facility did not provide the requested job description for the dietary manger.

Review of the DM's personnel file showed:
-Date of hire 3/1/2024;
-Position title: Food Service Manager;
-A Food Handler Certificate from Always Safe Food Company, dated 11-5-2024;
-No food service training was found prior to the DM being hired as the DM;
-No certification for food service management or dietary manger was found.

During an interview on 11/04/24 at 11:32 A.M., the DM said:
-He/she has been DM for eight months;
-He/she has worked as a dietary aide but does not have any managerial experience;
-The facility is getting ready to start on his/her dietary manager training;
-He/she has not completed his/her dietary manager's course.

During an interview on 11/06/24 12:15 P.M., the Registered Dietitian (RD) said:
-The facility is trying to work on training the DM;
-He/she would expect the DM to have the required training to manage the kitchen.

During an interview on 11/7/24 at 5:06 P.M., the Administrator said:
-He/she would expect the DM to know all regulations related to the kitchen
-The DM has not completed the dietary training yet;
-He/she would expect the DM to have the training

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F 801	Continued From page 70 completed.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff stored food in a sanitary manner and failed to maintain the kitchen in a sanitary manner. This had the potential to affect all residents residing in the facility. The facility census was 56. The facility did not provide a policy addressing food storage, kitchen cleaning and sanitation of the kitchen. Observation of the kitchen on 11/04/24 at 11:32 A.M.,showed:	F 812		

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F 812	Continued From page 71 -The light switch by the coffee station was covered in dirt; -The vent above the hand washing sink was covered in dust and debris; -The back-splash behind the stove had food particles on it and was coming away from the wall; -The light in the dish-room is cracked; -Multiple cracked tiles on the dish room floor; -The inside of the dish room door is scuffed and scratched and the paint is peeling off of it; -Multiple tiles on the kitchen floor are broken; -There is a black substance on the wall behind the three compartment sink. Observation and interview on 11/06/24 at 10:45 A.M., showed: -Raw chicken quarters setting in water in the middle compartment of the three compartment sink; -No water was running over the chicken in the three compartment sink; -Cook A said the DM told him/her to thaw out the chicken by putting it in water in the three compartment sink; -Cook A said the chicken was partially frozen when he/she put it in the sink; -Cook A said the chicken has been setting in the sink for one hour. Observation and interview on 11/6/24 at 11:32 A.M., showed: -Cook A brought a pan from the clean dish rack and set it on the prep table; -The pan had food debris on the bottom of the pan; -Cook A said the pan was supposed to be clean; -Cook A said there should not be dirty dishes setting on the clean dish rack.	F 812		

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F 812	Continued From page 72 During an interview on 11/06/24 12:15 P.M., the Registered Dietitian (RD) said: -He/she expects the kitchen to be maintained in a clean and sanitary manor; -He/she expects the kitchen to be in good repair; -He/she expects the kitchen staff to be responsible for the cleanliness of the kitchen; -The chicken should not be setting the three compartment sink without cool water running over it; -Staff should ensure the dishes are clean; -Maintenance is in charge of the repairs of the kitchen; -He/she did not know the last time the vents were cleaned in the kitchen. During an interview on 11/07/24 11:09 A.M., the Maintenance Supervisor said: -He/she is responsible for the repairs in the kitchen; -The staff tell him/her when repairs need to be made in the kitchen; -He/she was not aware of the repairs that needed to be made in the kitchen; -He/she was not aware the vent above the hand washing sink was dirty and needed to be cleaned; -The kitchen should be clean and in good repair. During an interview on 11/7/24 at 5:06 P.M., the Administrator said: -He/she expects the kitchen to be maintained in a clean and sanitary manor; -He/she expects the kitchen to be in good repair.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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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:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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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 the facility staff failed to provide sanitary resident care when facility staff did not practice hand hygiene when perform person care tasks for one resident of 14 sampled residents (Resident #39). The facility census was 56.

Review of the Handwashing/hand hygiene policy dated October 2023 showed:
- All staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare- associated infections;
- All staff are expected to adhere to hand hygiene

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policies;
- Hand hygiene is indicated immediately before touching a resident, after contact with body fluids, after touching a resident, before moving from work on a soiled body site to a clean area of the body on the same resident, and immediately after removal of gloves;
- Staff are supposed to wash hand when their hands are visibly soiled and after contact with residents with an infectious diarrhea including Clostridium Difficile (C. diff, a contagious bacteria that causes severe diarrhea in a resident).

1. Review of Resident #39's quarterly MDS, dated 10/16/24 showed:
- He/She had a BIMS score of 0, indicating severe cognitive impairment;
- Diagnoses included: Stroke, heart disease and schizophrenia (a disorder that affects a persons ability to think, feel and behave clearly).
- The resident was dependent on staff for toileting, personal hygiene, and transfers;
- The resident was incontinent of bowel and bladder.

Review of the resident's undated compressive care plan showed:
- The resident was incontinent of bowel and bladder;
- The staff were supposed to provide incontinent care after each incontinent episode;
- The resident was dependent on staff to complete his/her citifies of daily living.

Observation on 11/4/24 at 10:11 A.M. showed:
- NA A entered the resident's room and did not perform hand hygiene;
- CNA D pushed the resident into his/her room and did not perform hand hygiene;

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F 880	Continued From page 76 - Both staff members put gloves on with out performing hand hygiene; - CNA D wet a wash cloth in the sink by throwing it in the bottom of the sink, CNA D wrung out the wash cloth with his/her gloved and and washed the resident's face, including his/her eyes; - CNA D placed the soiled washcloth on the sink counter; - CNA D and NA A assist the resident to bed; - CNA D performed the resident urinated and CNA D performed perineal care; - NA A removed his/her gloves, did not perform hand hygiene, left the resident's room; - NA A returned to the resident's room with clean linen's, did not perform hand hygiene, put gloves on and resumed perineal care of the resident. During an interview on 11/6/24 at 2:45 P.M. Registered Nurse (RN) A said he/she expected staff to wash their hands with each glove change and when entering and exiting resident rooms. During an interview on 11/7/24 at 9:00 A.M. The Director of Nursing (DON) said: - She expected staff to perform hand hygiene upon entering the resident's room, before and between glove changes, and when leaving the resident's room; - She expected staff to wash their hands when they were visibly soiled and after performing perineal care; - She expected staff to use an Alcohol-Based Hand Gel (ABHG) up to three times in a row, and then staff were to wash their hands with soap and water; - She expected staff to wash their hand when exiting a resident room and reentering the resident room.	F 880		

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F 925	Continued From page 77	F 925		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		

§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program to prevent flies in the facility, potentially effecting all residents. The facility census was 56.

The facility did not provide the requested pest control policy.

1. Observation on 11/4/24 at 10:02 A.M. showed room 134 had six flies landing on the resident's property.

2. Observation: 11/4/24 at 10:11 A.M. showed room 136 had multiple flies in the room landing on the resident.

3. Observation on 11/4/24 at 12:30 P.M. showed:
- Residents were at the dining tables with their heads on the table;
- There was flies in the dining room;
- The flies landed on residents and on their food;
- Residents were swatting at the flies with their hands;
- The residents ate the food that the flies landed on.

4. Observation on 11/6/24 at 5:51 P.M. showed:
- Flies seen in the south dining room and crawling on the table's where residents were sitting;
- Flies landed on residents hands and clothing;

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F 925	Continued From page 78 - Residents were swatting at the flies with their hands; - Flies landed on the resident's food when it was served, the residents ate the food the flies landed on. During an interview on 11/7/24 at 11:35 A.M., the Maintenance Director said: -He/she said some of the flies are coming in from outside due to the the door gap by the gazebo exit door; -The facility just started using a new pest control program; -The residents should not have flies in their rooms or in the dining room; -The residents should not have flies landing on their food and then eat the food. During an interview on 11/7/24 at 5:06 P.M., the Administrator said: -The facility was working with an outside pest control service to develop a fly program; - The residents should not have flies in their rooms or in the dining room; - The residents should not have flies landing on their food and then eat the food. MO243723	F 925		

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
	03829	A. BUILDING: _____ B. WING _____	C 11/07/2024

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A1131	19 CSR 30-85.012(124) Nurses' Call System Requirements Facilities shall provide an electrically-powered nurses ' call system with indicator lights at the corridor entrance of each bedroom. Audible signals and indicating panels shall be located in each nurses ' station and utility room. Facilities shall provide signal buttons at the head of each resident bed, in each toilet room and in each bathroom. III This regulation is not met as evidenced by: Class III 1. Please refer to F584.	A1131		
A3001	19 CSR 30-85.032(2) Substantially Constructed/Maintained The building shall be substantially constructed and shall be maintained in good repair. New facilities shall comply with the requirements in accordance with the provisions found in 19 CSR 30-85.012. Existing licensed facilities shall meet and maintain the facility's physical plant in accordance with the construction standards in effect at the time of initial licensing, unless there is a specific rule governing the subject cited in this section or in 19 CSR 30-85.022, except that those facilities licensed between 1957 and 1965 shall not increase the capacity of any room or the total capacity of the facility without meeting new construction requirements. Existing licensed facilities with plans approved after April 8, 1972 and prior to January 1, 1999, shall comply as Existing Health Care Occupancies with NFPA 101, 2000 edition. Facilities whose physical plant requirement plans are approved on or after January 1, 1999, shall comply as New Health Care Occupancies with NFPA 101, 2000 edition.	A3001		

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A3001	Continued From page 1 II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F584. *The higher classification merited due to the effect on the residents.	A3001		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F759, F760	A4055		
A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident. Irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F756	A4061		

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A4061	Continued From page 2 *The higher classification merited due to the extent of the violation.	A4061		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F658, F677	A4075		
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		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record	A4108		

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A4108	Continued From page 3 contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III 1. Please refer to F656.	A4108		
A5014	19 CSR 30-85.052(14) Personnel Sufficient, Trained There shall be sufficient personnel properly trained in their duties to assure adequate preparation and serving of food. II This regulation is not met as evidenced by: Class II 1. Please refer to F801.	A5014		
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 repair. III This regulation is not met as evidenced by: Class III 1. Please refer to F584.	A6015		
A6028	19 CSR 30-87.020(28) Backflow Requirements The potable water system shall be installed to	A6028		

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A6028	Continued From page 4 preclude the possibility of backflow. Devices shall be installed to protect against backflow and back siphonage at all fixtures and equipment where an air gap at least twice the diameter of the water supply inlet is not provided between the water supply inlet and the fixture ' s flood level rim. A hose shall not be attached to a faucet unless a backflow prevention device is installed. II This regulation is not met as evidenced by: Class II 1. Please refer to K584.	A6028		
A6039	19 CSR 30-87.020(39) Inspect/Rodent Control Effective measures intended to minimize the presence of rodents, flies, cockroaches and other insects on the premises shall be utilized. The premises shall be kept in such condition as to prevent the harborage or feeding of insects or rodents. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F925. * The higher classification merited due to the extent of the violation.	A6039		
A7016	19 CSR 30-87.030(14) Food-Clean Containers, Storage, Covers Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be stored in a clean covered container except during necessary periods of preparation or service. Container covers shall be	A7016		

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A7016	Continued From page 5 impervious and nonabsorbent except that linens or napkins may be used for lining or covering bread or roll containers. III This regulation is not met as evidenced by: Class III 1. Please refer to F812.	A7016		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care.	A8010		

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A8010	Continued From page 6 II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F578. *The higher classification merited due to the extent of the violation.	A8010		
A8020	19 CSR 30-88.010(20) Exercise Rights/Voice Grievances Each resident shall be encouraged and assisted, throughout his or her period of stay, to exercise his or her rights as a resident and as a citizen and to this end a resident may voice grievances and recommend changes in policies and services to facility personnel or to outside representatives of his or her choice. A staff person shall be designated to receive grievances and the residents shall be free to voice their complaints and recommendations to the staff designee, an ombudsman or to any person outside the facility. Residents shall be informed of and provided a viable format for recommending changes in policy and services. The facility shall assist residents in exercising their rights to vote. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F565 and F585. *The higher classification merited due to the extent of the violation and when combined with other deficiencies.	A8020		

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A8030	Continued From page 7	A8030		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F550. *The higher classification merited due to the extent of the violation.	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Quail Run Health Care Center
Street Address, City, Zip:	1405 W Grand Ave, Cameron, MO 64429
Date of Survey:	11/07/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	03829

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 the state and federal regulations and not because Quail Run Health Care Center agrees with the allegations and citations listed on the statement of deficiencies. Quail Run Health Care Center maintains that the alleged deficient practices 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 Quail Run Health Care Center's written credible allegation of compliance. By submitting this plan of correction, Quail Run Health Care Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Quail Run Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F 550	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 33 will be addressed per his/her stated preferences by the compliance date. Resident # 41 will not experience any alteration of dignity due to stained clothing and/or his financial status. Resident # 44 will receive assistance with consuming meals in a dignified manner. Refer to F925 for pest control How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice.	12/22/24

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator and/or Director of Nurses will provide an in-service to nursing staff that provide assistance for dressing, assisting residents with meals and regarding use of preferred names, while interacting with residents by the date of compliance. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The DON and or designee will perform hall rounds at mealtime 3 x per week for 3 weeks, then weekly x 3 weeks and provide re-education when needed then report findings to QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 39 and # 46 will have call lights within reach while they are in their rooms. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Nursing staff that provide bedside care will be in-serviced by the DON and/or designee regarding placement of call lights within reach of residents while in their room or in bed by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	12/22/24

	The DON and/or designee will perform walking rounds 3x weekly for 3 weeks, then weekly on-going to validate call lights are within reach of residents for use when needed. Re-education will occur when need noted. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Don to report results of audit to QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 565	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident council members' concerns will be followed up within 7 days of the original meeting date regarding concerns with a written memo, listing resolutions to concerns. Any grievance will be followed up and/or resolved within 24 working hours. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the activity director and SSD regarding how to perform resident council and document the concerns and/or grievances voiced with appropriate follow-up by the compliance date. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	12/22/24

	The activity director and/or SSD will provide the Administrator with resident council meeting forms for review after each meeting monthly and follow the guidance and direction of the Administrator regarding required follow-up How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The activity director and/or SSD will report the outcomes of resident council and resolution to QAA committee monthly and on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 578	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 30 will have an appropriate signed OHDNR form by the date of compliance. Resident # 18 will have an order for code status, and care plan updated to reflect code status by the date of compliance. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The SSD, Don and care plan coordinator will be in-serviced by the Administrator regarding the need to obtain orders for code status upon admission and monitoring for the need of a durable power of attorney and/or guardian with cognitive decline by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The SSD, Don and care plan coordinator will review current BIMS score's and possible cognitive decline, presence of DPOA and/or guardian's weekly during risk meeting and notify the	12/22/24

	Administrator when action needs taken weekly x3 weeks then monthly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The SSD and/or designee will review outcomes of weekly reviews with the QAA committee, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 584	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Room 124 floor will be clean and without debris, toilet bowl will be clean and without debris and in working order by the date of compliance. The South shower room toilet will be clean, tiles and cove base replaced and/or repaired, light cover will be repaired and/or replaced, window blinds above the sink will be repaired and/or replaced by the date of compliance. Room 134 will be clean and free of odors, the stool will be repaired and/or replaced by the date of compliance. Room 138 ceiling will be repaired by the date of compliance by the date of compliance. The gap of the exit door to the outside smoking area will be ordered/repaired and/or replaced by the date of compliance. The shower across from the nurses' station by room 111 will have a backflow preventer installed by the date of compliance. The call light cords in the bathrooms of rooms 111,136 and 139 will be repaired and/or replaced by the date of compliance. The middle dining room door will be repaired to open easily by the date of compliance. The south hallway will be cleaned, rooms 120,121,122,123 and 125 will be cleaned and floors without sticky residue by the date of compliance.	12/22/24

	How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the maintenance director and housekeeping supervisor of daily cleaning and facility repairs to maintain compliance of a safe, homelike environment at all times. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will perform daily rounds of facility to monitor cleanliness, odors and the need of repairs 5 times weekly for 2 weeks, then 3 times weekly for 2 weeks, then weekly on-going and will provide education when need identified. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Administrator will report outcomes of rounds to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 585	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A special resident council will be held identifying who the grievance coordinator is and how to file a grievance, and an informational memo will be distributed to residents with same information and signage will be added to the resident hallways identifying who the grievance coordinator is. How you will identify other residents having the potential to be affected by the same deficient practice.	12/22/24

	All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the activity director to review at least one resident right monthly and to document the review. The grievance coordinator will introduce his/herself if allowed to join the resident council, or to make room rounds to introduce his/herself to the residents. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will do 2-3 in-person resident interviews to assess that the residents understand who the grievance coordinator is and that a resident right was covered in the most recent resident council meeting weekly x 4 weeks, then monthly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Administrator and/or designee will report the outcome of resident interviews to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 18, # 25 and # 49 will have comprehensive care plans in place by the date of compliance. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	12/22/24

	The Administrator will provide an in-service to the MDS care plan coordinator regarding the need for a comprehensive care plan to be completed by day 21 following admission. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The administrator and/or designee will monitor completion of comprehensive care plans with new admissions to the facility 2 times weekly times 4 weeks, then ongoing. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The administrator will report outcome of review to QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 36 and resident # 43 care plans will be reviewed and revised to reflect current needs, behaviors and/or health status. How you will identify other residents having the potential to be affected by the same deficient practice. All residents at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the MDS care plan coordinator to review and revise all care plans according to the MDS schedule per regulatory guidelines by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator and/or designee will monitor the completion of care plan updates weekly times 4 weeks,	12/22/24

	then monthly times 3 months and provide re-education as need is noted. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Administrator and/or designee will report findings of audit to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F658	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 49 care plan will be updated to reflect he/she goes to dialysis and facility will obtain an order for him/her to receive dialysis by the date of compliance. Resident #21 care plan will be updated to reflect manufactures guidelines for use of low air loss mattress regarding weight or comfort level and facility will obtain an order for the use of low air loss mattress with setting instructions. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The DON and/or designee will be in-serviced by the Administrator to review new orders and care plans 5 times weekly during clinical meeting and to correct and/or educate subordinate staff members as the need is noted. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Don will audit new orders 5x weekly times 3 weeks then 1-2 times weekly ongoing. Will provide education to subordinate staff members as need is noted.	12/22/24

	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Don and/or designee will report audit results along with education efforts to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 677	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 1, # 21 and # 25 received complete perineal care. Residents #21 and # 43 received bathing hygiene. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Don will provide an in-service to staff that provide peri-care and bathing on how to perform procedures correctly and reflect professional standards of care for dependent residents by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Don and/or designee will perform walking rounds to monitor the cleanliness of residents and for the need of hygiene five times weekly times 4 weeks, then 2-3 times weekly times 4 weeks then weekly times 1 month providing education as need is noted. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained.	12/22/24

	This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Don will report findings of audit and education provided to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F729	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Cna's E, D and C no longer are employed by the facility. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will provide in-service to Don regarding the need for newly hired Cna's that have not been employed in healthcare for 24 months and annual competencies to be completed for certified nursing staff that provide bedside care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The DON will monitor and track new hire and annual competency completion for certified bedside care providers weekly, ongoing. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Don will report the completion of new hire and annual competencies to QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	12/22/24

F756	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 1, # 4, # 51 pharmacy recommendations will be addressed with the PCP in a timely manner by the date of compliance. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator and/or Don will in-service medical director of the need to address, respond and return the pharmacy recommendations to the facility monthly in a timely manner by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Don will monitor drug regimen reviews monthly ongoing and contact the PCP when the response is not received in a timely manner, providing re-education as needed. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Don will report the completion of drug regimen reviews and timeliness to QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	12/22/24
F 760	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 48 insulin was replaced with a new vial.	12/22/24

	How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The DON will in-service certified, licensed and registered staff who administer medication to discard insulin after 28 days from opening vial. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Don to monitor nurse treatment carts and medication carts weekly times 3 weeks, then monthly times 2 months and provide re-education when the need is noted. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Don is to report audit findings and re-education completed to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 801	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The dietary manager will be enrolled in a dietary managers course by the date of compliance. How you will identify other residents having the potential to be affected by the same deficient practice. No residents experienced any adverse event related to this alleged deficient practice.	12/22/24

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the dietary manager regarding the need to complete the dietary manager course and monitor the progress during the course. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will keep the record of the dietary manager's course enrollment, progress and completion . How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Administrator will report enrollment, progress and completion of the dietary manager course to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The light switch by the coffee station will be clean by the date of compliance. The vent above the hand washing sink will be clean by the date of compliance. The backsplash behind the stove will be clean by the date of compliance. The light in the dish room will be repaired and/or replaced by the date of compliance. The tiles on the dish room floor and kitchen will be repaired and/or replaced by the date of compliance. The paint on the dish room door will be repaired by the date of compliance. The wall behind the three-compartment sink will be clean by the date of compliance. The dietary staff will thaw meat in a sanitary manner by the date of compliance.	12/22/24

	How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service dietary staff to perform daily, weekly and monthly cleaning lists, how to thaw frozen meat in the three-compartment sink with the use of cool water and how to cleanse cooking equipment fully to include the bottom of pans. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will make weekly inspections of the dietary department times 4 weeks and provide re-education when need noted then, the RD will make monthly inspections of the dietary department and inform the Administrator and DM of need for any corrections ongoing. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Administrator will report the findings of audits and re-education to the monthly QAA committee then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 39 received cares after hand hygiene was performed by staff. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice.	12/22/24

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The DON to provide in-service to nursing staff members who provide bedside cares to residents regarding hand hygiene. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Don and/or designee will perform on the spot rounds with bedside care givers to evaluate knowledge of the need for hand hygiene and provide re-education when the need is noted 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, then 1-2 times monthly for 4 months. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The DON will report finding of rounds to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F 925	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The flies in the facility are killed when seen and/or reported. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The facility will contact the pest control company regarding placing fly lights in facility.	12/22/24

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will provide an in-service to the maintenance director regarding effective pest control for the facility. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Maintenance director will report to QAA committee monthly regarding the current pest control efforts in place then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
A 1131	Refer to F584	12/22/24
A 3001	Refer to F584	12/22/24
A 4055	Refer to F759, F760	12/22/24
A 4061	Refer to F756	12/22/24
A 4075	Refer to F658, F 677	12/22/24
A 4086	Refer to F 880	12/22/24
A 4108	Refer to F 656	12/22/24
A 5014	Refer to F 801	12/22/24
A 6015	Refer to F 584	12/22/24
A 6028	Refer to K 584	12/22/24
A 6039	Refer to F925	12/22/24
A 7016	Refer to F 812	12/22/24
A 8010	Refer to F578	12/22/24
A 8020	Refer to F656 and F 585	12/22/24
A 8030	Refer to F 550	12/22/24
F759	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 48 insulin was replaced with a new vial. Resident # 35 has received eye drops correctly and orders for MiraLAX and Metamucil have been clarified to list the amount of fluid to mix with medication and has received Flonase per manufactures guidelines. Resident # 23 has received eye drops and Flonase per manufacturers guidelines. How you will identify other residents having the potential to be affected by the same deficient practice. All residents are at risk of this alleged deficient practice.	12/22/24

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The DON will in-service certified, licensed and registered staff who administer medication on proper use of eye drops, Flonase and to discard insulin after 28 days from opening vial. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Don to monitor nurse treatment carts and medication carts weekly times 3 weeks, then monthly times 2 months and provide re-education when the need is noted. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Don is to report audit findings and re-education completed to the QAA committee monthly then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	

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