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	265677	A. BUILDING _____ B. WING _____	C 09/12/2024

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CAMPBELL HEALTHCARE & SENIOR LIVING	17108 US HIGHWAY 62 CAMPBELL, MO 63933

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F 550 SS=D	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
Donald Hutts	Adm.	10/4/24

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	Continued From page 1 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 ensure staff treated residents with dignity and in a respectful manner by leaving two residents (Residents #9 and #11) out of 18 sampled residents exposed during care. The facility census was 72. The facility did not provide a policy regarding maintaining a resident's dignity. 1. Review of Resident #9's medical record showed: - Admission date of 05/20/24; - Diagnoses of cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing), apraxia following unspecified cerebrovascular disease (neurological disorder that makes it difficult to perform certain movements), contracture, right hand (a permanent tightening of muscles, tendons, causing the joints to shorten and become stiff); Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 08/14/24 showed: - Cognition severely impaired; - Always incontinent of bowel; - Dependent (helper does all the effort) for toileting hygiene;. Observation of the resident on 09/11/24 at 11:24 A.M., showed: - The resident lay in bed; - Certified Nurse Assistant (CNA) D and CNA E	F 550		

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entered the room to perform incontinent care;
- The CNAs did not close the curtains to the windows;
- The residents' bed was closest to the window;
- A parking lot and yard could be seen through the window;
- The resident required his/her clothing to be changed, CNA D and CNA E changed resident shirt and brief;
- The resident's breast and genitalia were exposed to the window.

2. Review of Resident #11's medical record showed:
- Admission date of 06/28/24;
- Diagnoses of dementia with mild agitation (condition that causes loss of cognitive function, such as thinking, remembering, and reasoning that interferes with daily life), mood disorder (disturbance of mood, in the form of depression or euphoria), and metabolic encephalopathy (a brain dysfunction that occurs when a chemical imbalance in the blood affects the brain).

Review of the resident's admission MDS, dated, 07/01/24, showed:
- Cognition not impaired;
- Always incontinent of bowel and bladder;
- Dependent for toileting hygiene;

Observation of the resident on 09/12/24 at 9:12 A.M., showed:
- The resident lay in bed;
- CNA I and CNA J assisted LPN F with wound care;
- The CNA's closed the door to hallway to provide privacy;
- The residents' window curtain remained open to yard;

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F 550	Continued From page 3 - The resident had wounds to both hips; - The resident did not have a brief covering private areas; - CNA I and CNA J assisted LPN F to turn resident from side to side exposing the resident's genitalia and buttocks to the outside window. During an interview on 09/11/24 at 2:10 P.M. Licensed Practical Nurse (LPN) G said before peri-care is started, staff should always ensure privacy by pulling the curtain within the room, pull the window curtains and close the door. During an interview on 09/12/24 at 12:19 P.M., CNA D said before performing peri-care, staff should provide privacy by closing the door, pull the curtain in front of the door, the curtain on the window. If the resident has a roommate and they are in the room, then staff should pull the curtain to divide the room. During an interview on 09/12/24 at 12:47 P.M., the Director of Nursing (DON) said the curtains on the window and in the room should be pulled closed before providing peri-care to any resident.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		

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possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 72.

Review of the facility's policy titled, "Homelike

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Environment," revised February 2021, showed:
- Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible;
- The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting which include a clean, sanitary and orderly environment.

1. Observations made on 09/09/24 at 9:38 A.M. and 09/11/24 at 11:02 A.M., of the 500 hall unit, showed:
- A three foot (ft.) piece of base trim peeled off the bottom wall of the closet located in room 509;
- A piece of wood trim hung off the bottom of the closet onto the floor located in room 509.
- Several areas of exposed sheet rock and peeled paint on the wall above bed 1 located in room 514.

2. Observations made on 09/09/24 at 10:54 A.M., 09/10/24 at 11:06 A.M., and 09/11/24 at 10:54 A.M., of the courtyard, showed two electrical conduits (a pipe or tube designed to enclose and protect cables or wires from moisture and physical damage) with broken zip ties hung low from the top of the wooden awning attached from the side of the building leading to two outside air-conditioner units.

3. Observation made on 09/10/24 at 11:30 A.M., of room 305 showed five stuffed animals sat on top of the overbed light fixture of bed 1.

4. Observations made on 09/11/24 at 6:48 A.M., of the shower room on the left side of the 400 hall, showed:

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F 584	Continued From page 6 - The left side of shower stall with a four ft. cove base trim missing; - The bottom of the floor of the shower stall showed a buildup of brown/grime/stain near the drain; - The toilet with dried fecal matter on the top of lid; - A large shower chair with a dried brown substance on seat and surrounding surfaces. During an interview on 09/12/24 at 9:00 A.M., Housekeeper A said it was the housekeeping department's job to keep the showers and bathrooms clean. He/She said staff had not made it in there yet this morning. During an interview on 09/12/24 at 9:13 A.M., Housekeeper A said there is maintenance request form that can be filled out for any environmental issues such as peeled paint, exposed sheetrock, loose base boards or any other concerns. He/She has not seen any environmental issues to report to maintenance. During an interview on 09/12/24 at 9:16 A.M., Housekeeper B said there is maintenance request form that can be filled out for any environmental issues such as peeled paint, exposed sheetrock, loose base boards or any other concerns. He/She has not seen any environmental issues to report to maintenance. During an interview on 09/12/24 at 9:20 A.M., the Maintenance Supervisor (MS) said he would secure the electrical conduits with new zip ties immediately. He/She would expect staff to write down any needed repairs as well to be addressed in a timely manner. It makes it easier to keep up with repairs instead of staff verbally telling him.	F 584		

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F 584	Continued From page 7 During an interview on 09/12/24 09:43 AM, the Administrator said she would expect staff to write down environmental concerns so the MS could address in a timely manner. This will be addressed.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		

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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party and to the representative of the Office of Long-Term Care (LTC) Ombudsman (a program that advocates for residents, provides information and help resolve problems) for three residents (Residents #9 and #21) out of four sampled residents. The facility census was 72.

Review of the facility's policy titled, "Transfer or Discharge Policy," revised March 2021, showed:

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F 623	Continued From page 10 - Residents and/or representatives are notified in writing, and in a language and format they understand prior to transfer or discharge; - The resident and representative are notified in writing of the specific reason for transfer, the effective date, the location, and the bed-hold policy; - The reasons for the transfer or discharge are documented in the resident ' s medical record; - The policy did not address sending a monthly transfer log to the Office of the State LTC Ombudsman. 1. Review of Resident #9's medical record showed: - Admitted on 05/20/24; - The resident transferred to the hospital on 07/18/24, returned to the facility on 07/20/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. 2. Review of Resident #21's medical record showed: - Admitted on 07/23/20; - The resident transferred to the hospital on 05/07/24, and returned to the facility on 05/21/24; - The resident transferred to the hospital on 06/02/24, and returned to the facility on 06/12/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC	F 623		

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F 623	Continued From page 11 Ombudsman. During an interview 08/22/24 at 1:09 P.M., the Regional LTC Ombudsman said he/she had not received a single transfer log from the home this year. During an interview on 09/12/24 at 10:14 A.M., the Administrator said she did not know a written notice of the discharge/transfer form needed to be given to the resident and/or the responsible party. She was not aware transfer logs had to be sent on a regular basis to the Regional LTC Ombudsman. She said a social service director had been hired to assist with this task to ensure compliance.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) (a federally mandated assessment tool completed by the facility)	F 637		

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assessment within 14 days for one resident (Resident #66) out of three sampled closed resident records. The facility's census was 72.

Record review of the facility's policy titled, "Comprehensive Assessments," revised October 2023 , showed:
- Comprehensive MDS assessments are conducted to assist in developing person-centered plans;
- Significant Change in Status Assessment (SCSA) is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (ITD, a group of health care professionals from diverse fields who work in a coordinated effort toward a common goal for a resident) has determined that a resident meets the significant change guidelines for either major improvement or decline;
- The policy did not address a timeframe to submit a significant change.

1. Record review of Resident #66's medical record showed:
- An admission date of 02/09/24;
- Admitted to hospice (health care focused on the quality of life of a terminally ill person) care on 06/07/24;
- The facility failed to complete a significant change MDS within 14 days after the election of the resident's hospice benefit.

During an interview on 09/12/24 at 11:18 A.M., RN C said there should be a significant change within 14 days when a resident goes on hospice services.

During an interview on 09/11/24 at 11:31 A.M., the Director of Nursing (DON) said a significant

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F 637	Continued From page 13 change assessment should have been completed within 14 days upon a resident receiving hospice services due to a change in condition. During an interview on 09/12/24 at 11:34 A.M., the Administrator said a significant change assessment should be completed within 14 days upon a resident receiving hospice services. The facility does not have an in-house MDS Coordinator. Instead, they use a virtual coordinator, who is part of the corporate office.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for one resident (Resident #9) out of 18 sampled residents and one resident (Resident #15) outside the sample. The facility's census was 72. The facility did not provide a MDS policy. 1. Review of Resident #9's medical record showed: - Admission date of 05/20/24; - Diagnoses of cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing), apraxia following unspecified cerebrovascular disease (neurological disorder that makes it difficult to perform certain movements),	F 641		

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- Resident had a fall and sent to hospital on 07/18/24;

Review of the resident's admission MDS, dated 05/24/24, showed no prior falls.

Review of the resident's quarterly MDS, dated 08/14/24, showed:
- No falls;
- The facility did not code the resident's MDS accurately.

2. Review of Resident #15's medical record showed:
- Admission date of 06/12/23;
- Diagnoses of chronic atrial fibrillation with defibrillator (an irregular and rapid heart beat that requires an implantable device to treat the irregular rhythm), insomnia (sleep disorder that makes it difficult to fall, stay and get quality sleep) Type 2 diabetes (chronic disease that occurs when the body is unable to use insulin properly, resulting in high blood sugar levels);

Review of Physicians Order Sheet (POS), dated April 2024-September 2024 showed no insulin injections prescribed.

Review of the resident's annual MDS, dated 06/14/24, showed:
- Resident received one insulin injection weekly;
- The facility did not code the resident's MDS accurately.

Review of the resident's quarterly MDS, dated, 03/18/24, showed:
- Resident received zero insulin injections weekly;

During an interview on 09/12/24 at 10:25 A.M.,

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F 641	Continued From page 15 Licensed Practical Nurse (LPN) G said Resident #9 did have a fall in July. During an interview on 09/12/24 at 10:45 A.M., Registered Nurse (RN) C said if a resident has a change in condition it should be reflected on MDS. During an interview on 09/12/24 at 1:00 P.M., the Administrator and Director of Nursing (DON) said they would expect the MDS to accurately reflect falls and if the resident is receiving insulin.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		

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F 645	Continued From page 16 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an	F 645		

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F 645	Continued From page 17	F 645		

intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide documentation of a Level I Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder to determine the level of care needed) for two residents (Residents #21 and #43) out of 18 sampled residents. The facility's census was 72.

The facility did not provide a PASARR policy.

1. Review of Resident #21's medical record showed:
- An admission date of 07/30/23;
- Diagnoses of schizophrenia (a disorder that affects one's ability to think, feel and behave clearly) violent behavior and generalized anxiety disorder (an excessive, ongoing anxiety and worry that are difficult to control);
- No level I PASARR.

2. Review of Resident #43's medical record showed:
- An admission date of 07/30/21;
- Diagnoses of psychotic disorder (a mental disorder characterized by a disconnection from reality), traumatic brain injury (TBI) (an injury to the brain) and dementia (thinking and social symptoms that interfere with daily functioning);
- No level I PASARR.

During an interview on 09/11/24 at 7:30 A.M., the Administrator said she was unable to find the

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F 645	Continued From page 18 PASARR on these two residents. She said she had contacted the previous facilities and was not able to obtain the PASARR's and would start the process of completing new ones. Every resident should have a Level I PASARR in their chart.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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F 655	Continued From page 19 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the baseline care plan (initial plan for delivering of care and services) included specific interventions and the resident and/or guardian received a written summary of the baseline care plan for one resident (Resident #120) out of two sampled residents. The facility was census was 72. Review of the facility's policy titled, "Baseline Care Plan Policy," revised 03/2022, showed: - The baseline care plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission; - The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders;	F 655		

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F 655	Continued From page 20 c. Dietary orders; d. Therapy services; e. Social services: and f. Preadmission Screening and Resident Review (PASARR) recommendation, if applicable. - The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. - The resident and/or representative are provided a written summary of the baseline care plan (in language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. - Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #120's medical record, showed: - Admitted to the facility on 03/29/24 ; - Diagnoses of coronary artery disease (CAD), renal insufficiency (a condition in which the kidneys lose the ability of remove waste and balance fluids, diabetes mellitus (DM) (a chronic disease that occurs when the body cannot control its blood sugar levels) and depression (a mood disorder that causes a persistent feeling of	F 655		

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F 655	Continued From page 21 sadness and loss of interest); - No documentation of a written summary of the baseline care plan. During an interview on 09/09/24 at 10:45 A.M., the resident said he/she did not receive any paperwork and is own responsible party. During an interview on 09/09/24 at 3:00 P.M., the Director of Nursing (DON) said the Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) coordinator and care plan coordinator work offsite. She said there is a nurse that works part-time to help with the tasks, however she does not complete the MDS's and care plans. The DON said the MDS coordinator always does a care plan on admission of the residents and is a computer generated care plan. The DON said she was not aware the baseline care plan had to be given to the resident or the resident representative. During an interview on 09/12/24 at 1:45 P.M., the Administrator said the MDS coordinator worked off-site. However, the Administrator said information is shared with the staff member on each resident and she has access to the facility's computer system.	F 655		
F 658 SS=D	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	F 658		

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by:
Based on interview and record review, the facility failed to follow physician's order for fall mats (a soft landing surface to help prevent injuries) for one resident (Resident #6) out of two sampled residents. The facility census was 72.

Review of the facility's policy titled, "Attending Physician Responsibilities," revised August 2014, showed:
- The attending physician's shall be the primary practitioners responsibility for providing medical services and coordinating the healthcare of each resident in the facility;
- The physician will provide orders to ensure that individuals have appropriate comfort and supportive measures as needed;
- The policy did not address facility following physician orders.

1. Review of Resident #6's medical record showed:
- Admitted on 02/05/16;
- Diagnoses of abnormal involuntary (cannot control) movements, epilepsy (a disease that causes recurrent seizures), and muscle spasm (involuntary tightening of a muscle or group of muscles).

Review of the resident's Physician Order Sheet (POS), dated September 2024, showed an order for fall mats to both sides of the bed dated 01/29/24.

Observations made on 09/09/24 at 10:55 A.M., 09/09/24 at 2:43 P.M., 09/10/24 at 08:43 A.M. and 09/11/24 at 8:23 A.M., showed:
- Resident laid in bed;
- A fall mat placed on the left side of the resident's

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F 658	Continued From page 23 bed. - No fall mat in place on the right side of the resident's bed. During an interview on 09/12/24 at 1:46 P.M., the Director of Nursing (DON) said if there is an order for fall mats for both sides of the bed she would expect fall mats to be placed on both sides of the resident's bed. During an interview on 09/12/24 at 1:48 P.M. , the Administrator said if there is a physician order for fall mats to be on both sides of the bed she would expect fall mats to be placed on both sides of the resident's bed.	F 658		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify, assess and provide supportive interventions for one resident (Resident #52) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of one sampled resident. The facility's census was	F 699		

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72.

Review of the facility's policy titled, "Trauma Informed Care," revised March 2019, showed:
- To guide staff in appropriate and compassionate care specifics to individuals who have experienced trauma;
- All staff are provided in-service training about trauma, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting;
- Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization;
- As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools.

1. Review of Resident #52's medical record showed:
- Admitted on 12/16/22;
- Diagnoses of PTSD, major depressive disorder (MDD - long-term loss of pleasure or interest in life), and anxiety disorder (persistent worry and fear about everyday situations);
- No documentation of a PTSD assessment.

Review of the resident's Physician's Order Sheet (POS), dated September 2024, showed:
- An order for donepezil (an anti-depressant medication) 10 milligram (mg) tablet once a day for PTSD dated 09/4/24;
- An order for venlafaxine (an anti-anxiety medication) 37.5 mg tablet at bedtime dated 09/04/24.

Review of the resident's Preadmission Screening

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F 699	Continued From page 25 and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 03/31/23, showed: - PTSD, major depression, and anxiety; - No behaviors documented. Review of the resident's care plan, last updated 06/09/24, showed: - PTSD not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 09/12/2024 at 10:53 A.M., the Director of Nursing (DON) said she had never seen a PTSD assessment. A PTSD assessment will be implemented. DON said PTSD should be part of the resident's care plan with triggers and interventions. During an interview on 09/12/2024 at 10:53 AM, the Administrator said she was not aware of an assessment for residents with a PTSD diagnosis. She would expect a resident to be care planned for PTSD with triggers and interventions.	F 699		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		

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diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to answer call lights in a timely manner to meet each resident's rights, physical, mental and psychosocial (how someone feels and copes with changes in their social environment) well-being. The deficient practice had the potential to affect all residents in the facility. The facility census was 72.

Review of the facility's policy titled, "Answering the Call Light," undated, showed:
- The purpose of this procedure is to respond to the resident's requests and needs;
- Explain the call light to the new resident;
- Demonstrate the use of the call light;
- Ask the resident to return the demonstration so that you will be sure that the resident can operate the system;

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- Be sure the call light is plugged in and functioning at all times;
- When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident;
- Some residents may not be able to use their call light, provide alternative such as bell and check on these residents frequently;
- Report all defective call lights to the administration and maintenance;
- When answering call light, present to resident room in timely manner;
- Call light must be acknowledged on the phone and residents room;
- Assist resident at this time and make sure all needs are med before leaving the room;
- If assistance is needed from more than one staff member upon entering the room, staff member should press the call light again once both call lights have been acknowledged.

Review of the facility layout, dated 11/13/19, showed:
- A call light central monitoring unit located at the nurse workstation on the 300 hall;
- A call light central monitoring unit located in a nurse office on the 500 hall;
- A call light central monitoring unit located in the Director of Nursing (DON) office;
- A call light central monitoring unit located in the Administrator's office.

Review of the facilities wireless nurse call system report log, dated 09/03/24 through 09/8/24, showed:
- 09/03/24 at 12:47 P.M., Room 413 response time of 7 hours (h)18 minutes (m);
- 09/03/24 at 1:52 P.M., Room 201 response time of 1 h 21 m;

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F 725	Continued From page 28 - 09/03/24 at 3:17 P.M., Room 407 response time of 4 h 47 m; - 09/03/24 at 9:20 P.M., Room 106 response time of 1 h 8 m; - 09/03/24 at 9:38 P.M., Room 407 response time of 1 h 9 m; - 09/04/24 at 3:02 A.M., Room 408 response time of 2 h 41 m; - 09/04/24 at 6:59 A.M., Room 407 response time of 2 h 56 m; - 09/04/24 at 8:54 A.M., Room 201 response time of 2 h 36 m; - 09/04/24 at 9:59 A.M., Room 407 response time of 1 h 31 m; - 09/04/24 at 10:39 A.M., Room 303 bathroom response time of 2 h 59 m; - 09/04/24 at 12:27 P.M., Room 413 response time of 1 h 30 m; - 09/04/24 at 1:49 P.M., Room 309 response time 1 h 41 m; - 09/04/24 at 3:48 P.M., Room 314 response time 2 h 16 m; - 09/04/24 at 4:15 P.M., Room 407 response time of 3 h 45 m; - 09/06/24 at 7:19 A.M., Room 309 response time of 1 h 12 m; - 09/06/24 at 5:05 P.M., Room 413 response time of 2 h 48 m; - 09/06/24 at 10:22 P.M., Room 407 response time of 1 h 22 m; - 09/07/24 at 7:45 A.M., Room 407 response time of 6 h 2 m; - 09/07/24 at 11:02 A.M., Room 401 response time of 2 h 35 m; - 09/07/24 at 12:33 P.M., Room 314 response time of 1 h 24 m; - 09/07/24 at 3:03 P.M., Room 407 response time of 5 h 36 m; - 09/08/24 at 5:59 A.M., Room 309 response time	F 725		

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of 1 h 22 m;
- 09/08/24 at 6:39 A.M., Room 411 response time of 4 h 44 m;
- 09/08/24 at 7:04 A.M., Room 407 response time of 4 h 19 m;
- 09/08/24 at 5:52 P.M., Room 401 response time of 2 h 14 m.

During an interview on 09/09/24 at 9:08 A..M, Resident #69 said he/she had been lying in bed with his/her call light on for over an hour. Resident said he/she had a bowel movement and had not been changed all night. The resident said call lights do not get answered during the night.

Observation made on 09/09/24 at 9:13 A.M. showed a strong, foul odor coming from resident #69's room.

During an interview on 09/09/24 at 10:22 A.M., Resident #219 said the call lights take a long time to be answered.

During an interview on 09/09/24 at 10:45 A.M., Resident #120 said the call lights take a long time to get answered. The resident said the call light was on from 7:45 A.M. until noon when the staff brought his/her lunch tray to the room.

During an interview on 09/09/24 at 11:04 A.M., Resident #15 said call lights do not get answered, especially at night.

During an interview on 9/09/24 at 12:33 P.M., Resident #29 said that call lights are a constant issue and are not answered. The resident said he/she does not even push the call light anymore. He/She will use wheelchair, leave room, go find

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staff for help themselves and/or ask roommate for assistance.

During an interview on 09/10/24 at 1:57 P.M., Resident #18 said it takes a long time for staff to answer the call lights. He/she said night time was the worse usually.

During an interview on 09/09/24 at 2:47 P.M., Resident #27 said it took a long time for the call lights to be answered. The resident said he/she just kept pushing the button, hoping someone would answer it.

During an interview on 09/09/24 at 2:53 P.M., Resident #13 said sometimes the call lights are not answered in a timely manner. The resident said sometimes it takes up to 1-2 hours before someone comes in to check on him/her.

During an interview on 09/09/24 at 3:06 P.M., Resident #26 said it takes awhile for staff to answer his/her call light.

During an interview on 09/09/24 at 3:24 P.M., Resident #35 said the day shift answers call lights for the most part, but the night shift is terrible about answering call lights.

During an interview on 09/10/24 at 9:03 A.M., Resident #69 said he/she pushed the call light over an hour ago and still had not been changed. The resident said staff came to his/her room, turned off his/her call light and said they would be back, but never did. The resident said he/she pushed the call light again and was still waiting to be changed.

Observations made on 09/10/24 at 9:05 A.M.

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showed:
- CNA P walked toward Resident #69's room;
- CNA P's facility-issued iPhone (mobile device) with an alert notification and resident's room number identified;
- A response time of 42 minutes.

During an interview on 09/11/24 at 3:11 A.M., CNA T said the call light notification on the iPhone has a two-step process. When a resident presses the call light, the iPhone will show an alert notification with the time and room number listed. The first step is to tap the button on the iPhone to clear the call light time. The second step is for staff to turn off the call light by pressing the button on the wall in the resident's room before leaving. He/She clears the alert on the iPhone, but does not always press the call light button on the wall before leaving. CNA T said by clearing the alert notification on the iPhone should take care of the call light notification.

Observation on 09/11/24 at 3:15 A.M., showed CNA T with a facility-issued iPhone in his/her possession at the time of interview.

During an interview on 09/12/24 at 10:25 AM, CNA N said he/she was headed to a resident's room to turn a call light off. CNA N was asked if he/she would be taking care of residents needs when the call light was turned off. CNA N said no and the resident's aides were currently busy. CNA N said he/she would turn off the resident's call light and the resident's aides would get to the resident when they were done. CNA N said he/she did not think staff should wait to turn call lights off until care is provided and he/she tries to turn call lights off as soon as possible regardless if care is provided at that time.

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F 725	Continued From page 32 During an interview on 09/12/24 at 12:43 P.M., the Administrator said she does not expect staff to go in and turn off call lights without providing resident care. The call light system is a two-step process. She would expect staff to complete both steps upon receiving the alert notification on their facility-issued iPhone and providing care before leaving the resident's room.	F 725		
F 812 SS=F	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 store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These deficient practices had the potential to	F 812		

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affect all residents. The facility census was 72.

Review of the facility's policy titled, "Sanitation," revised November 2022, showed:
- The food service area is maintained in a clean and sanitary manner;
- All kitchen areas and dining areas are kept clean;
- All utensils, counters, shelves and equipment are kept clean, maintained in good repair and free of breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning.

Review of the facility's policy titled, "Food Receiving and Storage," revised November 2022, showed:
- Foods shall be received and stored in a manner that complies with safe food handling practices;
- All foods stored in the refrigerator or freezer are covered, labeled and dated;
- Functioning of the refrigerators and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements;
- Refrigerated foods are labeled, dated and monitored so they are used by their "use by" date, frozen or discarded.

1. Observations made on 09/09/24 at 9:44 A.M. and 09/09/24 2:04 P.M., of the temperature check logs, showed:
- A two-door standup refrigerator with no temperature checks from 09/01/24 through 09/08/24;
- A three-door standup refrigerator with no temperature checks from 09/01/24 through

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F 812	Continued From page 34 09/08/24. 2. Observations made on 09/09/24 at 9:47 A.M. and 09/09/24 at 2:09 P.M., of the standup freezers, showed: - A plastic container of yellow shredded cheese undated; - A bag of tortilla shells with an expiration date of 06/21/24; - A bag of dinner rolls undated. 3. Observations made on 09/09/24 at 10:01 A.M. and 09/09/24 at 2:12 P.M., of the kitchen, showed: - No lid on the trash can by the stove; - No lid on the trash can by the food disposal; - A build up of grease and grime on the bottom surface leg supports and wheels of the deep fryer; - A build up of grease on the area of the cracked and missing floor tile under the deep fryer; - Several broken floor tiles under the deep fryer. 4. Observations made on 09/09/24 at 10:10 A.M., 09/09/24 at 2:18 P.M. and 09/10/24 at 1:14 P.M. , of the canned goods area, showed: - Two bags of flour tortillas with an expiration date of 06/21/24; - A bag of flour tortillas with an expiration date of 08/02/24. 5. Observations made on 09/09/24 at 10:16 P.M. and 09/09/24 at 2:25 P.M., of the dish machine, showed: - A buildup of dirt and debris on the floor underneath; - A black and gray bristle brush with a buildup of dirt laid on the floor underneath; - A panel unattached and/or unglued from the wall	F 812		

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F 812	Continued From page 35 laid on the floor underneath; - A buildup of dirt and grime on the trash disposal. During an interview on 09/09/24 at 2:31 P.M., the Dietary Manager (DM) said the kitchen floors should be free of dirt, debris and kitchen equipment should be cleaned daily. Daily refrigerator temperatures should be checked by staff and initialed when completed. There should be dates on all food and expired foods should be thrown away. The DM said these areas of concern will need to be monitored more closely. During an interview 09/09/24 at 4:01 P.M., the Administrator said the kitchen floors should be free of dirt and debris. Kitchen equipment should be cleaned daily. Refrigerator temperatures should be checked by staff daily and initialed when completed. There should be dates on all food and expired foods should be thrown away accordingly. The DM should ensure areas of the kitchen are checked and monitored on a regularly to meet compliance.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the 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.

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§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 failed to maintain proper infection control practices during incontinent care for one resident (Resident #9) out of four sampled residents and during wound care for one resident (Resident #24) out of two sampled residents. The facility failed to follow enhanced barrier precautions (EBP) for four residents (Residents #7, #9, #11 and #31) out of six sampled residents during care. The facility also failed to implement a risk management process specific to Legionella disease (a serious type of pneumonia caused by legionella bacteria) which had the potential to affect all residents, staff and the public. The kitchen staff failed to perform hand hygiene between the residents during a meal pass. The facility census was 72.

Review of the facility's policy titled, "Wound Care," revised, October 2019, showed:
- Put on gloves, loosen tape and remove dressing;
- Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands

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thoroughly;
- Put on gloves;
- Use a no-touch technique to apply creams and ointments.

Review of the facility's policy titled, "Perineal Care", revised, February 2019, showed:
-Did not address when during the procedure of perineal care to change gloves.

Review of the facility's policy titled, "Legionella Water Management Program," revised July 2017, showed:
- The water management program includes the following elements:
- A detailed description and diagram of the water system in the facility, including the following: a) receiving b) cold water distribution c) heating d) hot water distribution e) waste;
- The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: a) storage tanks b) water heaters c) filters d) aerators e) showerheads and hoses f) misters, atomizers, air washers and humidifiers g) hot tubs h) fountains i) medical devices such as continued positive airway pressure (CPAP), hydrotherapy equipment, etc.;
- Specific measures used to control the introduction and/or spread of Legionella (temperature, disinfectants):
- The control limits or parameters that are acceptable and that are monitored;
- A diagram of where control measures are applied;
- A system to monitor control limits and the effectiveness of control measures;
-Documentation of the program.

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Review of the facility's policy titled, "Enhanced Barrier Precautions," revised March 2024, showed:
- An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters (a tube inserted into the bladder to drain urine), feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with multi-drug resistant organism (MDRO);
- High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing.

Review of the facility's policy titled, "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices," revised October 2017, showed:
- Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness;
- All employees who handle, prepare or serve food will be trained in the practices for safe food handling and preventing foodborne illness;
- Employees must wash their hands:
    - whenever entering or re-entering the kitchen;
    - after handling soiled equipment or utensils;
- Antimicrobial hand gel cannot be used in place

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of handwashing in food service areas;
- Gloves are considered single-use items and must be discarded after completing the task for which they were used. The use of disposable gloves does not substitute for proper handwashing.

1. Observation of Resident #7's incontinent care on 09/11/24 at 5:35 A.M., showed:
- EBP sign on the resident room door; personal protective equipment (PPE) stored outside the resident door;
- Certified Nurse Aid (CNA) O and CNA Q entered the resident room without gowns;
- The resident with a gastrostomy (G-tube - a tube inserted into the stomach to deliver nutrition);
- CNA O and CNA Q performed incontinent care for the resident.

2. Observation of Resident #9's incontinent care on 09/11/24 at 6:07 A.M., showed:
- EBP sign on the resident room door;
- PPE stored in clear drawers outside the resident room;
- CNA O and CNA Q entered the resident room without gowns;
- The resident with a G-tube;
- CNA O and CNA Q performed incontinent care for the resident.

Observation of the resident's incontinent care on 09/11/24 at 11:24 A.M., showed:
- EBP sign on the resident door;
- CNA D and CNA E put on gowns and gloves outside the resident room and entered the room;
- CNA D and CNA E removed the resident's dirty pants and brief soiled with urine;
- CNA D cleaned the front peri-area, did not

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change gloves and did not perform hand hygiene;
- CNA D placed a clean brief on the resident.

3. Observation of Resident #11's incontinent care on 09/11/24 at 6:58 A.M., showed:
- EBP sign on the resident room door;
- PPE stored in clear drawers outside the resident room;
- CNA O and CNA Q entered the resident room without gowns;
- The resident with a Foley catheter (a type of urinary catheter);
- CNA O and CNA Q performed incontinent care for the resident.

4. Observation of Resident #24's wound care on 09/12/24 at 12:46 P.M., showed:
- LPN G put on an isolation gown and a N95 mask;
- LPN G performed hand hygiene, removed the soiled dressing, used a 4x4 gauze and wound cleaner to clean the wound, patted the wound dry with a new 4x4, and applied skin prep and a border dressing;
- LPN G did not perform hand hygiene and change gloves between removing the soiled dressing and applying the clean dressing.

5. Observation of Resident #31's wound care on 09/12/24 at 10:38 A.M., showed:
- EBP signage on the resident room door;
- LPN G performed hand hygiene and put on gloves;
- LPN G failed to put on an isolation gown
- LPN G removed the dressing from the resident's right second toe, removed the gloves, performed hand hygiene and put on clean gloves;
- LPN G cleaned the wound with wound cleanser and gauze, applied a non-adherent pad and a toe

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guard, applied a clean sock, removed the gloves and performed hand hygiene.

6. Observations on 09/09/24 at 12:14 P.M. showed:
- Dietary Staff (DS) K served residents' meal plates in the dining room;
- DS K re-entered the kitchen, received residents' plates, exited the kitchen and served the residents' plates, touched the table, and the residents;
- DS K did not perform hand hygiene between serving the residents.

7. Observations on 09/09/24 at 12:16 P.M. showed:
- Dietary Manager (DM) served residents' meal plates in the dining room;
- The DM entered the kitchen, picked up a scoop, placed au gratin potatoes onto the resident's plate, replaced the scoop in the potatoes, picked up another scoop, placed green beans onto the resident's plate, then replaced the scoop into the green beans, exited the kitchen and served the resident's plate;
- The DM did not perform hand hygiene before entering the kitchen after serving residents' plates and before exiting the kitchen and serving another resident's plate.

8. Observations made on 09/10/24 at 8:30 A.M. showed:
- Dietary staff L wore disposable gloves and served the meal plates to the residents' in the dining room;
- Dietary staff L did not change gloves or perform hand hygiene between the residents.

9. The facility did not provide a water flow

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diagram.

During an interview on 09/11/24 at 12:23 P.M., the Maintenance Supervisor (MS) said he/she did not have a waterflow diagram with areas that were potentially at risk for the growth of Legionella. He/she said water temperatures were monitored weekly.

During an interview on 09/11/24 at 11:44 A.M., Certified Nurse Aid (CNA) D said during incontinent care, the only time gloves were changed was if they were visibly dirty.

During an interview on 09/12/24 at 1:26 P.M., Licensed Practical Nurse (LPN) G said gloves were changed after removing a soiled dressing and before applying a clean dressing during wound care.

During an interview on 09/12/24 at 12:34 P.M., Dietary Staff M said the residents were served by the dietary staff. He/She was new to this position, but the staff should wash their hands before serving a resident's plate and staff should wash their hands in the kitchen before getting another resident's plate.

During an interview on 09/12/24 at 12:50 P.M., the DM said the dietary staff pass the residents' plates, they do not clean their hands between each resident unless they touch the resident, chair, table or anything else. The DM said, "I did not know you had to clean between each resident."

During an interview on 09/12/24 at 1:00 P.M., the Administrator said she thought there was a hand sanitizer dispenser in the dining room or kitchen

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F 880	Continued From page 44 and staff should be using it between each resident. During an interview on 09/12/24 at 1:05 P.M., the Corporate Nurse said staff should cleanse their hands between serving each resident. During an interview on 09/12/24 at 2:17 P.M., the Director of Nursing said when staff were providing care to residents with EBP, gowns and gloves should be worn. During incontinent and wound care, gloves should be changed when going from dirty to clean care.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		

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(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to document pertinent education provided to the residents or the resident's representative regarding benefits, side effects or warnings of the influenza (a viral respiratory infection) and/or the pneumococcal (an infectious lung disease) vaccine for five residents (Residents #2, #6, #21,

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#24, and #31) out of five sampled residents. The facility's census was 72.

Review of the facility's policy, titled, "Influenza Vaccine", revised March 2022, showed:
- Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical record.
- A resident's refusal of the vaccine shall be documented on the informed consent for the influenza vaccine and placed in the resident's medical record.

Review of the facility's policy, titled, "Pneumococcal Vaccine", revised March 2022, showed:
- Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record.
- Resident/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination.

1. Review of Resident #2's medical record showed:
- Admission date of 10/06/22;
- Influenza vaccine administered on 10/20/23;
- Pneumococcal vaccine administered on 10/20/23;
- No documentation the facility provided information and education to the resident or the

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resident's representative of the influenza vaccine.
- No documentation the facility provided information and education to the resident or the resident's representative of the pneumococcal vaccine.

2. Review of Resident #6's medical record showed:
- Admission date of 02/05/16;
- Influenza vaccine refused on 09/25/23;
- No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine;

3. Review of Resident #21's medical record showed:
- Admission date of 07/20/23;
- Influenza vaccine administered on 10/20/23;
- No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine.

4. Review of Resident #24's medical record showed:
- Admission date of 09/30/16;
- Influenza vaccine administered on 10/20/23;
- No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine;

5. Review of Resident #31's medical record showed:
- Admission date of 06/13/24;
- Influenza vaccine refused on 06/13/24;
- Pneumococcal vaccine refused on 06/13/24;
- No documentation the facility provided information and education to the resident of the influenza vaccine;
- No documentation the facility provided

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F 883	Continued From page 48 information and education to the resident of the pneumococcal vaccine. During an interview on 09/12/24 at 2:30 P.M., the Director of Nursing (DON) said education should be provided prior to any vaccine being administered. The education should be documented when provided. During an interview on 09/12/24 at 2:32 P.M., the Administrator said Social Services Designee (SSD) usually handles obtaining the consents and providing residents and representatives with information and education. There was no SSD during annual survey.	F 883		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 947		

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This REQUIREMENT is not met as evidenced by:
Based on interview an record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year for two out of two Certified Nurse Aides (CNA) out of two sampled CNAs. The facility census was 72.

Review of the policy titled, "In-Service Training, All Staff," revised August 2022 showed:
- All staff must participate in initial orientation and annual in-service training.
- The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training.
- Completed training is documented by the staff development coordinator, or his or her designee and includes:
    a. the date and time of the training;
    b. topic of the training;
    c. the method used for training'
    d. a summary of the competency assessment; and
    e. the hours of training completed.

1. Review of CNA N's April 2023 through April 2024 in-service records showed:
- Hire date of 04/07/23;
- No documentation of annual in-service trainings provided;
- The facility failed to provide CNA N with at least twelve hours of in-service education for April 2023 through April 2024.

2. Review of CNA O's July 2023 through July 2024 in-service records showed:
- Hire date on 07/27/23;

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F 947	Continued From page 50 - No documentation of annual in-service trainings provided; - The facility failed to provide CNA O with at least twelve hours of in-service education for July 2023 through July 2024. During an interview on 09/12/24 at 2:05 P.M., the Administrator said CNAs should have at least 12 hours of training annually. She said she thought the trainings had documented times on the sheets, however would get this done from this point on.	F 947		

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class III Refer to F584	A3038		
A4026	19 CSR 30-85.042(22) In-service Training-Nursing Personnel The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs related to problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency. II/III This regulation is not met as evidenced by: Class III Refer to F947	A4026		
A4029	19 CSR 30-85.042(25) In-service Records Facilities shall maintain records which indicate the subject of, and attendance at, all in-service sessions. III This regulation is not met as evidenced by: Class III	A4029		

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A4029	Continued From page 1 Refer to F947	A4029		
A4046	19 CSR 30-85.042(37) Nursing Staff Sufficient/Qualified All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II This regulation is not met as evidenced by: Class II Refer to F725	A4046		
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	A4086		

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A4086	Continued From page 2 Refer to F880.	A4086		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record 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 Refer to F645	A4108		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: Class III Refer to F812	A6012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02820	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPBELL HEALTHCARE & SENIOR LIVING	17108 US HIGHWAY 62 CAMPBELL, MO 63933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A6015	Continued From page 3	A6015		
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 Refer to F812	A6015		
A6031	19 CSR 30-87.020(31) Kitchen Waste Containers Covered Waste containers used in food-preparation and utensil-washing areas shall be kept covered when not in actual use. III This regulation is not met as evidenced by: Class III Refer to F812	A6031		
A7028	19 CSR 30-87.030(26) Hazardous Food Cooking Temperatures Potentially hazardous foods requiring cooking shall be cooked to heat all parts of the food to a temperature of at least one hundred forty degrees Fahrenheit (140°F), except that poultry, poultry stuffings, stuffed meats and stuffings containing meat shall be cooked to heat all parts of the food to at least one hundred sixty-five degrees Fahrenheit (165°F) with no interruption of the cooking process. Pork and food containing pork shall be cooked to heat all parts of the food to at least one hundred fifty degrees Fahrenheit (150°F); rare roast beef shall be cooked to an	A7028		

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CAMPBELL HEALTHCARE & SENIOR LIVING	17108 US HIGHWAY 62 CAMPBELL, MO 63933

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A7028	Continued From page 4 internal temperature of at least one hundred thirty degrees Fahrenheit (130°F); and rare beef steak shall be cooked to a temperature of one hundred thirty degrees Fahrenheit (130°F) unless otherwise ordered by the resident. II/III This regulation is not met as evidenced by: Class III Refer to F812	A7028		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Refer to F812	A7067		
A8016	19 CSR 30-88.010(16) Reasons to Transfer/Discharge A resident may be transferred or discharged only for medical reasons or for his or her welfare or that of other residents, or for nonpayment for his or her stay. II This regulation is not met as evidenced by: Class II Refer to F623	A8016		
A8030	19 CSR 30-88.010(29) Dignity/Privacy	A8030		

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A8030	Continued From page 5 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 III Refer to F550	A8030		

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F 550	**The corrective action taken for those residents found to be affected by the deficient practice include:** All nursing staff were in-serviced by the DON on the company's Resident Rights Policy. R9 and R11 have had care provided in accordance with the Resident Rights Policy. **Other residents have potential to be affected have been identified by:** All residents have the potential to be affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include:** All nursing staff have been educated on the Residents Rights policy. Education was provided to prevent future incidents. A monitoring sheet has been created for rounding. The audit sheet and proof of staff in-service sheets are available for review. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The DON/ Designee will ensure that the correct steps are being taken to ensure the residents are treated with dignity during care. The DON/ Desginee will monitor weekly for x4 then monthly thereafter that all curtains are closed during care and that all residents are being treated with	10/26/2024

	dignity.	

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F 584	**The corrective action taken for those residents and areas found to be affected by the deficient practice include:** The base trim in room 509 was replaced, the trim on the bottom of the closet was replaced. The exposed sheet rock will be repaired and painted in room 514. The pipe will be reattached to the side of the building that houses the ac unit wiring. The stuffed animals were removed from the light fixture in room 305. The base trim in 400 hall shower room was replaced. The floor of the shower was deep cleaned to remove buildup. The toilet seat was cleaned in the shower room. The large shower chair was cleaned. **Other residents have potential to be affected have been identified by:** The residents of 300,400, and 500 halls have the potential to be affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The Maintenance Department and Housekeeping department will add a weekly inspection for all areas of the building and resident equipment. The maintenance staff/ housekeeping staff will do weekly inspections to identify and complete any needed repairs. All other staff were in-serviced by the Administrator on the process of work	10/26/2024

	orders, where they are located and where to turn them in. Administrator will review all work orders and will do inspections to monitor the progress of repairs. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Maintenance Director will present the Preventative Maintenance schedule and a report of any needed repairs to the QAPI team for review 3x weekly then monthly to ensure each deficient finding has been repaired or is in the process of being repaired. The housekeeping supervisor will do weekly checks to ensure the residents have a clean-living environment. The Administrator will monitor the needed repairs and ensure the completion of repairs to maintain this standard.	

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F 623	**The corrective action taken for those residents found to be affected by the deficient practice include:** The Business office manager was in serviced by the Administrator on the process of transfer discharge notices being sent to the Ombudsman. The last 6 months of transfer discharges has been submitted to the Ombudsman to include resident # 9 and 21.. **Other residents have potential to be affected have been identified by:** All Residents that transfer from the facility have to the potential to be affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The Business office manager was in serviced by the Administrator on the process of transfer discharge notices being sent to the Ombudsman. The Business office manager will complete a monthly log of all transfer discharges that will be sent to the Ombudsman monthly showing the where the resident discharged and when the resident returns to the facility or where the resident discharged too. A copy of the in-service sheets and notification to ombudsman log are available onsite. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Business Office Manager will present the monthly log of transfer discharges along with a fax confirmation or email receipt to the Administrator during the monthly	10/26/2024

	QAPI meetings.	

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F 637	**The corrective action taken for those residents found to be affected by the deficient practice include:** Resident 66 no longer resides in the facility. **Other residents have potential to be affected have been identified by:** Any resident with a significant change in condition could have been affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** Residents experiencing a "significant change" as defined by 483.20(b)(2)(ii) will be discussed during morning IDT meeting, including the need for hospice, and information will be communicated with the MDS coordinator to ensure the significant change is completed within 14 days. A progress note for those experiencing a "significant change" will be created in the EMR, and will serve as the log and worklist of what residents should have a "significant change" MDS completed. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** DON or Designee will review MDS before submission for residents with a possible significant change. This will be discussed weekly x4 in QA meetings and monthly	10/26/2024

	thereafter.	

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F 641	**The corrective action taken for those residents found to be affected by the deficient practice include:** Resident #9 MDS has been modified to accurately reflect falls, and correction of inaccurate coding. Resident 15 MDS has been modified to accurately show insulin injections and correction of inaccurate coding. **Other residents have potential to be affected have been identified by:** Residents that require a comprehensive assessment have the potential to be affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** All resident assessments completed have been reviewed by the IDT team to ensure assessments are accurately assessed and coded. All disciplines involved in the coding of MDS will participate in the development and ongoing validation of accuracy of assessments. The IDT have been in serviced on this requirement. A copy of the in-service sign in sheet is available onsite. Any areas of concern will result in reeducation. Audits of MDS completed will be validated during the next 90 days by the IDT team. **The corrective action taken to monitor performance to assure compliance through quality assurance is:**	10/26/2024

	To ensure ongoing compliance with this corrective action, the DON and or designee will randomly audit a percent of MDS'S completed monthly for accuracy. Any issues with accuracy of coding will result in correction of the MDS and reeducation of the IDT team member responsible for the inaccurate coding. All findings will be presented to the QAPI team during its next routinely scheduled meeting for review and follow up.	

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F 645	**The corrective action taken for those residents found to be affected by the deficient practice include:** A PASARR level one was completed for R21 and R43. **Other residents have potential to be affected have been identified by:** All residents newly admitted and residents with a change of condition have the potential to be affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** An audit was done to ensure all residents have a PASARR level 1 screening in place. Social Service Director was hired on 09/16/2024. Social Service Director has been in-service by the Administrator on the PASARR procedures and the level 1/2 screening process. Online training is in process with the New Social Service Director to ensure the proper procedures are followed to maintain compliance. A copy of the training provided is available onsite. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Social Service Director will report all PASARR level one screening to the administrator weekly in the QAPI meeting to ensure they are completed on admission and on	10/26/2024

	change of condition. A report will be implemented to show that all screenings are done timely. The report will be presented weekly x4 then monthly in the regularly scheduled QAPI meeting.	

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F 656	**The corrective action taken for those residents found to be affected by the deficient practice include:** A Baseline Care Plan has been completed for R120 and it was shared and reviewed with the resident and provision of the record to the resident has been documented in the EMR. **Other residents have potential to be affected have been identified by:** All residents newly admitted have the potential to be affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** An audit was completed of all residents to ensure they have an accurate and complete up to date care plan. The Baseline Pare Plan will : 1. Be completed within 48 hours 2. Include minimum healthcare information and physicians orders to properly care for resident. 3. Have initial goals based on admission orders. 4. Include dietary orders 5. Include therapy services 6. Include social services 7. And contain a PASARR recommendation if applicable. A Baseline Care Plan assessment has been added to the	10/26/2024

	new admission packet and will be done on admission with the Social Service Director and Nursing. The Baseline care plan will be uploaded online for staff to review. Once completed, the baseline care plan will be shared with the responsible party for the resident and provision of the summary will be documented in the medical record. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Social Service director will keep a copy of the Baseline care plan for all new admissions and will present them to the administrator during the QAPI meeting x1 weekly then 1x monthly thereafter to ensure that they are completed in a timely manner to ensure the residents needs are met.	

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F 658	**The corrective action taken for those residents found to be affected by the deficient practice include:** A Fall mat has been added to the right side of the bed for resident #6. **Other residents have potential to be affected have been identified by:** All residents who have physicians orders could be affected by the same alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** Care plans have been audited by the care plan team to ensure that the services provided or arranged by the facility as outlined by the comprehensive care plan are implemented accordingly. All orders for Fall mats will be care planned and physician's orders will be followed. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** DON/Designee have implemented a report to show the residents care planned for fall mats, the DON/Designee will do visual check to ensure the fall mats are in place 3x weekly for 3 weeks the monthly thereafter. The report will be reviewed during the scheduled QA meeting weekly then	10/26/2024

	monthly by the Administrator to ensue the physician orders are being followed and care plans are followed.	

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F 699	**The corrective action taken for those residents found to be affected by the deficient practice include:** A Trauma informed care assessment was completed on R 52. **Other residents have potential to be affected have been identified by:** Residents who are trauma survivors have the potential to be affected by the same alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** A audit was completed of all residents requiring the Trauma informed care assessment and is completed on any resident that triggered a need. The trauma informed care assessment has been added to the Social Service Director admission packet and will be completed on admission, quarterly or at significant change of condition on residents that trigger the need. The assessment will be completed on the EMR software after the initial admission assessment is done it will be uploaded to the EMR software. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Social Service director will keep a copy of the Trauma	10/26/2024

	Informed Case assessments from admissions on residents that triggered a need and will present them to the administrator during the weekly QAPI meeting to ensure that they are completed on admission. Social Services will keep a spreadsheet on all residents that require a Trauma informed care assessment monthly x3 and quarterly thereafter. The report will be presented to the QA team during the regularly scheduled QAPI meeting.	

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F 725	**The corrective action taken for those residents found to be affected by the deficient practice include:** The Administrator and DON spoke with Residents, 69,219,120,15, 29,18,27,13,26, and 35 regarding call light responses times. The Administrator and DON reviewed the concerns expressed by the residents about timely responses and explained to the residents that the nursing staff was in serviced on the call light system and the Administrator is reviewing reports daily to ensure their needs are met in a timely manner. The DON and ADON have in-serviced and reeducated all CNAS and nursing staff on the call light system. **Other residents have potential to be affected have been identified by:** All residents have the potential to be affected by the same alleged deficient finding. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** Administration has taken steps to ensure sufficient staffing needs of the facility have been evaluated based on census and resident needs. The DON and ADON have in-serviced and reeducated all nursing staff on acknowledging the call light system including the following two steps, patients room reset button as well as the call light phone and the importance of timely responses to obtain or maintain the highest practicable physical, mental and psychosocial well	10/26/2024

	being of each resident. All new hires will be trained and checked off on the call light system to ensure all nursing staff have the appropriate competencies and skills set to meet the needs of each resident. The competencies will be documented on a orientation form and signed off by the staff member, RN/LPN completing the orientation, DON and Administrator that this orientation has been completed. A copy of the in-service sign in sheet is available at the facility. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** The Administrator and DON/designee will review call light reports 4x weekly for 4 weeks then 2x weekly for 2 weeks then monthly thereafter to ensure the call lights are being answered timely. These reports will be reviewed during the regularly scheduled QAPI meeting.	

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F 812	**The corrective action taken for those residents found to be affected by the deficient practice include:** All residents mentioned did not experience any negative outcomes and were free from illness related to the alleged deficient concerns. All dietary staff were in-serviced and reeducated by the RD and Dietary manager regarding the following. 1. Temperature logs are in place on two door refrigerator. 2. Temperature logs are in place on three door standup refrigerator. 3. All undated food was removed from kitchen immediately. 4. Expired food was removed the kitchen immediately. 5. Lids were placed on trash cans when not in use. 6. The grease build was removed from the broken tile under the fryer, The tile will be replaced. 7. The floor was cleaned of buildup under the dishwasher. The brush was removed from under the dishwasher. 8. Panel was replaced. 9. Trash disposal was cleaned from buildup of dirt. **Other residents have potential to be affected have been identified by:** All residents have the potential to be affected by the same alleged deficient practice.	10/26/2024

	The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include. All new dietary staff responsible for cleaning, maintaining temperature logs, labeling and removing expired food will be educated by dietary manager. RD and or Dietary manager, we will in-service and educate new hires along with current employees as needed to ensure the sanitary service by food handlers and dietary staff sustain this plan of correction. The RD recommendations and outcomes of observation of the kitchen will be given to the DM and the Administrator to be reviewed at the QAPI meeting. A copy of the in-services and sign in sheet is available at the facility. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** All completed temperature logs will be kept in a binder for easy access for review by the QA committee, DM and Administrator will inspect kitchen to ensure all mentioned deficient practices are corrected weekly x3 then quarterly x3 the results will be reviewed in the scheduled QAPI meetings.	

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F 880	**The corrective action taken for those residents found to be affected by the deficient practice include:** All residents mentioned, #7, 9,11,24 and 31 did not experience any negative outcomes related to the alleged deficient concerns. The following actions were taken. DON/Designee in-service and reeducated staff on hand washing/hygiene policy. DON/Designee in-service all nursing staff on gloving and gowning. . DON/ Designee All nursing staff were reeducated on proper infection control/ EBP during wound care and incontinent care. RD and Dietary Manager in-serviced all dietary staff on hand washing/hygiene. RD and Dietary Manager in-serviced all dietary staff on gloving. The Maintenance Director is now following the Legionella Water Management Program as outlined for the facility, including the site specific water flow diagram. **Other residents have potential to be affected have been identified by:** All residents could have been affected by the alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** DON/Designee will orientate all new nursing staff will be	10/26/2024

on hand washing/hygiene and new hires will be checked off to ensure the policy is being followed correctly. All current nursing staff will be reeducated and in-serviced Check offs will be completed quarterly.

DON/Designee will orientate all new nursing staff on gowning and new hires will be checked off to ensure the policy is being followed correctly. All current nursing staff will be reeducated and in-serviced on gowning with check completed quarterly.

DON/Designee will orientate all new nursing staff on EBP and all new hires will be checked off to ensure the policy is being followed correctly. All current nursing staff will be reeducated and in-serviced on EBP with check offs completed quarterly.

DON/Designee will orientate all new nursing staff will be on gloving and new hires will be checked off to ensure the policy is being followed correctly. All current nursing staff will be reeducated and in-serviced on gloving. Check offs will be completed quarterly.

DM/RD will orientate new hires on hand hygiene and will do check off to ensure the policy is being followed correctly.
A new serving system has been implemented. Plated food is being served by one person that is not reentering the kitchen between residents. Hand sanitizer dispenser has been added to the wall in the dining room by the entry door for easy access for all staff.

Any issues identified will be immediately corrected. Copies of the in-services provided and auditing in place are available at the facility.

The corrective action taken to monitor performance to assure compliance through quality assurance is:

DON/Designee will be responsible for random audits/check off's of all facility staff providing care where opportunity to witness handwashing is possible, x3 weekly and x3 monthly then quarterly x3, documenting the check off's to be reviewed during the scheduled QAPI meeting. DM/RD will be responsible for audits/check offs of dietary staff to witness handwashing/hygiene x3 weekly and x3

	monthly then quarterly x3, documenting the check off's to be reviewed during the scheduled QAPI meeting .	

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

PLAN OF CORRECTION

Provider/Supplier Name:	Campbell Healthcare and Senior Living
Street Address, City, Zip:	17108 US HWY 62 Campbell MO 63933
Date of Survey:	09/09/2024-09/12/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265677
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 883	**The corrective action taken for those residents found to be affected by the deficient practice include:** Residents or resident's representative #2,6,21,24, and 31 have been educated on the benefits of the flu and pneumococcal vaccine. **Other residents have potential to be affected have been identified by:** All residents could have been affected by the same alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** Social Service Director has added CDC information regarding the benefits of the flu and pneumococcal vaccine and the consent forms and to the admission packet to be reviewed on admission and annually to ensure the resident or residents representative is educated and understands the benefits of the vaccines. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** Social Service Director will ensure All signed consent forms with education provided stating the resident or resident's representative have been educated on the benefits of the flu and pneumococcal vaccine will be uploaded into the EMR software under the "documents	10/26/2024

	tab" and a report will be kept for all new admissions stating the date the consent form along with the education was provided. The report will be reviewed by the administrator weekly x4 then monthly thereafter during the regular scheduled QA meetings.	

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PLAN OF CORRECTION

Provider/Supplier Name:	Campbell Healthcare and Senior Living
Street Address, City, Zip:	17108 US HWY 62 Campbell MO 63933
Date of Survey:	09/09/2024-09/12/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265677

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 947	**The corrective action taken for those residents found to be affected by the deficient practice include:** Moving forward all in services will be timed for employees N and O. Moving forward all in-services will be timed to ensure the required in service hours are met annually on all staff. **Other residents have potential to be affected have been identified by:** All staff and residents could have been affected by the same alleged deficient practice. **The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include.** DON/ Designee will provide the needed in services, and each in-service will have the following information documented. 1. Date and time of training. 2. Topic of the training 3. The method used for training. 4. A summary of the competency assessment 5. The hours of training completed. 6. **12 Hours of education will be provided annually to nurse aides in accordance with 483.95(g)** **The corrective action taken to monitor performance to assure compliance through quality assurance is:** DON/Designee will keep a monthly report of all in-services completed; the report will be reviewed during the	10/26/2024

	regularly scheduled QAPI meeting monthly to ensure the requirements are being met.	

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PLAN OF CORRECTION

Provider/Supplier Name:	Campbell Healthcare and Senior Living
Street Address, City, Zip:	17108 US HWY 62 Campbell MO 63933
Date of Survey:	09/09/2024-09/12/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		02820
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A3038	REFER TO F584	10/26/2024
A4026	REFER TO F947	10/26/2024
A4029	REFER TO F947	10/26/2024
A4046	REFER TO F725	10/26/2024
A4086	REFER TO F880	10/26/2024
A4108	REFER TO F645	10/26/2024
A6012	REFER TO F812	10/26/2024
A6015	REFER TO F812	10/26/2024
A6031	REFER TO F812	10/26/2024
A7028	REFER TO F812	10/26/2024
A7067	REFER TO F812	10/26/2024
A8016	REFER TO F623	10/26/2024
A8030	REFER TO F550	10/26/2024

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