STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265415	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CARE CENTER	9503 HIGHWAY 100 NEW HAVEN, MO 63068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to maintain professional standards of care when they failed to utilize the electronic medication administration record (eMAR), while administering insulin to three residents (Resident # 2, 18 and 20), and failed to document insulin dosages for five residents (#2, #18, #20, #24 and #30). Staff failed to administer extended release medication per pharmacy recommendations for one resident (Resident 8), who was unable to swallow pills, and failed to obtain a physician's order for oxygen for one resident (Resident #63) out of 30 sampled residents. The facility census was 69 . 1. Review of Medication Administration policy, undated, directed staff to utilize the MAR to select medications from the resident's medication slot. Verify the drug name, dose and route on the medication label with the MAR/physician order. Document administration and any essential information on the MAR immediately after administering the medication. Consult Pharmacy to determine if crushing is appropriate for the medication ordered. Review of National Institutes of Health (NIH) "The Five Rights of Medication Administration", dated September 4, 2023, showed right patient, right drug, right route, right time and right dose.	F 658		

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

Charlie Tech | Administrator | 4/9/2025

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 658	Continued From page 1	F 658		

2. Review of Resident #2's Admission Minimum Data Set (MDS), dated 12/19/24, showed staff assessed the resident as cognitively intact with a diagnosis of diabetes mellitus.

Review of the resident's Physician's Order Sheet (POS), showed an order dated 12/23/24, to administer Insulin Lispro 100 units/milliliter (Units/ml) by sliding scale every A.M., afternoon, and at supper.

Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Lispro Insulin and did not document the units of insulin administered on:

-March 8 at 8:32 A.M., and 11:30 A.M.;
-March 9 at 7:38 A.M., 10:48 A.M. and 15:46 P.M.;
-March 10 at 8:00 A.M., 10:58 A.M. and 3:44 P.M.;
-March 11 at 7:38 A.M. and 10:44 A.M.;
-March 12 at 7:49 A.M., 10:47 A.M. and 4:30 P.M.;
-March 13 at 7:16 A.M., 12:00 P.M. and 4:00 P.M.;
-March 14 at 7:15 A.M. and 11:10 A.M.;
-March 15 at 7:30 A.M. and 4:03 P.M.;
-March 16 at 7:18 A.M. and 10:44 A.M.;
-March 17 at 7:35 A.M., 10:51 A.M. and 3:41 P.M.;
-March 18 at 7:29 A.M., 11:05 A.M. and 3:44 P.M.;
-March 19 at 6:36 A.M., 10:35 A.M. and 3:42 P.M.;
-March 20 at 7:50 A.M., 11:09 AM. and 3:55 P.M.;
-March 21 at 7:09 A.M. and 10:54 A.M.

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F 658	Continued From page 2 Observation on 03/20/25 at 10:55 A.M., showed Licensed Practical Nurse (LPN) A administered three units of insulin for a blood sugar of 192 milligrams/deciliter (mg/dL) after he/she referenced a handwritten sliding scale note from the medication's box. Observation showed the LPN did not use the eMAR to verify the correct insulin dosage. The dosage was selected from the sliding scale table showing an insulin dose for specific blood sugar ranges. 3. Review of Resident #18's Quarterly MDS, dated 02/20/25, showed staff assessed the resident as cognitively intact with a diagnosis of diabetes mellitus. Review of the resident's POS , dated 10/16/24, showed an order to administer Insulin Aspart 100 Units/ml by sliding scale every A.M., Afternoon, P.M., and at bedtime. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered on: -March 8 at 7:02 A.M., 10:42 A.M. and 3:41 P.M.; -March 9 at 7:37 A.M., 10:48 A.M., 3:47 P.M. and 9:00 P.M.; -March 10 at 7:35 A.M., 10:57 A.M. 3 :45 P.M. and 8:38 P.M.; -March 11 at 7:27 A.M., 11:01 A.M., 3:55 P.M. and 9:30 P.M.; -March 12 at 7:38 A.M., 11:33 A.M., 4:30 P.M. and 8:22 P.M.; -March 13 at 11:30 A.M., 4:00 P.M. and 9:07 P.M.; -March 14 at 7:15 A.M., 11:00 A.M., 3:16 P.M.	F 658		

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F 658	Continued From page 3 and 9:00 P.M.; -March 15 at 8:18 A.M., 10:46 A.M., 4:00 P.M. and 9:00 P.M.; -March 16 at 11:00, 3:44 P.M. and 7:18 P.M.; -March 17 at 11:00 A.M., 15:49 P.M. and 7:46 P.M.; -March 18 at 11:00 A.M., 3:43 P.M. and 8:45 P.M.; -March 19 at 6:47 A.M., 10:39 A.M., 3:41 P.M. and 8:31P.M.; -March 20 at 7:45 A.M., 11:09 AM. and 3:52 P.M. and 8:00 P.M.; -March 21 at 7:04 A.M. and 10:34 A.M. Observation on 03/20/25 at 10:40 A.M., showed LPN A administered five units of insulin after he/she referenced a handwritten sliding scale note from the medication's box. Observation showed the LPN did not use the eMAR to verify the correct insulin dosage. The dosage was selected from the sliding scale table showing an insulin dose for specific blood sugar ranges. 4. Review of Resident #20's Quarterly MDS, dated 2/5/25, showed staff assessed the resident as cognitively intact with a diagnosis of diabetes mellitus. Review of the resident's POS, dated 11/14/24, showed an order to administer Insulin Aspart 100 units/ml twice a day at breakfast and midday by sliding scale. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered: -March 8 at 7:05 A.M. and 10:47 A.M.;	F 658		

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F 658	Continued From page 4 -March 9 at 7:38 A.M. and 10:23 A.M.; -March 10 at 7:36 A.M. and 12:52 P.M.; -March 11 at 7:29 A.M. and 11:07 A.M.; -March 12 at 8:45 A.M.; -March 13 at 7:15 A.M. and 12:00 P.M.; -March 14 at 7:18 A.M. and 11:05 A.M.; -March 15 at 7:30 A.M. and 10:47 A.M.; -March 16 at 6:43 A.M. and 11:00 A.M.; -March 17 at 7:37 A.M. and 11:08 A.M.; -March 18 at 7:27 A.M. and 11:00 A.M.; -March 19 at 6:42 A.M. and 10:33 A.M.; -March 20 at 8:00 A.M. and 11:08 A.M.; -March 21 at 7:11 A.M. and 10:38 A.M. Observation on 03/20/25 at 10:48 A.M,. showed LPN A administered five units of insulin after he/she referenced a handwritten sliding scale from the medication's box. Observation showed the LPN did not use the eMAR to verify the correct insulin dosage. The dosage was selected from the sliding scale table showing an insulin dose for specific blood sugar ranges. 5. During an interview on 03/20/25 at 10:40 A.M., LPN A said he/she does not use the eMAR when administering insulin because he/she knows what everyone gets and it is easier. The LPN said there is a cheat sheet in the medication box and he/she would check the computer if he/she has any questions. The LPN said he/she documents in the eMAR after he/she administers everyone's insulin. 6. Review of Resident #24's Quarterly MDS, dated 02/5/25, showed staff assessed the resident as severely cognitively impaired and diagnosis of diabetes mellitus. Review of the resident's POS, dated 08/13/24,	F 658		

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F 658	Continued From page 5 showed an order to administer Lispro Insulin 100 units/ml per sliding scale three times a day at midday, afternoon and at bedtime. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered for: -March 8 at 10:49 A.M.; -March 9 at 10:50 A.M., 3:47 P.M. and 7:13 P.M.; -March 10 at 10:45 A.M. and 8:49 P.M.; -March 11 at 10:50 A.M.; -March 12 at 2:44 P.M.; -March 13 at 3:55 P.M.; -March 14 at 10:44 A.M., 3:18 P.M. and 8:49 P.M.; -March 15 at 10:57 A.M., 3:43 P.M. and 8:46 P.M.; -March 16 at 10:53 A.M., 3:36 P.M. and 8:35 P.M.; -March 17 at 11:04 A.M., 3:31 P.M. and 8:01 P.M.; -March 18 at 10:42 A.M.; -March 19 at 10:53 A.M., 3:37 P.M. and 7:25 P.M.; -March 20 at 11:10 A.M. and 3:49 P.M.; -March 21 at 10:45 A.M. Observation on 03/20/25 at 11:17 A.M., showed, showed RN B used the eMAR to administered 15 units of Lispro Insulin for a blood sugar of 302 mg/dL. Observation showed the RN did not document the administration in the eMAR. 7. Review of Resident #30's Quarterly MDS, dated 2/5/25, showed staff assessed the resident as cognitively intact and with a diagnosis diabetes mellitus.	F 658		

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F 658	Continued From page 6 Review of the resident's POS, dated 08/13/24, showed an order to administer Insulin Aspart 100 units/ml per sliding scale three times a day in the morning, midday and evening. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered for: -March 8 at 10:30 A.M. and 3:45 P.M.; -March 9 at 7:14 A.M. and 3:49 P.M.; -March 10 at 7:29 A.M., 10:46 A.M. and 3:38 P.M.; -March 11 at 7:07 A.M., 10:53 A.M. and 4:04 P.M.; -March 12 at 8:06 A.M., 10:45 A.M. and 3:35 P.M.; -March 13 at 11:27 A.M. and 4:00 P.M.; -March 14 at 10:48 A.M. and 3:21 P.M.; -March 15 at 11:00 A.M. and 3:44 P.M.; -March 16 at 11:04 A.M. and 3:38 P.M.; -March 17 at 7:19 A.M., 11:06 A.M. and 3:41 P.M.; -March 18 at 7:15 A.M., 10:46 A.M. and 3:42 P.M.; -March 19 at 6:43 A.M., 10:35 A.M. and 3:47 P.M.; -March 20 at 7:11 A.M., 11:10 A.M. and 4:01 P.M.; -March 21 at 7:15 A.M. Observation on 03/20/25 at 11:20 A.M., showed RN B used the eMAR to administer five units of Lispro Insulin for a blood sugar of 235 mg/dL. Observation showed the RN did not document the dose administered in the eMAR.	F 658		

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F 658	Continued From page 7 8. During an interview on 03/20/25 at 11:26 A.M., RN B said he/she doesn't usually watch medication administration but did notice today that LPN A did not have a computer with him/her while administering insulin so he/she took one to him/her. RN B said the eMAR should always be used to check orders and document the dosages administered. He/She said staff should not administer medication from memory. RN B said most residents have an insulin cheat sheet inside the medication box but he/she does not use it. RN B said he/she does not know how others do it. During an interview on 03/20/25 at 11:56 A.M., the Assistant Director of Nursing (ADON) said staff should not administer medications without first verifying the medication and dosage with the eMAR. The ADON said if staff does this it puts the residents at risk for medication errors. The ADON said staff do not document the units of insulin administered for residents who receive insulin via sliding scale because the doses are listed in the eMAR instructions by the blood sugar ranges. The ADON said he/she did not know the eMAR had a designated field to document the administered dose. During an interview on 3/20/25 at 12:00 P.M., the administrator said he/she expects staff to follow the facility policy for medication administration. He/She said he/she did not know staff did not document the units of insulin administered for resident who received it via sliding scale. He/She said he/she did not the eMAR had a designated field to document the administered dose. He/She said now that he/she knows, staff will be expected to complete this.	F 658		

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F 658	Continued From page 8 8. Review of the Merck Pharmaceutical Manual, Professional Version, online, undated, showed ER Potassium chloride tablets should be swallowed whole; do not crush or chew or allow to dissolve in the mouth. For patients with difficulty swallowing, the tablets may be broken in half and each half taken separately with a glass of water. These formulations can be made into an aqueous solution by placing the whole dose in a glass or cup containing 120 ml of water. Allow two minutes for tablets to dissolve and then stir for approximately 30 seconds. Swirl the suspension and drink immediately. To ensure administration of the entire dose, add 30 ml of water to the glass or cup, swirl, and consume immediately; repeat with a final 30 ml water. 9. Review of Resident #8's Admission MDS, dated 3/13/25, showed staff assessed the resident as severely cognitively impaired and received a mechanically altered diet. Review of the resident's care plan, dated 03/18/25, showed staff identified the resident received a mechanically altered diet. Review of the resident's POS, dated March 2025, showed an order to administer one 20 milliequivalents (mEq) tablet of extended release potassium chloride by mouth three times daily. Observation on 03/18/25 at 11:40 A.M., showed LPN C crushed a 20 mEq tablet of extended release potassium chloride, added it to applesauce, and administered it to the resident. During an interview on 03/18/25 at 11:45 A.M., LPN C said he/she believed it is okay to crush the potassium chloride tablet for this resident. The	F 658		

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F 658	Continued From page 9 LPN said he/she did not know if the pharmacy or resident's physician had been consulted. During an interview on 03/20/25 at 11:56 A.M., the ADON said extended release potassium chloride should not be crushed. If a resident can not swallow the pill, the pharmacy should be notified that liquid is needed, or it should be dissolved in water. The ADON said the pharmacy can send a liquid version, but he/she did not know if the pharmacy had been contacted. During an interview on 03/21/25 at 2:40 P.M., the DON said staff should not crush extended release potassium chloride. The DON said he/she did not know staff were crushing the medication and administering it that way to the resident. 10. Review of the facility's policy titled "Oxygen Administration" , revised 07/22/24, showed: -Oxygen is administered under orders of a physician, except in the case of an emergency; -The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: -The type of oxygen delivery system; -When to administer, such as continuous or intermittent and /or when to discontinue; -Equipment setting for the prescribed flow rates; -Monitoring for complications associated with the use of oxygen. 11. Review of Resident # 63's Admission MDS, dated 2/13/25, showed staff assessed the resident as cognitively intact and did not require oxygen.	F 658		

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F 658	Continued From page 10 Review of the resident's care plan, reviewed on 3/21/25, showed it did not address oxygen use for the resident. Review of resident's POS, dated 3/20/25, showed it did not contain an order for oxygen. Observation on 03/18/25 at 2:02 P.M., showed the resident in his/her room with oxygen on at three liters per minute. Observation on 03/20/25 09:37 A.M., showed a concentrator in the room with bagged tubing. Observation on 03/21/25 at 1:08 P.M., showed the resident with an oxygen concentrator in his/her room with oxygen tubing hung on the wall. During an interview on 03/18/25 at 2:05 P.M., the resident said he/she used the oxygen when needed. During an interview on 03/21/25 at 2:14 P.M., the administrator said if the resident does not have an order for a current treatment staff should contact the DON and physician. During an interview on 03/21/25 at 2:25 P.M., LPN C said all residents who use oxygen should have an order, even if it is as needed. LPN C said he/she did not know the resident did not have an order for oxygen. During an interview on 03/21/25 at 2:40 P.M., the DON said all residents who use oxygen should have an order. The DON said he/she did not know the resident did not have an order for oxygen.	F 658		

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Missouri Department of Health and Senior Services

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	05738	A. BUILDING: _____ B. WING _____	03/21/2025

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II. Please Refer to F658.	A4055		
A6005	19 CSR 30-87.020(5) Toxic Material Storage Poisonous or toxic materials consist of the following categories: insecticides and rodenticides; disinfectants, sanitizer and related cleaning or drying agents; and caustics, acids, polishes and other chemicals. Each of these three (3) categories set forth shall be stored and physically located separate from each other. All poisonous or toxic materials shall be stored in locked cabinets or in a similar physically separate place used for no other purpose which is not accessible to residents. II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, facility staff failed to store toxic chemicals in a manner not accessible to residents. The facility census was 69. 1. Review of the facility's Chemical and Sharps Storage policy, dated 07/22/24, showed the policy directed staff to store all chemicals in locked cabinets or behind locked doors. Observation on 03/19/24 at 2:55 P.M., showed the door to the 200 hall shower room unlocked and the area unattended by staff. Observation	A6005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05738	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CARE CENTER	9503 HIGHWAY 100 NEW HAVEN, MO 63068

(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
A6005	Continued From page 1 showed a 19 ounce (oz.) aerosol can of quaternary ammonium based disinfectant spray stored inside an unlocked cabinet with the key to the cabinet inserted into the lock. Review of the disinfectant spray's label showed hazard warnings that the product could cause eye and skin irritation and was hazardous to humans. Observation showed residents near the area. Observation on 03/19/25 at 3:05 P.M., showed the door to the 300 hall shower room unlocked and the area unattended by staff. Observation showed a 32 oz. spray bottle of industrial strength tub and tile cleaner stored in an unlocked cabinet in the room with the doors to the cabinet open. Review of the cleaner's product label showed hazard warnings which included "DANGER", causes serious eye damage and harmful if swallowed. Observation showed a sign placed on the front of the cabinet which read "Make sure your cabinets are locked when you leave the shower room No razors, sharps containers, chemicals or bleach wipes out." Observation showed residents near in the area. Observation on 03/19/25 at 3:10 P.M., showed the door to the 300 hall nursing supply room unlocked, the area unattended by staff, and the key to the room hung on the wall at door knob height. Observation showed a one gallon bottle of quaternary ammonium based combination disinfectant, fungicide and virucide and a 32 oz. bottle of power cleaner and degreaser stored unsecured in the room. Review of the disinfectant bottle's product label showed hazard warnings which included "DANGER", hazardous to humans, corrosive, causes irreversible eye damage, and causes skin burns. Review of the cleaner bottle's product label showed a hazard warning that the product could cause serious eye	A6005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05738	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CARE CENTER	9503 HIGHWAY 100 NEW HAVEN, MO 63068

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A6005	Continued From page 2 damage. Observation showed residents near the area. During an interview on 03/20/25 at 11:45 A.M., the environmental services supervisor said chemicals should be stored locked up not accessible to residents and staff are trained on how to store chemicals. The environmental services supervisor said each department is responsible to ensure their chemicals are stored properly and if staff see a chemical unsecured they should lock it up right away. The environmental services supervisor said no one is assigned to routinely monitor the storage of chemicals and the facility had residents who would know how to operate a key in a lock and residents who were confused and wandered. During an interview on 03/20/25 at 11:55 A.M., the administrator said chemicals should be stored locked up not accessible to residents and staff are trained on how to store chemicals. The administrator said the environmental services supervisor is responsible for to monitor the storage of chemicals routinely. The administrator said facility had residents who would know how to operate a key in a lock and residents who were confused and wandered.	A6005		

PLAN OF CORRECTION

Provider/Supplier Name:	New Haven Care Center
Street Address, City, Zip:	9503 Highway 100 New Haven, MO 63068
Date of Survey:	3/21/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 658	It is the policy of the New Haven Care Center to ensure that all	4/23/25
	medication is administered appropriately to residents within the	
	time frame of each medication pass. All facility personnel	
	responsible for the administering of medication will be	
	in-serviced on the facility "Medication Administration Policy"	
	within two weeks. These personnel are to include DON,	
	MDS Coordinator, Social Services Designee, Medical Records,	
	and all other RN's, LPN's, and CMT responsible for medication	
	administration at New Haven Care Center. DON will audit	
	appropriate staff members weekly for one month to ensure	
	proper medication administration in accordance with the	
	"Medication Administration Policy". If no errors in medication	
	administration are noted DON will begin bi-weekly audits for one	
	month. If no errors in medication administration are noted, DON	
	will begin monthly audits for two months. The above mentioned	
	audits will consist of a skills check and a documentation audit. If	
	no issues are found during monthly audits, DON will move to	
	monthly charting audits for medication administration. F658	
	SOD will be reviewed quarterly at QAPI meetings, to ensure	
	progress is being made. The DON will continue monthly	
	charting audits to ensure no further issues arise. If further	
	issues arise, audits will be reinstated on a weekly basis, with	
	progression to bi-weekly, and then monthly audits when no	
	errors are discovered. Updates to EMR completed that include	
	requiring individuals responsible for administering medications	
	to input insulin dosages administered when charting.	
	It is the policy of the New Haven Care Center to ensure that	
	oxygen administration is performed appropriately with a	
	doctor's orders, except in cases of emergency per the	
	facilities "Oxygen Administration" policy. All staff	
	responsible for oxygen administration and the in-putting	
	of physician's orders will be in-serviced on the facilities	
	"Oxygen Administration" policy within two weeks. DON will	
	perform weekly chart audits for residents utilizing oxygen	
	for one month, progressing to bi-weekly checks for one	
	month if no issues are noted. Progress to monthly audits	

	for two months if no issues are noted. The DON will	
	continue monthly chart audits for individuals utilizing	
	oxygen and if issues are found, reinstate weekly audits	
	with progression to bi-weekly, the monthly audits with	
	improvement.	
	This POC will continue indefinitely as determined by the	
	QAPI committee and reviewed at each meeting for effectiveness	
	and maintained compliance.	
	All residents of the facility had the potential to be impacted by	
	this alleged deficient practice.	

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:	New Haven Care Center
Street Address, City, Zip:	9503 Highway 100 New Haven, MO 63068
Date of Survey:	3/21/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4055	Refer to F658	4/23/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	New Haven Care Center
Street Address, City, Zip:	9503 Highway 100, New Haven MO 63068
Date of Survey:	3/21/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A6005	It is the policy of the New Haven Care Center to ensure the	4/23/25
	safe and proper storage of chemicals, toxic, and or poisonous	
	materials in areas not accessible to residents. All staff will be	
	in-serviced on the "Chemical and Sharps Storage Policy" within	
	two weeks. Weekly chemical storage room audits will be	
	conducted by the Administrator for one month. These audits	
	will include review of chemical storage rooms such as nursing	
	supplies, dietary storage, housekeeping carts, supply carts, and	
	housekeeping supply area. If no issues are presented during	
	weekly audits, the Administrator will audit chemical storage	
	areas bi-weekly for one month. If no issues arise from the	
	bi-weekly audits, audits will be moved to every month for two	
	months. Tag A6005 will be discussed and monitored by the	
	QAPI committee quarterly to ensure progress is being made.	
	If progress is made the QAPI committee will then determine	
	whether continued monitoring by the Administrator is	
	appropriate or if Environmental Services, Dietary, and Nursing	
	Departments should be responsible for their chemical storage	
	areas. If issue present at any time during monthly audits, or	
	in discussions during QAPI meetings, weekly audits will be	
	reinstated, with progression towards bi-weekly, then monthly	
	audits with decreased instances of improper storage of	
	chemicals.	
	The facility will also place self-locking doors on all chemical	
	storage rooms to ensure these rooms remain locked except	
	when in use. Key for all self-locking doors will be placed in	
	metallic key boxes on metal door frames.	
	All residents of the facility had the potential to be impacted by	
	this alleged deficient practice.	

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