STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	1910 NURSING HOME ROAD, OWENSVILLE, MO 65066

(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 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide an ongoing program of activities designed to meet the residents' interest on the weekends for two residents (#3 and #54) out of two sampled residents. The facility census was 61. 1. Review of the facilities policy titled, "Resident acitvity policy", undated, states activities refer to an endeavor, other than routine Activities of Daily Living (ADLs) in which a resident participates that is intended to enhance his/her sense of well-being and to promote physical, cognitive, emotional health. The certified Activity Director (AD) completes an Activity Assessment within 72 hours of resident admission in order to implement an effective daily activity program meeting their physical, cognitive social, spiritual, educational, and recreational needs with options essential for preserving and enhancing resident's sense of well-being. 2. Review of the facilities Activity Calander, dated May 2024, showed:	F 679		

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

Crystal M Bag | Administrator | 6-12-2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 679	Continued From page 1 -Saturday, 05/04/2024, library, music room, pool table, streaming service in the activity oom and use gaming console; -Sunday, 05/05/2024, did not contain acitvities; -Saturday, 05/11/2024, library, music room, pool table, streaming service in the activity oom and use gaming console; -Sunday, 05/12/2024, National Nursing Home Week Radiant Memories- A Tribute to the Golden Ages of Radio; -Saturday, 05/18/2024, library, music room, pool table, streaming service in the activity oom and use gaming console; -Sunday, 05/19/2024, did not contain acitvities; -Saturday, 05/25/2024, library, music room, pool table, streaming service in the activity oom and use gaming console; -Sunday, 05/26/2024, did not contain acitvities. 3. During an interview on 05/29/24 at 3:39 P.M., Resident #3 said the facility does not have activities on the weekends. The resident said he/she would participate in activities on the weekends if they were offered. During an interview on 05/29/24 at 2:29 P.M., Resident #54 said the facility does not offer activities on Saturday and Sunday. The resident said he/she would attend activities on Saturday and Sunday if they were offered. During an interview on 05/30/24 at 3:45 P.M., Certified Medication Technician (CMT) D said he/she works every other weekend. The CMT said activities are not offered regularly on the weekends. The CMT said when nursing staff have time they will provide activities on their hall. The CMT said there are not scheduled activities	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 679	Continued From page 2 on the weekends. During an interview on 05/30/24 at 3:55 P.M., Regisitered Nurse (RN) E said he/she works some weekends. The RN said he/she thinks there is church every now and then on Sundays but there are no scheduled activities on the weekends. During an interview on 05/30/24 at 4:02 P.M., Acounts Payable/Receptionist said he/she also assists with acitvities. He/She does not work weekends and rarely does the weekend have scheduled activities. He/She said the activities on the weekends are what the residents choose to do on their own. During an interview on 05/31/24 at 3:27 P.M., the Director of Nursing (DON) said weekend activities are resident choice, there are no scheduled activities. The DON said residents can do things such as color, play the gamin console, watch movies, play board games, or do puzzles. The DON said the nursing staff should be offering activities on the weekend. The DON said he/she is aware activities are not always getting done on the weekends, it is only being done when staff have the time. During an interview on 05/30/24 at 4:15 P.M., the administrator said activities are offered on the weekends by the nursing staff and usually involve going outside, games, or independent activities. The administrator said there is not a way for the residents to know what activities are offered on the weekend because they are not listed on the schedule.	F 679		
F 732 SS=C	Posted Nurse Staffing Information	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 732	Continued From page 3 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 732	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to post the required nurse staffing information in an easily accessible place for residents and visitors, and failed to include the required data in the posting. The facility census was 61. 1. Review of the facility's policy titled, "Posted Nursing Data", dated 10/23/23, showed per state and federal guidelines, it is the policy of the facility that the day charge nurse post the following data on a daily basis located at the skilled nurses station area: Facility name, current date, census, number of Registered Nurses (RN), Licensed Piratical Nurses (LPN), and Certified Nurse Aides (CNA). Observation on 05/30/24 at 2:00 P.M., showed the nurse staff posting at the nurse's desk behind a locked door, not easily accessible to residents and visitors. Review showed the nurse posting did not contain the facility name, resident census, or the total hours worked for direct care nursing staff. Observation on 05/31/24 at 9:49 A.M., showed the nurse staff posting at the nurse's desk behind a locked door, not easily accessible to residents and visitors. Review showed the nurse posting did not contain the facility name, resident census, or the total hours worked for direct care nursing staff. During an interview on 05/31/24 at 10:49 A.M., RN B said the nurse staff posting is located behind the nurses desk. RN B said the night shift nurse fills the form out and it is always done when	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 732	Continued From page 5 he/she arrives at the facility. RN B said there is no other staff posting in the building, and it is not accessible to residents and visitors when locked behind the nurses desk. The RN did not know what should be listed on the form. During an interview on 05/31/24 at 3:31 P.M., the Director of Nursing (DON) said the night shift charge nurse is responsible for filling out the nurse staff posting form. The DON said the form changed, and it did not include the required information. The DON said the form was moved behind the nurses station when the staffs first and last name was added. The DON said the form should be filled out per regulation. The DON said the form is not kept in an accessible area for residents and visitors. During an interview on 05/31/24 4:17 P.M., the administrator and assistant administrator said the nurse staff posting should include the date, facility name, census, the number of LPN's, RN's, CNA's and the total hours worked. The Administrator said there is a dry erase board outside the nurses station for it to be posted on. The posting should be accessible to visitors and family and should be filled out per the regulation.	F 732		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 759	Continued From page 6 Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than 5% out of 25 opportunities observed, two errors occurred, resulting in a 8% error rate, which affected one resident (Residents #2) of 11 sampled residents. The facility census was 61. 1. Review of the facility's, "Insulin Administration Policy", not dated, showed if using an insulin pen, prime needle with two units prior to dialing to the amount of insulin. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/09/24, showed staff documented the resident diagnosis of Diabetes and received insulin injections seven days of the seven days in the look back period. Review of the resident's Physician Order Sheet (POS), dated 05/01/24, showed Humalog Kwik Pen (Insulin Lispro) 100 Units/milliliter (ml) per sliding scale three times a day. Review of the resident's Medication Administration Record (MAR), dated 05/01/24, showed staff documented the following medication administrations: -05/30/24, five units before lunch; -05/31/24, five units before breakfast. Observation on 05/30/24 at 11:37 A.M., showed Certified Medication Technician (CMT) C dialed the resident's Humalog Kwik Pen to five units and administered the insulin to the resident. The CMT did not prime the insulin pen prior to administration.	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 759	Continued From page 7 Observation on 05/31/24 at 8:44 A.M., showed CMT A dialed the resident's Humalog Kwik Pen to five units and administered the insulin to the resident. The CMT did not prime the insulin pen prior to administration. During an interview on 05/31/24 at 11:44 A.M., CMT A said he/she should have primed the the insulin pen, that was his/her mistake. The CMT said he/she knows to prime the insulin pen, he/she just missed it. During an interview on 05/31/24 at 2:48 P.M., The Director of Nursing (DON) said staff should prime the insulin pen, he/she thinks two units. The DON said staff prime the needle to remove air. The DON said if staff did not prime the insulin pen, then the resident would not get the correct amount of insulin.	F 759		
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.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 812	Continued From page 8 §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 and interview, the facility staff failed to maintain the mechanical dishwasher in good repair to ensure dishes were effectively washed and sanitized to prevent cross-contamination. This failure has the potential to affect all residents. The facility census was 61. 1. Observation on 05/28/24 at 10:35 A.M., showed the Certified Dietary Manager (CDM) washed a rack of soiled cups in the chemical sanitizing mechanical dishwasher.Observation showed the CDM did not check the temperature of the dishwasher during the cycle. Observation showed the gauge of the dishwasher registered the water temperature during the wash cycle as 110 degrees Fahrenheit (dF) and the water temperature of the rinse cycle registered 112 dF. Observation showed when the dishwasher cycle finished, the CDM removed the rack of cups to the clean side of the station to dry and then loaded another rack of soiled dishes into the machine to wash. Observation showed the gauge of the dishwasher registered the temperature during the wash cycle as 110 dF and the rinse cycle as 112 dF. Observation of the manufacturer's instruction label on the dishwasher showed direction for the minimum water temperature to be 120 dF. During an interview on 05/28/24 at 10:37 A.M., the CDM said the temperature of the dishwasher should be at least 120 dF for the wash and rinse cycles and he/she did not know the machine did	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 812	Continued From page 9 not reach 120 dF during the two cycles of dishes he/she washed in the machine. Observation on 05/29/24 at 7:20 A.M., showed dietary staff loaded a soiled sheet pan into the mechanical dishwasher, started the machine and walked away. Observation showed the dietary staff did not check the temperature of the water during the wash and rinse cycles of the machine. Observation showed the gauge on the dishwasher registered the water temperature of the wash cycle as 112 dF and the water temperature of the rinse cycle as 116 dF. Observations during a second run of the dishwasher, showed when tested with a calibrated metal stem-type thermometer, the water temperature of the wash cycle measured 112 dF and the gauge on the dishwasher registered the water temperature as 112 dF. Observation showed when tested with a calibrated metal stem-type thermometer, the water temperature of the subsequent rinse cycle measured 116 dF and the gauge on the dishwasher registered the water temperature as 116 dF. Observation showed the dietary staff returned to the kitchen, removed the sheet pan from the dishwasher and placed it on the clean side of the station to dry. Observation on 05/30/24 at 8:39 A.M., showed Cook F washed the soiled food processor in the mechanical dishwasher twice. Observations during a second run of the dishwasher, showed when tested with a calibrated metal stem-type thermometer, the water temperature of the wash cycle measured 112 dF and the gauge on the dishwasher registered the water temperature as 112 dF. Observation showed when tested with a calibrated metal stem-type thermometer, the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 812	Continued From page 10	F 812		

water temperature of the subsequent rinse cycle measured 117 dF and the gauge on the dishwasher registered the water temperature as 117 dF. Observations showed the cook checked the water temperatures during the wash and rinse cycles of the machine when they measured less than 120 dF. Observation showed, when the dishwasher cycle finished, the cook removed the food processor from the machine to dry.

During an interview on 05/30/24 at 8:40 A.M., Cook F said staff are supposed to check the water temperature first thing in the morning on the machine and the water temperature should be at least 120 dF. The cook said the water is always the hottest in the morning and it loses temperature throughout the day.

Observation on 05/30/24 at 8:42 A.M., showed Cook F used the food processor to prepare pureed waffles for service to a resident at breakfast.

During an interview on 05/30/24 at 8:53 A.M., the Cook F said if the dishwasher is not reaching the proper temperature then staff should not use it and wash the dishes another way. The cook said he/she knew the water temperature of the dishwasher did not reach 120 dF when he/she washed the food processor and he/she went ahead and used it anyway because he/she needed to get the pureed waffles out for breakfast.

During an interview on 05/31/24 at 9:15 A.M., the CDM said the cooks are responsible to monitor the dishwasher water temperature on both shifts and the temperature should be at least 120 dF. The CDM said the water temperature of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265546	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	**1910 NURSING HOME ROAD, OWENSVILLE, MO 65066**

(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 812	Continued From page 11 dishwasher is not very hot first thing in the morning or after it sits for a while until it is used a few times and staff should check the temperature to make sure the machine is working appropriately before they use it to wash dishes. The CDM said if the dishwasher is not working correctly, staff should not use it and report the issue to him/her or the production manager for correction. The CDM said the facility did not have a policy for use and maintenance of the mechanical dishwasher, but staff are trained on proper use of the dishwasher upon hire. During an interview on 05/31/24 at 9:25 A.M., the administrator said the CDM and staff are responsible to monitor the condition of the dishwasher and check the water temperature of the machine before they use it to wash dishes to make sure it is right and they may need to run it a couple of times to get the temperature up properly. The administrator said the water temperature of the dishwasher should be close to 120 dF and staff have been trained on this requirement. The administrator said if staff have ran the dishwasher a few times and the water temperature is still not correct, then they should not use it and report it to the CDM or maintenance staff for repairs.	F 812		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02804	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	1910 NURSING HOME ROAD, OWENSVILLE, MO 65066

(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
A4033	19 CSR 30-85.042(29) Employee Hours Documented Facilities shall maintain written documentation on the premises showing actual hours worked by each employee. III This regulation is not met as evidenced by: Refer to F732. Class III.	A4033	Refer to POC F732	6/5/24
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 F759	A4055	Refer to POC F759	6/5/24
A4101	19 CSR 30-85.042(92) Activity Program The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities, and activities outside the facility as appropriate to his/her needs and interests. II/III	A4101		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02804	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	1910 NURSING HOME ROAD, OWENSVILLE, MO 65066

(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
A4101	Continued From page 1 This regulation is not met as evidenced by: Refer to F679. Class III.	A4101	Refer to POC F679	6/1/24
A7083	19 CSR 30-87.030(81) Machine Chemical Sanitization, PPM Measured Machines (single-tank, stationary-rack, door-type machines and spray-type glass washes) using chemicals for sanitization may be used provided that-the temperature of the wash water is not less than one hundred twenty degrees Fahrenheit (120°F), the wash water is kept clean, chemicals added for sanitization purposes are automatically dispensed; utensils and equipment are exposed to the final chemical sanitizing rinse in accordance with manufacturers ' specifications for time and concentration, the chemical sanitizing rinse water temperature is not less than seventy-five degrees Fahrenheit (75°F) nor less than the temperature specified by the machine ' s manufacturer; chemical sanitizers used shall meet the requirements of 21 CFR 178.1010 (Revised 2005), Food and Drug Code of the United States Food and Drug Administration, Department of Health and Human Services and a test kit or other device that accurately measures the parts per million concentration of the solution is available and is used. II/III This regulation is not met as evidenced by: Class III Please refe to F812	A7083	Refer to POC F812	6/4/24 6/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02804	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASCONADE MANOR NURSING HOME	1910 NURSING HOME ROAD, OWENSVILLE, MO 65066

(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
A4101	Continued From page 1 This regulation is not met as evidenced by: Refer to F679. Class III.	A4101		
A7083	19 CSR 30-87.030(81) Machine Chemical Sanitization, PPM Measured Machines (single-tank, stationary-rack, door-type machines and spray-type glass washes) using chemicals for sanitization may be used provided that-the temperature of the wash water is not less than one hundred twenty degrees Fahrenheit (120°F), the wash water is kept clean, chemicals added for sanitization purposes are automatically dispensed; utensils and equipment are exposed to the final chemical sanitizing rinse in accordance with manufacturers ' specifications for time and concentration, the chemical sanitizing rinse water temperature is not less than seventy-five degrees Fahrenheit (75°F) nor less than the temperature specified by the machine ' s manufacturer; chemical sanitizers used shall meet the requirements of 21 CFR 178.1010 (Revised 2005), Food and Drug Code of the United States Food and Drug Administration, Department of Health and Human Services and a test kit or other device that accurately measures the parts per million concentration of the solution is available and is used. II/III This regulation is not met as evidenced by: Class III Please refe to F812	A7083		

PLAN OF CORRECTION

Provider/Supplier Name:	Gasconade Manor Nursing Home District
Street Address, City, Zip:	1910 Nursing Home Rd. PO Box 520 Owensville, MO 65066
Date of Survey:	May 28-31, 2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F679	In accordance with F679 facility must provide activities 7 days per week based on the comprehensive assessment and care plan of resident preferences provided by Certified Activity Director.	6/1/24
	Effective June 1, 2024 Activity Director initiated new June activity calendar to include scheduled weekend group activities of resident choice throughout each month yearly provided by a designated staff member. The new June activity calendar was dispersed to all residents and family members. Activ ity Director will provide copy of monthly activity calendar to Administrator each month for review assuring activities are provided 7 days per week.	6/1/24
	See attached June Activity Calendar	
	See attached July Activity Calendar which was revised per request. Sunday Schedule Activity added.	7/1/24

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:	Gasconade Manor Nursing Home
Street Address, City, Zip:	1910 Nursing Home Rd. PO Box 520 Owensville, MO 65066
Date of Survey:	May 28-31, 2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F732	Per State and Federal Nurse Staffing Information and Posting Requirements, Director of Nursing updated Policy and Procedure for Daily Posted Nursing Data, in-serviced charge nurses, and created daily staffing census sheet. See Attached Policy and Procedure, Daily Staffing/Census Sheet, and in-service.	6/5/2024
	Daily Posted Nursing Data is located by skilled nurses' station and rehab nurses' station where it is accessible to residents and visitors.	6/5/2024

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:	Gasconade Manor Nursing Home
Street Address, City, Zip:	1910 Nursing Home Road PO Box 520 Owensville, MO 65066
Date of Survey:	May 28-31, 2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F759	In accordance with State and Federal regulations, facility must ensure Medication error rates of less than 5%.	6/5/2024
	Director of Nursing in-serviced all CMTs on proper procedural steps when administering insulin to include step by step instructions for preparing insulin pen. Charge Nurse will observe CMTs each shift when administering insulin per proper procedures ensuring insulin pen is primed prior to administration. Residents will be selected at random. All medication errors will be reported to the Director of Nursing who will provide further education as needed.	6/5/2024
	See attached in-service and procedural steps to give insulin along with step by step instruction for preparing your insulin pen.	

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:	Gasconade Manor Nursing Home District
Street Address, City, Zip:	1910 Nursing Home Road PO Box 520 Owensville, MO 65066
Date of Survey:	May 28-31, 2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F812	In accordance with State and Federal Regulations to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, CDM and RD in-serviced all dietary personnel regarding Dish Machine Operating Procedures. See attached	6/4/2024
	Dishwasher personnel will record dish machine temperatures twice daily (am and pm) prior to washing on the temp log located in each dishwashing area. See attached Dish Temp Log. CDM will routinely inspect dish room area ensuring temp logs are completed. If critical control point of 120 F or higher is not met, dish service must be stopped and CDM must be informed of non-compliance. CDM will contact Maintenance Supervisor to repair ensuring critical control point is maintained. Dish service will then be resumed once control point has been re-established and dish temperature is meeting 120 F or higher. In the event control points of 120 F or higher are not being met, dish service will be resumed in other dishwashing area located in another kitchen.	6/4/2024
	Graves Menu Maker Foods inspected main kitchen dish machine replacing temperature gauge P/N099-1001. See attached	6/3/2024