STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265835	A. BUILDING _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN NURSING & REHAB	3405 WEST MT VERNON SPRINGFIELD, MO 65802

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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- (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	F 645		

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

Administrator

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 645	Continued From page 1 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 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 complete the required Preadmission Screening and Resident Review (PASARR - a two-level tool used to screen each resident in a nursing facility for a mental disorder or intellectual disability prior to admission) for one resident (Resident #5), prior to or upon admission to the facility, to ensure the resident received appropriate care and services, out of a selected sample of three residents. The facility census	F 645		

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F 645	Continued From page 2 was 75. Review showed the facility did not provide a policy or procedure addressing completion of PASARR forms. 1. Review of Resident #5's face sheet showed the following information: -Admission date of 06/04/10; -Diagnoses included paranoid schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 11/18/24, showed the following: -Cognitively intact; -Resident was taking antipsychotic medication on a routine basis. Review of the resident's care plan, last reviewed 11/18/24, showed the following: -Resident had delusions (fixed, false beliefs that persist despite clear evidence to the contrary); -Staff should redirect resident; -Staff should administer medication per physician orders; -Staff will be aware that a delusion is an actual "reality" to the resident; -Staff will not argue with the resident about the delusion; -Staff will attempt to distract resident from the delusion,	F 645		

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F 645	Continued From page 3 Review of the resident's medical record showed no documentation of a PASARR available. During an interview on 12/10/24, at 3:05 P.M., the Business Office Manager (BOM) said he/she was unable to locate a documention of the level one PASARR for the resident. During an interview on 12/13/24, at 9:10 A.M., the Social Services Director (SSD) said that he/she and the BOM were involved in completion of the forms for the level one and level two PASARR. They try to complete them within 48 hours of a resident admission. During an interview on 12/13/24, at 1:00 P.M., Administrator said that the resident's PASARR was done in 2007 before electronic records. Staff should check that residents have a DA 124 on admission if needed according to their diagnosis.	F 645		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident's choice of code status (resident's wish to receive cardiopulmonary resuscitation (CPR - an emergency procedure for a person whose heart has stopped or who is no longer breathing) or do not resuscitate (DNR - does not wish to receive	F 678		

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CPR)) was consistent throughout one resident's (Resident #55) medical records. The facility census was 75.

Review showed no facility policy provided.

1. Review of Resident #55's face sheet showed the following:

-Admission date of 05/11/23;
-Code status of DNR;
-Diagnoses included cerebral infarction (stroke - medical emergency that occurs when blood flow to the brain is interrupted), Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) without dyskinesia (uncontrolled, involuntary muscle movement), cognitive communication deficit, and Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) .

Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/17/24, showed moderate cognitive impairment.

Review of the resident's care plan, last reviewed 11/18/24, showed the following:

-Resident had chosen to be DNR;
-Staff should follow the resident's wishes;
-No CPR and do not call 911 call for cardiac arrest;
-Review quarterly and as needed to ensure residents wishes are as he/she chooses.

Review of the resident's Outside the Hospital Do

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Not Resuscitate (OHDNR - written order that authorizes emergency medical services to withhold (CPR) from a person in a non-hospital setting if they experience cardiac or respiratory arrest showed the resident signed the form on on 10/03/24 and the physician signed the order on 10/03/24.

Review of the resident's progress notes, showed the Social Service Director documented the following:

-On 10/03/24, at 2:36 P.M., the resident changed his/her code status from a full code (whish to received CPR) to a DNR status. The resident verbalized understanding of the difference between full code and DNR, including that resuscitation efforts will not be initiated in the event of cardiac arrest. This order has been updated in resident files and documented.

Review of the resident's current physician's order sheet showed an order, dated 05/11/23, for resident to be a full code.

During an interview on 12/12/24, at 12:00 P.M., Certified Nurse Aide (CNA) A said resident code status was located on each resident's door, either a red or green dot, and in the care plan. He/she said staff could also ask the nurse for code status. The code status should be the same in each area.

Observation on 12/12/24, at 1:00 P.M., showed the resident's the name tag on his/her door had a red dot.

During an interview on 12/13/24, at 9:10 A.M., MDS Coordinator & Social Service Director (SSD)

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said resident code status was located in the care plan and should be consistent throughout the chart. The SSD ensured that code status was consistent in chart and on the resident door. They would not expect the code status to be DNR on the door and in the care plan, but have an physician order noting full code.

During an interview on 12/13/24, on 10:05 A.M., Certified Medication Tech (CMT) B said code status was on the resident door and on the face sheet. It should be the same status in each area.

During an interview on 12/13/24, on 10:12 A.M., CMT C said code status was located on resident doors with colored dots. He/she did not know if there was a second location, but would expect the information to be the same if it was in nursing notes.

During an interview on 12/13/24, on 11:02 A.M., Licensed Practical Nurse (LPN) D said code status was located in the computer system and a colored dot system on resident doors. There was also an advance directive form in the chart. He/she expected the status would be consistent throughout chart.

During an interview on 12/13/24, at 11:16 A.M., LPN E said code status was located in the electronic medical record and on the resident door. He/she said it should be the same throughout the chart.

During an interview on 12/13/24, at 12:19 P.M., the Assistant Director of Nursing (ADON) said resident code status should be consistent throughout the chart.

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F 678	Continued From page 7 During an interview on 12/13/24, at 12:48 P.M., the Director of Nursing (DON) said code status was in the medical record on the face sheet and under advance directives tab. The physician orders should not say full code if the face sheet and advance directives show DNR. The information should be the same throughout chart. During an interview on 12/13/24, at 1:00 P.M., the Administrator said staff should follow policy and ensure accurate code status.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice when the facility failed to follow consistently document and physician orders and failed to routinely document of notification of the physician and assessments in an elbow wound for one resident (Resident #60), out of 17 sampled residents. The facility census was 75. Review of the facility's policy titled "Physician Orders," undated, showed the following	F 684		

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F 684	Continued From page 8 information: -Current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors; -Orders must be reviewed and renewed; -Treatment orders must specify what is to be done, location, and frequency and duration of the treatment. Review of the facility's policy titled "Resident Examination and Assessment," undated, showed the following information: -Examine and note the intactness, moisture, color, texture, and presence of bruises, pressure sores, redness, edema, and rashes of the resident's skin; -Document the following in the resident's chart date and time the assessment was performed; name and title of individuals who performed the assessment; assessment data obtained during the assessment; how the resident tolerated the assessment; if the resident refused and why; the signature and title of the person recording the data; and notify the supervisor if the resident were to refuse; -Notify the physician of any abnormalities such as wounds or rashes on the resident's skin, worsening pain as reported by the resident. 1. Review of the Resident #60's face sheet (brief look at resident information), showed the following information: -Admission date of 01/08/24; -Diagnoses included fusion of the spine, dislocation of other internal joint prosthesis, and anxiety.	F 684		

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Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/16/24, showed the following information:

-Cognitively intact;
-No skin conditions documented.

Review of the resident's care plan, last revised on 01/11/24, showed staff to observe for changes in skin condition during daily care and bath days and report.

Review of the resident's Comprehensive Shower Sheet, dated 11/05/24, showed the resident did not have any skin abnormality to the left elbow.

Review of the resident's Comprehensive Shower Sheet, dated 11/12/24, showed the resident had his/her elbow circled with the indication as "other."

Review of the resident's physician visit note, dated 11/12/24, showed the following:

-Resident had a history of osteomyelitis (inflammation of bone caused by infection) and methicillin-resistant staphylococcus aureus (MRSA - a type of staph bacteria that is resistant to many antibiotics).
-Olecranon bursitis (a condition characterized by swelling, redness, and pain) of the left elbow. The resident had an aspiration last week and swelling had returned. Physician reviewed labs from the week prior on the resident's phone. Culture and sensitivity was normal with no need for antibiotics at this time;
-Reported increased anxiety. Staff will get psych

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F 684	Continued From page 10 to visit the resident for adjustments. Review of the resident's nurse's note dated 11/14/24, at 8:47 A.M., showed the resident complained of pain in his/her right elbow. There was a small area that was leaking serosanguineous (a type of wound drainage that contains both blood and serum) fluid. Staff applied bandage and called on-call physician. Staff was waiting for a return phone call. Review of the resident's nurse's note dated 11/14/24, at 1:40 P.M., showed the nurse spoke with the physician's nurse practitioner, who said due to the resident's elbow increasing in blood loss, saturating two rolls of kerlix (a type of bandage), the resident was to be sent to the hospital. The resident left the building at 1:40 P.M. Review of the resident's medical record showed staff did not document when the resident returned to the facility nor any discharge instructions from his/her hospital visit. Review of the resident's comprehensive shower sheet, dated 11/15/24, showed the resident had his/her elbow circled with a note stating "pin-hole" and the indication as "other." Review of the resident's nurse's note dated 11/18/24, at 9:33 P.M., showed the resident had his/her left arm wrapped at around 5:30 P.M.. The resident asked the nurse to loosen the dressing. While loosing the dressing, the nurse observed red moisture on the kerlix under the ace wrap. Staff changed the kerlix. There was no bleeding observed at the time of the dressing change. Staff reapplied the ace wrap. Resident continued	F 684		

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F 684	Continued From page 11 to complain of pain. (Staff did not document notifying the resident's physician of the resident's complaints of pain or of the wound change.) Review of the resident's medical record from 11/19/24 through 11/23/24, showed staff did not document regarding the resident's left elbow wound. Review of the visiting wound clinic visit notes, dated 11/23/24, showed the following information: -The resident had a history of hardware in his/her left elbow following a severe fracture. To date he/she was unable to use the left arm. In the left joint was a large effusion (escape of fluid into the body cavity) and it was apparent that it had been a problem for a while; -The resident has seen his/her specialist for the elbow a few weeks ago and some fluid was aspirated. There was no evidence at that time of infection. Bleeding had since started after the aspiration; -The resident had been to two hospital emergency rooms and the suggestion was for the staff to hold pressure. On today's visit, it took 40 minutes of holding pressure to the area and expressing as much of the serosanguinous fluid as possible; -Measurements included 0.2 centimeters (cm) in length, and 0.3 cm in width; -New orders for treatment included cleanse with hypochlorous (a weak unstable acid that is a powerful disinfectant and antimicrobial agent) acid, apply calcium alginate (a wound dressing material that absorbs excess moisture and promotes healing) to the wound bed, cover with abdominal pad, cover with conforming gauze roll, and change dressing as needed for soiling.	F 684		

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F 684	Continued From page 12 Review of the resident's physician order sheet, dated 11/01/24 through 11/26/24, showed staff did not document any order for treatment of the resident's left elbow wound. Review of the resident's physician visit notes, dated 11/26/24, showed the following information: -Left wound had dehisced (gape or burst open) and was then lanced by the visiting wound clinic. The resident sent to the hospital due to the bleeding (which continued after pressure was applied), reinforcement of the wound was given, and warm compress. Anxiety present. -Resident previously positive for MRSA of another wound. Left arm continues with abscess and is still having some slight bleeding, would like to obtain a culture again if possible; -Obtain culture if possible and keep pressure dressing in place if drainage/bleeding continues. Review of the resident's nurses' notes, dated 11/26/24, showed the following information: -New orders received to increase Buspar (an anxiolytic drug used to treat anxiety) to 20 milligram (mg) three times a day, obtain culture of elbow if possible, and utilize pressure dressing to left elbow if bleeding continues. Review of the resident's physician order sheet, dated 11/01/24 through 12/13/24, showed staff did not document regarding the new wound treatment obtained during November. Review of the resident's medical record from 11/25/24 through 11/30/24, showed staff did not document assessment or treatment of the	F 684		

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F 684	Continued From page 13 resident's left elbow wound. Review of the visiting wound clinic's visit notes showed the following information: -The resident's left elbow wound drained "just as much as it ever has". The opening has gotten larger and there is now more than just serosanguinous drainage coming out. It is difficult to describe the tissue other than the elbow joint debris. There is one free floating bone portion that expressed out of the wound as well, which measured 1.2 cm by 3 cm. -After expressing as much of the contents of the joint effusion, the wound was covered with dressing. Recommend changing daily for this week. -The resident requested another wound culture, this time of his/her elbow drainage. Given the presence of bone shard, he/she did prepare a portion of the bone to send off to the lab for bacterial identification and sensitivity. Review of the resident's medical record, dated 11/30/24 through 12/02/24, showed staff did not document assessment or treatment regarding the resident's left elbow wound. Review of the resident's physician visit notes, dated 12/03/24, showed the following information: -The resident and staff were concerned regarding the swelling and drainage on the left elbow, now followed by swelling of the resident's wrist and hand; -The resident reports feelings of weakness, increased pain, and a decreased appetite; -Will get a wound culture. The resident reports his/her surgeon said he/she needs to be on	F 684		

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F 684	Continued From page 14 antibiotics. Review of the resident's physician order sheet showed staff did not document new orders were entered after the physician's visit on 12/03/24. Review of visiting wound clinic's visit notes, dated 12/06/24, showed the following information: -Wound culture results were back showing staphylococcus epidermis (common blood infection that can cause virulence (damage) once it invades the human body via prosthetic devices). The Assistant Director of Nursing (ADON) sending report to primary care provider; -The entrance of the left elbow wound continued to grow. The resident reported he/she had a similar issue in the past with osteomyelitis and his/her elbow and a replacement of the hardware; -This could best be described as a rejection or infection of the hardware in the elbow; -Measurements included 1.5 cm in length and 1.6 cm in width. Review of the residents' nurses notes, dated 12/06/24, showed the nurse practitioner from the visiting wound clinic was in the facility and new orders received. Review of the resident's physician order sheet showed staff did not enter no new orders until 12/09/24. The new order was to cleanse left elbow with pure and clean, pat dry, place calcium alginate to the wound bed, cut to fit, cover with dry dressing, and change dressing daily and as needed. Review of the resident's medical record on 12/09/24, at 12:07 P.M., showed no weekly skin	F 684		

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assessments entered by the nursing staff and showed no weekly wound monitoring of the resident's left elbow wound.

Observation on 12/09/24, at 10:38 A.M., showed Licensed Practical Nurse (LPN) F removed the resident's dressing to the left elbow. As soon as LPN F removed the dressing, red and yellow drainage came pouring out of the wound. LPN attempted to stop the drainage with pressure and several pieces of gauze. The resident began weeping and questioning the state of his/her wound. At 11:02 A.M., the drainage continued, and LPN F went ahead and applied the ordered treatment. LPN F told the resident he/she would be getting into contact with the resident's physician regarding the amount of drainage.

During an interview on 12/09/24, at 1:44 P.M., the resident said the following:

-He/she had concerns regarding a wound to his/her left elbow. Staff have been notified of this wound, but he/she does not believe them when they say they will do something about it. The wound has been there a few weeks now and was supposed to be cultured;
-He/she continued to want a culture done. He/she has reported this to the staff. The ADON told him/her no, that she had one recently and the physician will just use those results.
-He/she had a history of abscess' busting and then testing positive for MRSA;
-His/her surgeon did collect a culture of the left elbow wound on 11/06/24, but the results did not indicate an infection at that time. However, the wound and his/her physical condition has worsened since that time;
-He/she most recently had tested positive for

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MRSA in his/her right hip wound.

Review of the resident's physician visit notes, dated 12/10/24, showed the resident was having an increase in drainage and pain. Will do x-ray to rule out any osteomyelitis due to his/her pain. Will use most recent culture and initiate Clindamycin (an antibiotic that fights bacteria in the body) 300 milligram (mg) capsule by mouth four times a day for 7 days, and Flagyl (antibiotic that is used to treat bacterial infections) 500 mg by mouth two times a day for 7 days.

Review of the resident's physician order sheet, showed the following orders entered for 12/10/24:

-Obtain wound culture of left elbow wound;
-Obtain x-ray of left arm to rule out osteomyelitis;
-Clindamycin 300 mg capsule, give one capsule by mouth four times a day;
-Flagyl 500 mg tablet, give one tablet by mouth two times a day;
-STAT (immediately) x-ray 2 view of left forearm and humerus related to severe pain and history of osteomyelitis.

During an interview on 12/10/24, at 11:44 A.M., Licensed Practical Nurse (LPN) F said he/she did not know of any orders for a culture to the resident's left elbow wound on 11/26/24. However, he/she did obtain new orders on this date for a wound culture and an x-ray.

Review of the resident's nurses' notes, dated 12/10/24, showed per the Director of Nursing (DON) the visiting wound clinic provider reviewed the culture that was completed on 11/13/24 and discontinued the order that was given on 11/26/24 due to at that time there was no evidence of

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F 684	Continued From page 17 increase in drainage. During an interview on 12/10/24, at 12:15 P.M., the ADON said the following: -She believed the DON said the visiting wound clinic's provider discontinued the 11/26/24 order for the wound culture from the resident's primary physician due to the visiting wound clinic's provider saying there was no drainage to the wound at that time; -She called the primary care physician's nurse practitioner today and told him that the drainage is worse. That nurse practitioner said they can just base treatment off the wound culture that was obtained on 11/13/24 by the visiting wound clinic's provider -The visiting wound clinic started seeing the resident on 11/13/24. Review of the resident's medical record showed staff did not document staff collected a culture collected of the resident's left elbow wound on 11/13/24. The only culture obtained was of the resident's right hip wound, which tested positive for MRSA. During an interview on 12/10/24, at 12:51 P.M., the ADON said the following: -She clarified with the DON regarding the wound culture and he told her that the culture obtained on 11/13/24 was actually on the right hip wound; -No culture has been obtained of the left elbow; -She contacted the primary care physician's nurse practitioner again and he said to go ahead and get a new culture, which is what is reflected in the physician's order sheet.	F 684		

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Review of the resident's medical record on 12/11/24 showed results from the x-ray showed no acute forearm or humerus fractures and did not given mention of osteomyelitis.

Review of the resident's nurses' notes, dated 12/11/24, showed the wound culture that was obtained per the visiting wound clinic's provider resulted. Staff spoke with primary care physician's nurse practitioner who said to continue with current antibiotic protocol and obtain a new culture.

Review of the resident's medical record, as of 12/12/24, showed staff did not document a wound culture had been collected.

During an interview on 12/12/24, at 10:29 A.M., the ADON said the following:

-She monitors wounds by performing treatments;
-Wounds that are not caused by pressure are not measured by her, only by the visiting wound clinic's provider she believes;
-She showed the surveyor the resident's wound management log inside the medical record, which did not list or provide any information regarding the resident's left elbow wound.

During an interview on 12/13/24, at 10:27 A.M., the visiting wound care provider said the following:

-They began treating the resident's left elbow wound on 11/23/24;
-He/she had never obtained any tissue cultures on the resident's left elbow wound, nor has he/she seen any results from a tissue culture;
-This resident was followed by several physicians

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which seemed to complicate treatment;
-He/she would not and has not discontinued any other physician's orders;
-He/she did obtain a bone culture from a bone that was expressed out of the wound. That culture showed staphylococcus epidermidis. The resident started the antibiotics due to these results;
-He/she would expect to be contacted regarding any worsening of the wound.

During an interview on 12/13/24, at 11:02 A.M., LPN D said the nurses do not measure any type of wounds. The visiting wound clinic does all the measurements. nurses just go and assess the area and report any findings.

During an interview on 12/13/24, at 11:18 A.M., LPN E said if a skin issue was brought to his/her attention, he/she would go and assess the area, measure, document, perform a treatment, and contact the physician.

During an interview on 12/13/24, at 12:19 P.M., the ADON said the following:

-There should be documentation as to when, and why a resident is sent out, as well as documentation as to when the resident returns. If there is no documentation, it's still known due to it being talked about in morning meetings;
-Skin assessments are completed weekly during showers. Any issues are reported to the nurses and they assess the issue and are supposed to document and/or tell her and she will measure the area;
-Wounds are tracked by visualizing the wound during treatments being completed on them; she realizes documentation is lacking;

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F 684	Continued From page 20 -The resident's left elbow wound is tracked by completing treatments on the wound, the visiting wound clinic's provider measures every Friday; -The resident has never had a culture on the left elbow wound tissue, he/she has only had the expelled bone cultured, which resulted on 12/05/24; -Once those results were obtained, she called the primary care physician and obtained antibiotic orders; -On 11/26/24, there was an order for a wound culture, but the primary care physician's nurse practitioner discontinued that; -The primary care physician came in and found no reason to do the wound culture at that time; -The resident has so many physicians involved in his/her care, it can make it difficult; -Physician orders should be followed, and residents have a little bit of say in their care but often times that doesn't change it much; -She expects staff to refer to social services if a resident has a mental decline; -The resident's mental status has not been brought to her attention; -Everything should be documented in the resident's chart, but she realized documentation is an issue. During an interview on 12/13/24, at 12:47 P.M., the DON said the following: -If a skin concern is brought to staff's attention, it should be reported to the charge nurse; the charge nurse will consult the primary care provider and put in any new orders; -Wounds should be monitored weekly and the nurses' notes should reflect that. During an interview on 12/13/24, at 1:00 P.M., the	F 684		

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F 684	Continued From page 21 Administrator said wounds should be documented somewhere and care planned.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received services consistent with professional standards of practice when the facility failed to document regular full wound assessments for one resident (Resident #60) out of 17 sampled residents, who had a pressure ulcer to the right hip. The facility census was 75. Review of the facility's policy titled "Resident Examination and Assessment," undated, showed the following information: -Examine and note the intactness, moisture, color, texture, and presence of bruises, pressure sores, redness, edema (swelling), and rashes of the resident's skin;	F 686		

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F 686	Continued From page 22 -Document the following in the resident's chart the date and time the assessment was performed; name and title of individuals who performed the assessment; assessment data obtained during the assessment; how the resident tolerated the assessment; if the resident refused and why; the signature and title of the person recording the data; and notify the supervisor if the resident were to refuse; -Notify the physician of any abnormalities such as wounds or rashes on the resident's skin, and worsening pain as reported by the resident. 1. Review of the resident's face sheet (brief look at resident information) showed the following information: -Admission date of 01/08/24; -Diagnoses included unspecified open wound of right hip. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument, completed by facility staff), dated 10/16/24, showed the following information: -Cognitively intact; -Not at risk for pressure ulcers; -No skin conditions or pressure ulcers documented; -Diagnoses included anemia, anxiety, and depression. Review of the resident's Physician Order Sheet, dated 10/21/24, showed resident visited wound clinic for evaluation and treatment of wound to right hip. Review of the resident's care plan, dated	F 686		

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F 686	Continued From page 23 10/22/24, showed the following information: -The resident had skin breakdown noted to the right hip measuring 3 centimeters (cm) by 2 cm. The wound bed had eschar (a collection of dry dead tissue within a wound which presents itself as tan, brown, or black) present with wound edges undefined and no drainage or odor noted. Resident visiting wound clinic to treat. Review of the resident's wound management log, dated 11/01/24, showed the right hip wound measured 3.5 cm by 2.5 cm. Review of the resident's medical record, dated 11/02/24 to 11/10/24, showed staff did not document an assessment or measurements of the resident's right hip wound. Review of the resident's progress note, dated 11/11/24, showed resident had a history of poor mobility, was up to the wheelchair most of the day and when was in bed, laid on his/her left side. The resident had a cushion in place on his/her wheelchair. Staff to continue with current orders. Staff educated the resident on offloading to reduce pressure to the hip. (Staff did not document an assessment of the wound.) Review of the resident's wound management log, dated 11/12/24, showed the right hip wound measured 2.3 cm by 3.1 cm (11 days after the prior log entry). Review of the resident's wound manage log, dated 11/13/24 to 12/13/24, showed staff did not document regarding the resident's right hip wound.	F 686		

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Review of the resident's medical record, dated 11/13/24 to 11/28/24, showed staff did not document an assessment or measurements of the resident's right hip wound.

Review of the resident's Physician Order Sheet, dated 11/29/24, showed the following:

-Current treatment for right hip wound included cleanse right hip wound with pure and clean (wound cleaner), pat dry, place calcium alginate ((a wound dressing made from calcium or sodium alginate, a natural polymer derived from cell walls of brown seaweed, which creates a moist healing environment for wounds and treats moderately heavy draining wounds) inside of the wound bed, and cover with foam border gauze, and change every other day and as needed.

Review of the resident's progress note, dated 12/09/24, showed the following:

-Resident had a history of poor mobility, was up to the wheelchair most of the day and when in bed, laid on his/her left side. The resident had a cushion in place on his/her wheelchair. Staff to continue with current orders. Staff educated resident on offloading to reduce pressure to the hip. The wound orders for right hip updated. (Staff did not document an assessment of the wound.)

Review of the resident's care plan, dated 12/09/24, showed the following information:

-A new order to cleanse right hip with pure and clean, pat dry, place calcium alginate inside of the wound bed and cover with foam border gauze every other day and as needed.

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Review of the resident's medical record, dated 11/13/24 through 12/13/24, showed staff did not document an assessment or measurements of the resident's right hip wound.

Review of the resident's medical record showed no visiting wound clinic notes had been scanned into the system.

During an interview on 12/09/24, at 12:07 P.M., the resident said staff do not come in and assess his/her wound on a weekly basis.

During an interview on 12/12/24, at 10:29 A.M., the Assistant Director of Nursing (ADON) said the following:

-She assesses and measured the resident's wounds and puts those measurements in the resident's medical record under the wound management log;
-She used the visiting wound clinic's providers measurements and that's what she enters into the chart. The visiting clinic came in weekly.

During an interview on 12/13/24, at 11:02 A.M., Licensed Practical Nurse (LPN) D said the following:

-When an open area was brought to his/her attention, he/she assessed the wound, called the physician, and documented in the progress notes;
-Measurements were not completed unless the resident was seen by the visiting wound clinic, then the clinic obtained measurements.

During an interview on 12/13/24, at 11:18 A.M., LPN E said if a new skin issue was brought to his/her attention, he/she would assess, measure,

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F 686	Continued From page 26 document, perform a treatment, and contact the resident's physician. During an interview on 12/13/24, at 12:19 P.M., the ADON said the following: -The nurses are expected to assess and document any new open areas. They should report to her the area, and she will go and measure it; -Wounds are tracked and or monitored by visual assessments during wound care; -Everything is expected to be documented, but she realized that documentation has been an issue. During an interview on 12/13/24, at 12:47 P.M., the Director of Nursing (DON) said wound monitoring should be completed weekly and documented in the nurses' notes. During an interview on 12/13/24, at 1:00 P.M., the Administrator said wound documentation should be somewhere in the residents medical record.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 689		

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review, the facility failed to ensure an environment as free of accident hazards as possible when the facility failed to complete a smoking assessment per policy and failed to care plan smoking for one resident (Resident #268) and when staff allowed three residents (Resident #27, #48, and #67), who were care planned to store smoking supplies at the nurses' station, to maintain smoking supplies on their person and in their room. The facility census was 75.

Review of the facility's Smoking and Marijuana Use Policy, undated, showed the following:

-All residents are advised that the facility is a supervised smoking facility;
-There is a designated smoking area outside;
-All smoking materials will be kept at the nurses' stations in an approved smoking container when not in use;
-Residents are not to keep smoking materials, electronic or vapor smoking replacement devices (including juice), or smokeless tobacco in their rooms.
-At no time are residents permitted to store tobacco, tobacco paraphernalia, or lighters in their rooms.
-Residents will be accompanied by a staff member during all smoke breaks where cigarettes will be provided and the staff member will have the lighter, unless a residents has been assessed to smoke on their own. At that time a resident will be able to ask a staff member to provide them with a cigarette and lighter and smoke on their own;
-After the resident has finished smoking all remaining materials will be turned back into the nurses' station;
-All smoking will be supervised to ensure the

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F 689	Continued From page 28 safety of the residents, staff, and the facility, unless a smoking assessment has determined that the resident is safe to smoke on their own. 1. Review of Resident #27's face sheet (admission data) showed the following: -Admission date of 01/22/22; -Diagnosis included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing restricted airflow and breathing problems), diabetes, atrial fibrillation (irregular rapid heart rate that causes poor blood flow), infection of the kidneys, and acute upper respiratory infections. Review of the resident's admission packet showed the following: -Resident rules and regulations related to smoking signed on 01/24/22 by the resident the Social Service Director (SSD) and a staff representative as the witness; -For safety reasons, the resident and any visitors to this facility are hereby advised not to smoke except under supervision and/or in designated smoking areas; -Residents may not retain matches or lighters. Review of the resident's Smoking Risk Assessment dated, 11/01/24, showed the resident was a safe smoker and should follow facility policy. Review of the resident's Care Plan, dated 01/03/23 and last reviewed on 12/03/24, showed following: -The resident was at risk for potential	F 689		

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F 689	Continued From page 29 complications related to smoking cigarettes; -The resident will continue to be safe and follow instructions with smoking; -The resident will maintain cigarettes and lighter at the nurses' station; -The resident will not smoke in his/her room or bathroom or other portions of the facility Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 11/01/24, showed the resident was cognitively intact. During an interview on 12/09/24, at 2:30 P.M., the resident said he/she can smoke when he/she wants to and he/she carries cigarettes and a lighter on his/her person. He/she keeps his/her cigarettes and lighter in his/her room. The staff do not keep his/her cigarettes or lighter locked up. An interview and observation on 12/10/24, at 12:20 P.M., showed the following: -The resident's pack of cigarettes with two cigarettes and one black lighter was in his/her black/red checkered jacket in his/her room; -The resident had a brand new pack of cigarettes in his/her jacket pocket; -The resident said he/she orders cigarettes and lighters from another state; -The resident showed a package of what would have been four to five lighters with one blue lighter left in pack kept in his/her nightstand cabinet near bed. During observations throughout the survey process, 12/08/24 through 12/13/24, showed the resident independently propelled self to the end of the 200 hall and exited through the door to a patio	F 689		

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area, retrieved cigarettes and a lighter from his/her jacket pocket, and smoked several times through the day.

2. Review of Resident #268's face sheet showed the following:

-Admission date of 11/29/24;
-Diagnoses included COPD, stroke, nicotine dependence, high blood pressure, and heart disease.

Review of the resident's Admission Packet showed the following:

-Resident rules and regulations related to smoking signed on 12/02/24 by the resident, the SSD, and a staff representative as the witness.
-For safety reasons, the resident and any visitors to this facility are hereby advised not to smoke except under supervision and/or in designated smoking areas.
-Residents may not retain matches or lighters.

Review of the resident's care plan, dated 12/03/24, showed staff did not care plan related to the resident smoking or possession of smoking supplies.

Review of the resident's admission MDS, dated 12/05/24, showed the resident was cognitively intact.

Review of the residents medical record showed staff did not document completion of a smoking assessment.

During an interview on 12/10/24, at approximately 1:00 P.M., the following the resident said he/she

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F 689	Continued From page 31 smokes unsupervised and keeps his/her cigarettes on his/her person and in his/her room. 3. Review of Resident #49's face sheet showed the following: -Admission date of 05/11/23; -Diagnoses included polyosteoarthritis (degeneration of joint cartilage and the underlying bone affecting five or more joints at the same time) and tobacco use. Review of the resident's Smoking risk Assessment, dated 11/17/24, showed the reside was a safe smoker and should follow facility policy. Review of the resident's quarterly MDS, dated 11/17/24, showed the resident was cognitively intact. Review of the resident's care plan, last reviewed on 11/26/24, showed the following: -The resident was at risk for potential complications related to smoking cigarettes; -The resident will continue to be safe and follow instructions with smoking; -The resident will maintain cigarettes and lighter at the nurses' station; -The resident will not smoke in his/her room or bathroom or other portions of the facility. Interviews and observations showed the following: -On 12/08/24, at 4:30 P.M., the resident was on the edge of his/her bed eating soup and sandwich. There were four individual cigarettes	F 689		

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F 689	Continued From page 32 and one lighter on the resident's bedside table. The resident was planning to go outside to smoke after the meal; -On 12/09/24, at 2:25 P.M., the resident said he/she had to go to the nurses' station to get smoking supplies. The resident was leaving his/her room with a cigarette in his/her hand; -On 12/11/24, at 10:45 A.M., two cigarettes were on the resident's bedside table. The resident was not in the room; -On 12/11/24, at 11:16 A.M., after the nurse completed wound care the resident reached inside the bedside table and picked up a cigarette and left the room with the cigarette in his/her hand. 4. Review of Resident #67's face sheet showed the following: -Admission date of 08/26/24; -Diagnoses included acute gastric ulcer (open sore that develops in the stomach lining) with hemorrhage (loss of blood from damaged blood vessel) and myocardial infarction (heart attack). Review of the resident's Admission Packet showed the following: -Resident rules and regulations related to smoking signed on 08/26/24 by the resident, the SSD, and an registered nurse (RN) witness; -For safety reasons, the resident and any visitors to this facility are hereby advised not to smoke except under supervision and/or in designated smoking areas. Residents may not retain matches or lighters. Review of the resident's care plan, last reviewed on 12/01/24, showed the following:	F 689		

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F 689	Continued From page 33 -Resident chooses to smoke, at risk of injury or fire; -The resident usually smoked a pipe; -The resident will have supervised smoking in designated area and will smoke safety; -There will be a designated smoking area, designated time, and staff assigned will assist with residents that smoke; -Pipe and lighters are kept at the nursing station. Review of the resident's Smoking Risk Assessment, dated 12/01/24, showed the reside was a safe smoker and should follow facility policy. Review of the resident's quarterly MDS, dated 12/02/24, showed the the resident was cognitively intact. During interview and observation on 12/08/24, at 3:55 P.M., the resident was seated in a wheelchair in his/her room. The resident had a tobacco pipe, bag of tobacco grounds, and two lighters on the bedside table. The resident said he/she could come and go to smoke as wanted. 5. During an interview on 12/13/24, at 10:20 A.M., Certified Nurse Aide (CNA) H said that residents carry their own smoking supplies and extras supplies are kept in the medication room. The residents are able to visit each in others room. During an interview on 12/12/24, at 3:00 A.M., RN I said most of the residents who smoke keep their cigarettes and lighters on their person and in their rooms. The residents go outside unsupervised anytime of day or night. The smoking areas are the front entrance area or the patio off of 200 hall.	F 689		

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F 689	Continued From page 34 During an interview on 12/13/24, at 12:48 P.M., the Director of Nursing (DON) said that smokers should be assessed for safe smoking and should have the information in the care plan. Some residents carry cigarettes on them daily, their lighter and cigarettes, and some are kept in the medication room. During an interview on 12/13/24, at 11:30 A.M., the Administrator said all residents should turn in their cigarettes and lighters after the smoke breaks. All Cigarettes and lighters should be kept locked up. Cigarettes and lighters cannot be kept on the resident's person or in the residents' rooms. Residents and staff should follow the policy for safety. The Administrator was not aware that residents were allowed to keep their cigarettes and lighters.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		

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F 755	Continued From page 35 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide pharmacy services to meet the needs of each resident when staff failed to have ordered medications on hand for administration for two residents (Resident #49 and #13). The facility census was 75. Review of the facility policy titled "Medication Administration," undated, showed medications are given to benefit a resident's health as ordered by the physician. 1. Review of Resident #49's face sheet (brief information sheet about the resident) showed the following: -Admission date of 05/11/23; -Diagnoses included vitamin B12 deficiency (condition that develops when the body cannot make enough healthy red blood cells because it doesn't have enough vitamin B12).	F 755		

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F 755	Continued From page 36 Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/17/24, showed the resident was cognitively intact. Review of the resident's care plan, last reviewed 11/26/24, showed the following: -Resident had the potential for cardiac (heart) complications secondary to hypertension (high blood pressure), hyperlipidemia (high cholesterol), and vitamin deficiency (occurs when the body doesn't have enough of a vitamin over a long period of time); -Staff should administer cardiac medications as ordered. Review of the resident's Physician Order Sheet, current as of 12/13/24, showed an order, dated 06/05/23, for B Complex-Vitamin B12 tablet (group of B vitamins that play a role in your body's function), one tablet once per day. Review of the resident's November 2024 Medication Administration Record (MAR) showed the following: -On 11/01/24 through 11/08/24, staff documented B Complex-Vitamin B12 as administered; -On 11/09/24 and 11/10/24, staff documented B Complex-Vitamin B12 as not administered due to drug/item unavailable; -On 11/11/24 through 11/13/24, staff documented B Complex-Vitamin B12 as administered; -On 11/14/24 through 11/30/24 staff documented B Complex-Vitamin B12 as not administered due to the drug/item unavailable. (Staff documented 18 doses out of 30 doses for	F 755		

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F 755	Continued From page 37 the month of November as not available.) Review of the resident's MAR, dated 12/01/24 through 12/13/24, showed the following: -On 12/01/24 through 12/13/24, staff documented the B Complex-Vitamin B12 as not administered due to the drug/item unavailable. (Staff documented 13 doses out of 13 doses for the month of December as not available.) During an interview on 12/09/24, at 2:25 P.M., the resident said there were times that he/she was told that there medications not available. During an interview on 12/13/24, at 12:19 P.M., the Assistant Director of Nursing (ADON) said she was not aware the resident had not received the Vitamin B12 since November. 2. Review of Resident #13's face sheet showed the following: -Admission date of 02/02/21; -Diagnoses included constipation and pain. Review of the resident's care plan, last reviewed 11/07/24, showed the following: -Resident had idiopathic progressive neuropathy (a nerve condition that can cause a range of symptoms, including pain, numbness, tingling, swelling, or muscle weakness) which caused his/her pain and resident was not always able to tell staff he/she was in pain; -Staff should ask resident was having pain; -Resident was at risk for pain issues related to muscle spasms and arthritis; -Staff should administer pain medications as	F 755		

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directed;
-Assess/document/review with physician indications of side effects, ineffectiveness.
-Resident was at risk for complications due to constipation to include hemorrhoids and bowel;
-Staff interventions will be in place to prevent complications related to constipation to the extent possible related to medical complexities through review;
-Staff should administer stool softeners, laxative and/or other interventions as ordered/needed with follow up.

Review of the resident's quarterly MDS, dated 11/13/24, showed the resident had severe cognitive impairment.

Review of the resident's POS, current as of 12/13/24, showed the following:

-An order, dated 12/31/21, for acetaminophen (used to treat mild to moderate pain) 325 milligrams (mg), administer two tablets twice daily;
-An order, dated 05/09/23, for Senna Plus (two different types of laxatives combined in one formula) 8.6-50 mg capsule, administer one capsule twice daily.

Review of the resident's MAR, dated 12/01/24 through 12/13/24, showed the following:

-On 12/01/24 through 12/06/24, morning dose staff documented the Senna Plus as not administered, drug/item unavailable;
-On 12/07/24, staff documented the acetaminophen 325 mg morning dose as not administered; drug/item unavailable.
-On 12/08/24 through 12/11/24, staff documented

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the acetaminophen 325 mg morning and evening dose, as not administered, drug/item unavailable.
-On 12/07/24 evening dose through 12/11/24, staff documented the Senna Plus as not administered, drug/item unavailable;
(Staff documented nine doses of Tylenol 325 mg out of 25 doses as not available for December and 21 doses of Senna Plus out of 25 doses as not available for December.)

3. During an interview on 12/13/24, at 10:05 A.M., Certified Medication Technician (CMT) B said that staff should follow physician orders when administering medications. If a medication was not available, staff should look in the emergency kit and notify the nurse of medication not available. He/she did not know if the nurse notified the doctor of the unavailable dose.

During an interview on 12/13/24, at 10:12 A.M., CMT C said that staff should follow physician orders for medication administration. If a medication was not available, he/she would notify the ADON and make a list of medications needed. He/she would not expect a resident to miss a medication for multiple days to weeks.

During an interview on 12/13/24, at 11:02 A.M., Licensed Practical Nurse (LPN) D said staff should notify the ADON if a medication was not available for a resident. Ideally medications should be refilled before running out of medications or over-the-counter vitamins. He/she would not expect a resident to go multiple days without ordered medications without the nurse discussing with a physician.

During an interview on 12/13/24, at 11:16 A.M., LPN E said that nurses and CMTs should provide

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F 755	Continued From page 40 medications as ordered by the physician. If a medication was not available in the medication cart, staff should check the medication room and the emergency kit. If not available, staff should notify the charge nurse for instructions. During an interview on 12/13/24, at 12:19 P.M., the ADON said staff should provide medications according to the physician orders. If a medication was not available, staff should check the medication room and should notify the ADON to have the medication ordered. During an interview on 12/13/24, at 12:48 P.M., the Director of Nursing (DON) said staff should follow the physician orders for medication administration. If a medication was not available, staff should check the medication room for extra supplies or notify the ADON for ordering. Residents should not go multiple days without ordered medications. During an interview on 12/13/24, at 1:00 P.M., the Administrator said the staff should follow policy and procedure for medication administration. The staff should notify the charge nurse, ADON, or DON if a medication was not available.	F 755		
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: Based on record review and interview, the facility	F 759		

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	265835	A. BUILDING _____ B. WING _____	12/13/2024

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F 759	Continued From page 41 failed an medication error of less than 5 percent when staff made four medication errors out of 32 opportunities, affecting two residents (Resident #13 and #42) resulting in a 12.5 percent medication error rate The facility census was 75. Review of the facility policy, "Medication Administration,' undated, showed the following: -Medications are given to benefit a resident's health as ordered by the physician; -Read the label three times before administering the medication. First when comparing the label with the medication sheet. Second when setting up the medication. Third when preparing to administer the medication to the resident; -Administer the medication; -Record the medication given on the medication sheet. 1. Review of Resident # 13's face sheet showed the following: -Admission date of 02/02/21; -Diagnoses included Vitamin D deficiency, constipation, and pain. Review of the resident's physician orders, dated 12/01/24 through 12/13/24, showed the following: -An order, dated 12/31/21, for acetaminophen (generic for Tylenol) 325 milligrams (mg), administer two tablets twice daily; -An order, dated 11/27/22, for Vitamin D3 2,000 unit, 1 capsule once daily. The order was on hold from 10/16/24 at 12:01 A.M. to 12/11/24 12:59 A.M.; -An order, dated 10/17/24 to 12/12/24, vitamin D3 3,000iu, administer 2 capsules once daily for	F 759		

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F 759	Continued From page 42 eight weeks. -An order, dated 05/09/23, for Senna Plus 8.6-50 mg, administer 1 capsule twice daily; During an interview and observation on 12/12/24, at 7:46 A.M., Certified Medication Tech (CMT) B prepared medications for the resident near the nursing station. The CMT administered the following medications: -Vitamin D3 5,000 units, one tablet, and Vitamin D3 1,000 units, one tablet, for a total of 6000 units; -Vitamin D3 1,000 units, one tablet (ordered amount of two tablets); -The CMT did not administer and stated there was no Tylenol 325 mg available. The CMT said the Tylenol had not been available for a couple of days, they were waiting on the supply to arrive; -The CMT did not administer Senna Plus. During an interview on 12/12/24, at 9:30 A.M., CMT B said that he/she realized that he/she did not have the Senna-plus available at the time of administration and had notified the Assistant Director of Nursing (ADON) for supplies of both Tylenol 325 mg and Senna-Plus and they should be available later this day. During an interview on 12/13/24, at 10:05 A.M., CMT B said that if medications were not available, staff should look in the emergency kit and notify the nurse of any medication not available. He/she did not know if the nurses notified the doctor. The order for Vitamin D3 of 2,000 units should have been given as two tablets of the 1,000 units available. During an interview on 12/13/24, at 10:12 A.M.,	F 759		

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F 759	Continued From page 43	F 759		

CMT C said that staff should follow physician orders and provide all medications as ordered. If a medication was not available, he/she would tell the ADON and make a list of medications needed.

During an interview on 12/13/24, at 11:02 A.M., Licensed Practical Nurse (LPN) D said that if a medication was not available, the staff should notify ADON and put in an order, Ideally it should be refilled before running out of medications or over-the-counter medications. The nurse may need to notify the physician if a medication was unavailable to see if an alternative was recommended instead of the resident being without the medication.

During an interview on 12/13/24, at 11:16 A.M., LPN E said that staff should follow physician orders for medication administration and notify the physician if a medication was not available for recommendations to hold or change to an alternative option.

During an interview on 12/13/24, at 12:19 P.M., the ADON said staff should notify the ADON when medications were not available for medication administration.

During an interview on 12/13/24, at 12:48 P.M., the Director of Nursing (DON) said when medications were not available, staff should check medication room for extra supplies or notify ADON for ordering. Staff should follow physician orders when administering medications. Residents should not have to go without medications.

During an interview on 12/13/24, at 1:00 P.M.,

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F 759	Continued From page 44 Administrator said that staff should follow policy and procedure for medication pass. 2. Review of the facility's policy titled "Medication Administration," undated, did not show any direction regarding insulin administration and/or fast acting insulin requirements. Review of the publication of the National Library of Medicine, titled "Optimal Prandial Timing of Bolus Insulin in Diabetes Management", dated 11/2016, taking rapid acting insulin 15 to 20 minutes before a meal provides significant improvements in post-meal control and is recommended whenever possible. Review of the Mayo Clinic's "Insulin aspart,recombiant (intravenous route,subcutaneous (below the skin), updated 10/01/24, showed when used as a mealtime insulin, Novolog® and Insulin Aspart FlexPen® (a fast acting injectable insulin) should be taken within 5 to 10 minutes before a meal or immediately before a meal. Review of Resident #42's face sheet (brief look at resident information) showed the following information: -Admission date of 11/06/24; -Diagnoses included chronic kidney disease, high blood pressure, diabetes, and weakness. Review of the resident's care plan, last revised on 03/15/22, showed the following information: -Administer and assess side effects and effectiveness of medications as ordered to include both scheduled and sliding scale insulin;	F 759		

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F 759	Continued From page 45 -Accu-Check's (meter quantitatively measures glucose (sugar) in the blood) per physicians orders; -Assess/document/review signs and symptoms of low blood sugar. If symptoms are present, provide a high protein snack and follow physician orders. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 11/12/24, showed the following information: -Received insulin injections six days out of the week; -Received hypoglycemic (low blood sugar) medications. Review of the resident's physician order sheet, dated 12/13/24, showed the following: - A current order for insulin aspart 100 units/milliliter (ml), administer six units subcutaneously with meals at 7:00 A.M., 12:00 P.M., and 5:00 P.M. Observation on 12/11/24, at 11:21 A.M., showed LPN D obtain the resident's blood sugar reading. LPN D administered six units of insulin aspart subcutaneously (beneath the skin) in the resident's right lower quadrant of the abdomen. The LPN did not offer a snack to the resident room. There were no snacks visiable in the resident's room. Observation on 12/11/24, at 12:15 P.M., showed the resident had not been served a lunch tray (54 minutes after the administration of the fast-acting insulin).	F 759		

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F 759	Continued From page 46 During an interview on 12/11/24, at 12:15 P.M., the resident said he/she usually eats or should eat something within 30 minutes of staff administering insulin. The resident said if he/she had to wait an hour or more, it wouldn't be a good thing. During an interview on 12/13/24, at 10:12 A.M., CMT C said insulin should be given as close to meals as possible. During an interview on 12/13/24, at 11:02 A.M., LPN D said insulin administration times depends on the individual resident, some residents are fragile and some are not. The appropriate timing for a resident to have a snack or meal within insulin administration is 30 minutes. During an interview on 12/13/24, at 11:18 A.M., LPN E said a meal or snack should be provided within 30 minutes of insulin administration. During an interview on 12/13/24, at 12:19 P.M., the ADON said the appropriate timing for a resident to have a snack or meal within insulin administration is 30 minutes. It would be acceptable if a resident had to wait up to an hour for a snack or meal after insulin administration, that is just not best practice. During an interview on 12/13/24, at 12:47 P.M., the Director of Nursing (DON) said anytime fast acting insulin is administered, an immediate snack or meal should be provided. During an interview on 12/13/24, at 1:00 P.M., the Administrator said He expects staff to follow policy and procedure related to insulin	F 759		

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F 759	Continued From page 47 administration.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the residents were free of significant mediation errors when the facility failed to provide a meal service and/or a snack for one resident (Resident #42) after administering rapid acting insulin. The facility census was 75. Review of the facility's policy titled "Medication Administration," undated, did not show any direction regarding insulin administration and/or fast acting insulin requirements. Review of the publication of the National Library of Medicine, titled "Optimal Prandial Timing of Bolus Insulin in Diabetes Management", dated 11/2016, taking rapid acting insulin 15 to 20 minutes before a meal provides significant improvements in post-meal control and is recommended whenever possible. Review of the Mayo Clinic's "Insulin aspart,recombiant (intravenous route,subcutaneous (below the skin), updated 10/01/24, showed when used as a mealtime insulin, Novolog® and Insulin Aspart FlexPen® (a fast acting injectable insulin) should be taken within 5 to 10 minutes before a meal or immediately before a meal.	F 760		

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F 760	Continued From page 48 1. Review of Resident #42's face sheet (brief look at resident information) showed the following information: -Admission date of 11/06/24; -Diagnoses included chronic kidney disease, high blood pressure, diabetes, and weakness. Review of the resident's care plan, last revised on 03/15/22, showed the following information: -Administer and assess side effects and effectiveness of medications as ordered to include both scheduled and sliding scale insulin; -Accu-Check's (meter quantitatively measures glucose (sugar) in the blood) per physicians orders; -Assess/document/review signs and symptoms of low blood sugar. If symptoms are present, provide a high protein snack and follow physician orders. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 11/12/24, showed the following information: -Received insulin injections six days out of the week; -Received hypoglycemic (low blood sugar) medications. Review of the resident's physician order sheet, dated 12/13/24, showed the following: - A current order for insulin aspart 100 units/milliliter (ml), administer six units subcutaneously with meals at 7:00 A.M., 12:00	F 760		

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F 760	Continued From page 49 P.M., and 5:00 P.M. Observation on 12/11/24, at 11:21 A.M., showed Licensed Practical Nurse (LPN) D obtain the resident's blood sugar reading. LPN D administered six units of insulin aspart subcutaneously (beneath the skin) in the resident's right lower quadrant of the abdomen. The LPN did not offer a snack to the resident room. There were no snacks visible in the resident's room. Observation on 12/11/24, at 12:15 P.M., showed the resident had not been served a lunch tray (54 minutes after the administration of the fast-acting insulin). During an interview on 12/11/24, at 12:15 P.M., the resident said he/she usually eats or should eat something within 30 minutes of staff administering insulin. The resident said if he/she had to wait an hour or more, it wouldn't be a good thing. During an interview on 12/13/24, at 10:12 A.M., Certified Medication Tech (CMT) C said insulin should be given as close to meals as possible. During an interview on 12/13/24, at 11:02 A.M., LPN D said insulin administration times depends on the individual resident, some residents are fragile and some are not. The appropriate timing for a resident to have a snack or meal within insulin administration is 30 minutes. During an interview on 12/13/24, at 11:18 A.M., LPN E said a meal or snack should be provided within 30 minutes of insulin administration.	F 760		

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F 760	Continued From page 50 During an interview on 12/13/24, at 12:19 P.M., the Assistant Director of Nursing (ADON) said the appropriate timing for a resident to have a snack or meal within insulin administration is 30 minutes. It would be acceptable if a resident had to wait up to an hour for a snack or meal after insulin administration, that is just not best practice. During an interview on 12/13/24, at 12:47 P.M., the Director of Nursing (DON) said anytime fast acting insulin is administered, an immediate snack or meal should be provided. During an interview on 12/13/24, at 1:00 P.M., the Administrator said He expects staff to follow policy and procedure related to insulin administration.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food prepared by the facility was palatable to the residents. The facility census was 75. Review of the facility policy, "Food Temperatures,	F 804		

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F 804	Continued From page 51	F 804		

Nutrition and Dining Services Manual," dated May 2015, showed hot foods should be at least 120 degrees Fahrenheit (F) when served to the resident.

1. During an interview on 12/09/24, at 11:14 A.M., Resident #40 said the following:

-He/she preferred to eat his/her meals in his/her room;
-The food was cold probably at least half the time
-He/she would like to have food that is warm, most of the time;
-He/she said the eggs are always cold in the morning;
-Eggs are his/her biggest complaint about the food, but it would be nice if it could all be warm.

During interviews in the resident council meeting on 12/10/24, at 1:00 P.M., residents said the following:

-Resident #36 said he/she believed the meat was of low quality and the food is not hot;
-Resident #55 said he/she received at least half of his/her food barely warm or cold.
-Resident #17 said that day's meal was cold.

Observation of a sample hall meal tray on 12/11/24, at approximately 11:55 A.M., showed the following:

-The meal consisted of apple glazed chicken, rice, lima beans, a slice of bread, and pears;
-The food was not hot and tasted bland with no seasoning present;
-The chicken temperature measured 127 degrees F, rice 129.7 degrees F, lima beans 123.2 degrees F, pears at 58 degrees F and two cups

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F 804	Continued From page 52 of tea read at 75 degrees F each. During an interview on 12/11/24, at approximately 12:25 P.M., Resident #33, said the following: -This was one of the worst meals that he/she has had since being at the facility; -A lot of the food here is not great, but this was very bad; -He/she said it was dry, cold, bland and gross to look at. Observation on 12/12/24, at 8:05 A.M., of a sampled meal tray showed the following: -The sausage patty was greasy and shriveled up as if cooked too long. -Temperature for the scrambled eggs read at 97.1 degrees F; -Temperature for the sausage patty read at 85.9 degrees F; -Temperature for the orange juice read at 54.2 degrees F; During an interview on 12/13/24, at 12:51 P.M., Cook T said the following: -Staff do audit trays to check temps if anyone complains about temps; -Drinks should be 32 degrees F or under; -The apple chicken meal is not the normal meal, with all the same colors, as earlier today; During an interview on 12/13/24, at 1:13 P.M., the Dietary Manager said the residents were not too crazy about the chicken meal just served yesterday; During an interview on 12/13/24, at 2:08 P.M., the	F 804		

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F 804	Continued From page 53 Administrator said he expected staff to follow the policy regarding food service.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to keep food safe from potential contamination or bacterial growth when staff placed clean dishes upside down on a tray, while still wet, which could potentially contaminate any food, served from those items. The facility census was 75. 1. Review of the facility's policy, "Dish Machine, Nutrition and Dining Services Manual," dated May 2015, showed the following:	F 812		

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BROOKHAVEN NURSING & REHAB	**3405 WEST MT VERNON SPRINGFIELD, MO 65802**

(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 54 -Pull the rack out of the machine to air dry; -Allow to air dry and stack in proper area. Record review of the 1999 Food Code, issued by the Food and Drug Administration, showed the following information: -After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food; -Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Observation on 12/08/24, at 2:10 P.M., showed the following: -110 plastic bowls were stacked, upside down, with visible water droplets trapped, preventing air flow; -78 dessert cups were stacked, upside down, with visible water droplets trapped, preventing air flow; -74 ceramic plates were stacked, upside down, with visible water droplets trapped, preventing air flow; -73 serving trays were stacked, upside down, with visible water droplets trapped, preventing air flow. Observation on 12/10/24, at 10:00 A.M., showed the following: -114 plastic bowls were stacked, upside down, with visible water droplets trapped, preventing air flow; -76 dessert cups were stacked, upside down, with visible water droplets trapped, preventing air flow; -86 ceramic plates were stacked, upside down,	F 812		

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F 812	Continued From page 55 with visible water droplets trapped, preventing air flow; -73 serving trays were stacked, upside down, with visible water droplets trapped, preventing air flow; -72 plate covers were stacked, upside down, with visible water droplets trapped, preventing air flow; -6 metal steam table pans were stacked, upside down, with visible water droplets trapped, preventing air flow. Observation on 12/12/24, at approximately 11:50 A.M., showed the following: -58 Dessert cups were stacked, upside down, with visible water droplets trapped, preventing air flow; -29 plastic trays were stacked, upside down, with visible water droplets trapped, preventing air flow; -13 plate covers were stacked, upside down, with visible water droplets trapped, preventing air flow. During an interview on 12/13/24, at 12:35 P.M., Dietary Aide S said the following: -The dishes have to air dry before being putting away; -Dishes should be dry before being stacked. During an interview on 12/13/24, at 12:51 P.M., Cook T said all dishes should be dried and then put the dishes away. During an interview on 12/13/24, at 1:13 P.M., the Dietary Manager said the following: -Dishes should be air dried when pulled from the dishwasher, then stacked and put away. -Dishes should not be put away or stacked wet due to bacteria	F 812		

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F 812	Continued From page 56 During an interview on 12/13/24, at 2:08 P.M., the Administrator said he expected staff to following food service policy.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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F 880	Continued From page 57 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. §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, record review, and interviews, the facility failed establish and maintain an effect infection control program when the facility failed to screen all staff for tuberculosis (a contagious infection that usually attacks the	F 880		

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F 880	Continued From page 58 lungs) at hire when the facility failed to complete the two-step tuberculin (TB) skin test for three staff member (Certified Nurse Aide (CNA) N, Licensed Practical Nurse (LPN) D, Dietary Aide (DA) M), out of 10 sampled staff members, per facility policy and standards of practice. Staff also failed maintain catheters (a tube that is inserted into the bladder to drain urine) in a manner to prevent the possible introduction bacteria in the system when the catheter bag and tubing for one resident (Resident #14) was on the ground. Staff also failed to administer medication in manner to prevent possible contamination when staff touched medications and the inside of medication cups with bare hands to administer medications to five residents (Resident #47, #24, #24, #51, and #227). Staff also failed to conduct hand hygiene in a manner to prevent possible cross-contamination when staff failed to conduct hand hygiene during incontinent cares for one resident (Resident #38). Staff also failed to prevent possible cross-contamination when staff failed to sanitize items used in a resident room after providing wound care to two resident (Resident #49 and #60) prior to returning the items to the treatment cart. Staff also failed to complete hand hygiene to prevent possible cross-contamination when staff did not complete hand hygiene per standards of practice during wound care for one resident (Resident #60). Staff also failed to sanitize a multi-resident use glucometer (used to check blood glucose levels) per standards of practice and manufacture recommendations for two residents (Resident #42 and #3). The facility census was 75. 1. Review of the facility's policy, "Tuberculosis Control," undated, showed the following information:	F 880		

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F 880	Continued From page 59 -Provide a tuberculin skin test (Mantoux - five tuberculin units of purified protein derivative (PPD)) to all employees during the pre-employment procedures, unless a previous reaction greater than 10 mm (millimeters) is documented. If the initial skin test result is 0 to 9 mm, a second test should be given at least one week later and no more than three weeks after the first test; -All employees will be screened for TB; -Once the decision has been made to employ an individual, the individual will be asked for documentation of a prior PPD skin test that determines if an individual has TB; -If the employee does not have documentation of a prior PPD, the first step PPD will be administered by the nursing department, documented on the Employee Immunization Record, and must be read prior to or no later than the start date; -All PPDs will be documented on Employee Immunization Record including new hires and annual administration. After the PPD has been administered, the results will be documented in mm. Review of the Centers for Disease Control and Prevention website, updated 03/08/21, showed the following: -The TB skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm; -A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm; -Results should be documented in mm; -A second skin test should be administered one	F 880		

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F 880	Continued From page 60 to three weeks later; -The test should be read 48 to 72 hours after administration; -The results should be documented in mm. 2. Review of CNA N's personnel record showed the following: -Date of hire as 07/31/23; -The first step TB was placed on 08/04/23 (five days after the CNA's hire date) and read on 08/06/23; -The second step was placed on 08/20/23, and read on 08/22/23. 3. Review of LPN D's personnel record showed the following: -Date of hire as 02/13/24; -The first step TB was placed on 02/15/24 and read on 02/19/24 (after the 48 to 72 hours window); -The second step TB was placed on 02/19/24 (the same day the first step was read). The second step was read on 02/22/24. 4. Review of DA M's personnel record showed the following: -Date of hire as 10/14/24; -The first step TB was placed on 10/25/24 (nine days after the DA's hire date) and read on 10/27/24; -The second step TB was placed on 11/01/24 (five days after the first step was read). The second step was read on 11/03/24. 5. During interview on 12/13/24, at 1:00 P.M., the Administrator said that newly hired staff should	F 880		

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F 880	Continued From page 61 have the initial TB test done at orientation and the second step should not be started on the same day the first step was read. Staff should follow policy and procedure. 6. Review of the Centers for Disease Control and Prevention (CDC) Clinical Safety: Preventing Catheter-Associated Urinary Tract Infections (CAUTI) web-site showed a CAUTI occurs when germs (usually bacteria) enter the urinary tract through the urinary catheter and cause infection. Maintain the catheter's closed sterile drainage system Review of the "Guidelines for Prevention of Catheter-Associated Urinary Tract Infections 2009," updated 06/06/19, showed a catheter collection bag should not rest on the floor. Observation on 12/10/24, at 9:39 A.M., showed Resident #14 sat in his/her wheelchair in the dining room looking out the window. The resident's catheter (a tube that is inserted into the bladder to drain urine) bag was setting on the floor and the catheter tube was coming out of the resident's pant leg and was on the ground and under the resident's socked foot. Approximately one foot of tubing was touching the ground (potentially contaminating the tubing). Observation on 12/10/24, at 1:24 P.M., showed Resident #14 sat in his/her wheelchair in the hall near the nursing station. The resident's catheter bag was covered by a dignity bag with the bag dragging on the floor. The catheter tubing was coming out of the resident's pant leg and approximately one foot of tubing was dragging on the ground (potentially contaminate the tubing).	F 880		

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F 880	Continued From page 62 Observation on 12/10/24, at 1:53 P.M., showed the Activity Director pushed Resident #14 in his/her wheelchair from the hallway to the dining room for a music program. The resident's catheter tubing and dignity bag were dragging on the floor through the hall to the dining room (potentially contaminate the tubing). During an interview on 12/13/24, at 10:20 A.M., CNA H said catheters should be in a dignity bag and the tubing should not be dragging on the floor. During an interview on 12/13/24, at 11:02 A.M., LPN D said catheters are typically under the a resident in a dignity bag. The tubing should be coiled in the bag and should not be dragging on the floor. During an interview on 12/13/24, at 11:16 A.M., LPN E said resident catheters should be in a dignity bag and tubing should be in the bag as much as possible. Tubing and bag should not be dragging on the ground. During an interview on 12/13/24, at 12:48 P.M., the Director of Nursing (DON) said resident catheter tubing and bag should not be on the floor. During an interview on 12/13/24, at 1:00 P.M., the Administrator said resident catheter bags and tubing should not be dragging on the floor. 7. Review of the facility's policy titled "Medication Administration," undated, showed the following: -Medications are given to benefit a resident's health as ordered by the physician;	F 880		

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F 880	Continued From page 63 -Staff should wash hands; -Administer medications; -Discard disposable items and clean reusable items. Review of the facility's policy titled "Handwashing," undated, showed staff to use brush to clean under nails as necessary. Observation on 12/11/24, at 4:00 P.M., showed the following: -Certified Medication Tech (CMT) B was passing medications. The CMT's fingernails were approximately 1/4 inch in length and had black dirt appearance underneath the nails of both hands. -As the CMT prepared medication for Resident #47, he/she put his/her finger into the medication cup (potentially contaminate the medication cup) to remove from the pile of cups. He she prepared three medications and provided to the resident. -The CMT then prepared medications for Resident #24. The CMT put his/her finger into the medication cup (potentially contaminate the medication cup) to remove from the pile of cups. He/she prepared and provided three medications to the resident. -The CMT then prepared medications for Resident #34. The CMT put his/her finger into the medication cup (potentially contaminate the medication cup) to remove from the pile of cups and prepared and administered one medication to the resident. Observation on 12/11/24, at 4:15 P.M., showed the following: -CMT W was preparing medications for Resident	F 880		

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F 880	Continued From page 64 #51. The CMT removed a medication card of the medication cart drawer and pushed a tablet out of the card. The tablet landed on the top of the medication cart (potentially contaminating the tablet). The CMT picked up the tablet with his/her bare hands (potentially contaminating the tablet) and put into the medication cup. The CMT then picked up a second medication card and popped out a pill into his/her fingers (potentially contaminating the pill)and put into the medication cup. He/she then entered the resident room and provided the medications. -The CMT returned to the medication cart and prepared the next resident's medication without completing hand hygiene. The CMT removed medication cards for Resident #227. The CMT took the first medication card and pushed one tablet into his/her hand (potentially contaminating the tablet. and put into the medication cup. He/she then took the second medication card and pushed one tablet into his/her fingers (potentially contaminating the tablet) and put the tablet into the medication cup. He/she then entered the resident room and provided the medication. During an interview on 12/13/24, at 10:05 A.M., CMT B said staff should use hand sanitizer between each resident and before each medication pass. Staff should handle medication cups from the outside of the medication cup only. Staff should not put fingers inside the medication cup. If a pill dropped on the medication cart, staff should not touch the pill with their bare finger and put the medication back in the cup. Staff should not administer the dropped pill. Staff should not pop pills from the medication card into their fingers and then put into the cup. Staff should pop the pill directly from the card into the cup.	F 880		

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F 880	Continued From page 65	F 880		

During an interview on 12/13/24, at 10:12 A.M., CMT C said staff should clean hands before the start of the medication pass and should clean hands between each resident. The medication cups should be handled from the bottom or sides and should not be pick up by putting a finger into the cup. Staff should keep their fingernails clean when working.

During an interview on 12/13/24, at 11:02 A.M., LPN D said the following:

-Staff should not put their finger in the medication cup when picking up medication cups, the cups should be stacked upside down so they can be picked up by the outside of the cups;
-Staff should not pop out pills into their fingers or drop a pill on the cart and then pick up with their hand and put into the medication cup;
-Staff should keep their fingernails clean.

During an interview on 12/13/24, at 11:16 A.M., LPN E said staff should clean hands between each resident and staff should not have dirty fingernails. He/she was aware of staff with dirty fingernails, but had not personally talked to the staff about their fingernails. Staff should pick up medication cups from the sides of the cups and should not put their finger in the cup to pick up. Staff should pop out pills into the cup, not into their hands, and should not pick up a pill that dropped on to the cart and put into the medication cup and give to the resident.

During an interview on 12/13/24, at 12:19 P.M., the Assistant Director of Nursing (ADON) said staff should complete hand hygiene between residents before and after medication pass. Staff should take medication card to medication cup

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F 880	Continued From page 66 and pop the pill directly into cup. Staff should not pop pills into their hand and should not pick up a pill from cart and put into the cup and give to the resident. Staff should dispose of the pill dropped on cart. Staff should have clean fingernails while working. During an interview on 12/13/24, at 1:00 P.M., the Administrator said staff should follow policy and procedure for hand hygiene with medication pass. Staff fingernails should be per policy. 8. Observation on 12/11/24 showed the following: -At 11:18 A.M., CNA J was in Resident #38's room preparing to change resident's incontinent brief; -The CNA applied gloves and prepared the needed supplies; -The aide opened the front of the incontinent brief and provided incontinent care; -Without removing or changing gloves (potentially contaminated gloves) the aide assisted the resident to roll to his/her right side by holding edge of bed pad; -The aide then wiped the resident's buttock with a wet wipe and removed the brief. The brief was saturated with urine and small amount of bowel movement. The aide placed the brief into the trash; -Without changing gloves or completing hand hygiene the aide applied a clean brief; -The aide assisted the resident to roll to back to his/her back side by touching the resident's hip and leg with the same gloved hands; -The aide then pulled the clean brief through to the resident's right side; -The aide then wiped the residents front private area again with one wipe;	F 880		

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BROOKHAVEN NURSING & REHAB	**3405 WEST MT VERNON SPRINGFIELD, MO 65802**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 67 -He/she pulled the brief up and taped in place with the same gloved hands; -With the same gloved hands, the aide put both of his/her hands on resident's foot to hold the foot down for resident to reposition self; -The aide then pulled down resident's shirt with same gloved hands and put a pillow under the resident's left arm and another pillow under the resident's right arm; -The aide pulled up top sheet to cover resident, with the same gloves; -The aide gave the call light and bed controls to the resident and moved the side table closer to the bed; -The aide then sealed the clean wipes and removed the trash bag from the can; -At 11:29 A.M., the aide left the resident room and walked down the hall with the same gloves on and trash bag in hand; -He/she entered the soiled utility room and disposed of trash bags and removed his/her gloves; -Without using hand sanitizer or washing hands the aide took a drink from his/her pants pockets, opened and took a drink. Then put the drink back in their pocket; -The Aide walked down the hall to talk with other staff and then entered the clean utility to gather additional supplies, then returned to and entered the soiled utility and got trash bins; -The aide then stopped at the nurses' station and used hand sanitizer. During an interview on 12/13/24, at 10:20 A.M., CNA H said during incontinent care staff should clean hands before resident contact and apply gloves. Gloves should be changed at least once during cares, between dirty and clean. Staff should not put on gloves and never take off and	F 880		

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F 880	Continued From page 68 not clean hands until they enter the soiled utility room. During an interview on 12/13/24, at 10:12 A.M., CMT C said staff should clean hands before starting any personal cares and should clean their hands between each resident. During an interview on 12/13/24, at 11:02 A.M., LPN D said CNAs should be cleaning their hands before and after every resident care. They should be changing their gloves between dirty and clean tasks. Staff should not put on gloves and use from dirty to clean and leave the room with the same gloves on. During an interview on 12/13/24, at 12:19 P.M., the ADON said staff should wash hands with soap and water before entering resident rooms and should use hand sanitizer or wash hands between dirty and clean personal cares. Staff should change gloves and complete hand hygiene. Staff should not complete incontinent care with the same gloved hands through the entire procedure and then exit the room with same gloved hands to soiled utility room. During an interview on 12/13/24, at 12:48 P.M., DON said hand hygiene should be completed before and after every resident contact. Staff can use an alcohol-based cleanser or soap and water. Staff should clean their hands between every dirty and clean process and use clean gloves. Staff should not use the same gloved hands from beginning to end of cares. During an interview on 12/13/24, at 1:00 P.M., Administrator said staff should follow policy and procedure for hand hygiene with incontinent care.	F 880		

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F 880	Continued From page 69 9. Review of the facility's policy titled "Wound Care and Treatment," undated, showed the following: -The treatment cart should be left in the hall and locked; -Move the cart to the resident's room and park it outside the room; -Remove the supplies needed and re-lock the cart; -Set up the supplies on a clean surface at the bedside; -Supplies are never placed on the bed, but the soiled trash bag may be; -Hand washing must be done as outlined in the guidelines; -Remove the soiled dressing and place in the trash bag; -Place the soiled scissors on one corner of the setup, not touching any of the other supplies; -Removed the gloves and discard the bag; -Clean scissors with 60 seconds of contact with alcohol and place on a clean corner of setup; -Wash hands and put on clean gloves; -Clean the wound according to the order. Clean from the center outward; -Place soiled gauze in the trash bag; -Remove gloves, place in trash bag, and put on clean pair of gloves; -Apply clean dressing as ordered; -Wash hands; -Trash is bagged in the room and again in the bag on the cart, then disposed of in the soiled utility room in the infectious waste container. Observations on 12/12/24 showed the following: -At 9:40 A.M., LPN D prepared wound care	F 880		

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F 880	Continued From page 70 supplies for Resident #49 in the hallway outside the resident room; -The LPN put the full size wound cleanser bottle (medical product that removes debris, bacteria, and other contaminants from a wound to promote healing and reduce the risk of infection), an unopened package of 200 count gauze pads, an unopened package of 10 count 2 by 2 inch alginate wound dressing (type of absorbent wound dressing) on the table, two tubi-grips (tubular bandage that provides support and compression for a variety of injuries and conditions), 4 unopened packages of ABD pads (highly absorbent dressings that provide padding and protection for large wounds), an open package of sterile cotton tip applicators, a tube of gentamicin ointment (topical antibiotic used to treat infection of the skin), and an open box of exam gloves on the table; -The LPN applied a gown and entered the resident's room. The LPN washed his/her hands at the sink and then applied gloves. The LPN brought the bedside table with supplies into the resident's room; -At 10:19 A.M., after completing wound care the LPN removed the bedside table from the room with the remaining supplies, which included the wound cleanser bottle, an opened package of alginate wound dressing, 2 unopened packages of ABD pads, an open package of sterile cotton tip applicators, the tube of gentamicin ointment, the open box of exam gloves, and moved the table to the nursing station; -The LPN moved the treatment cart to the nursing station; -Without disinfecting any of the supplies the LPN put the wound cleanser bottle, gauze and wound dressing supplies, and the gentamicin ointment tube into the nurse cart.	F 880		

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F 880	Continued From page 71 During an interview on 12/13/24, at 11:02 A.M., LPN D said wound care supplies should be sanitized if they are shared supplies. Staff should not take in a whole bottle of wound cleanser and would generally just spray the clean gauze with wound cleanser before entering resident room. Any shared supply or equipment should be cleaned with bleach wipes before putting back into the treatment cart. During an interview on 12/13/24, at 11:16 A.M., LPN E said staff should sanitize wound care equipment between each resident. During an interview on 12/13/24, at 12:19 P.M., ADON said staff should not take wound cleanser bottle into the room. If needed, the bottle should be wiped down with the disinfecting wipes before using again. During an interview on 12/13/24, at 12:48 P.M., DON said staff should only take in the supplies needed and what they will use for wound care. They should not take an entire unopened package of gauze pads and the wound cleanser bottle into the resident room, only dedicated supplies. During an interview on 12/13/24, at 1:00 P.M., Administrator said staff should follow policy and procedure for infection control with wound care. 10. Review of the facility's undated policy titled "Handwashing", showed the purpose was to reduce transmission of organisms from resident to resident, nursing staff to resident, and resident to nursing staff.	F 880		

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F 880	Continued From page 72	F 880		

Review of the facility's policy titled "Wound Care and Treatment," undated, showed the following information:

-Clean technique is used. Care must be taken to prevent contamination of the supplies and surfaces used in wound care;
-Set up supplies on a clean surface at the bedside. Cover the surface with a clean barrier before putting the supplies down;
-Handwashing must be done as outlined;
-Explain the procedure to the patient, cut the tape with clean scissors, and don gloves;
-Remove the soiled dressing and place in a trash bag, place soiled scissors on one corner of setup, not touching any of the other supplies; remove gloves and discard, Clean scissors with 60 seconds of contact with alcohol and place on a clean corner of setup;
-Wash hands and don new gloves;
-Clean the wound according to the order, clean from the center outward;
-Place soiled gauze in the trash;
-Remove gloves, place in the trash, and don clean gloves;
-Apply clean dressing and wash your hands.

Review of Resident #60's face sheet (brief look at resident information), showed the following information:

-Admission date of 01/08/24;
-Diagnoses include unspecified open wound to right hip, chronic viral hepatitis C (a lifelong liver infection caused by the hepatitis C virus), and herpes viral vesicular dermatitis (a skin infection caused by the herpes simplex virus.

Review of the resident's care plan, revised on

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F 880	Continued From page 73 12/09/24, showed staff to clean hands before and when leaving the room. Staff to wear gloves and a gown for high contact resident care. Observation on 12/10/24, at 10:34 A.M., showed the following: -LPN F and LPN G were outside of the resident's room with gloves on. LPN F sanitized scissors and a bedside table that was being used as a clean barrier with bleach sani-wipes; -LPN F and LPN G entered the resident's isolation room with the supplies and bedside table, donned gowns and gloves, and placed scissors, wound cleanser, a large pack of gauze, calcium alginate, and foam pads on the bedside table; -Both LPN's entered the resident's bathroom, removed gloves, washed hands, and donned clean gloves; -LPN F obtained the scissors from the bedside table and cut off the dressing to the residents left elbow. He/she placed the scissors back down onto a corner of the clean bedside table; -LPN F cleansed the wound and attempted to manage an extensive amount of drainage from the resident's wound. LPN G handed LPN F clean supplies as needed. -LPN F removed gloves, did not complete hand hygiene, and donned clean gloves (potentially contaminating the gloves). The LPN applied the clean dressing to the wound; -LPN F removed gloves, washed hands, donned clean gloves, and moved onto the resident's right hip wound; -LPN F removed the soiled dressing to the right hip, removed gloves, washed hands, and donned clean gloves; -LPN F obtained the wound cleanser bottle and	F 880		

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F 880	Continued From page 74 sprayed the wound directly, cleansed wound with gauze, discarded gauze, used hand sanitizer on gloved hands with no glove change, obtained the soiled scissors from the bedside table, laid them back down on the bedside table. The LPN did not perform hand hygiene or change gloves. -LPN F obtained a clean pair of scissors LPN G had laid down onto the bedside table and LPN F cut a small square out of the calcium alginate which was placed onto the right hip's wound bed; -Without performing hand hygiene or a glove change, LPN F moved onto a scabbed area on the residents hip and cleansed the area with wound cleanser and gauze. -LPN F removed gloves, did not perform hand hygiene, donned clean gloves, and collected trash, soiled supplies such as wound cleanser, scissors, gauze pack, and left over supplies left on bedside table; -LPN F and LPN G entered the resident's bathroom, removed gowns and gloves, and washed hands; -Both LPN's exited the room with the bedside table of soiled supplies and sanitized the scissors. Staff did not sanitize the the wound cleanser bottle that had entered the residents isolation room. During an interview on 12/13/24, at 11:02 A.M., LPN D said hand hygiene should be performed before care, when going from dirty to clean, and after care. Supplies brought into resident rooms for wound care, such as wound cleanser and scissors should be sanitized before and after use. During an interview on 12/13/24, at 11:18 A.M., LPN E said all supplies that go into multiple areas should be sanitized before and after use.	F 880		

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F 880	Continued From page 75 During an interview on 12/13/24, at 12:19 A.M., the ADON said staff are expected to wash their hands with soap and water when they enter a resident's room, when going from a dirty to clean surface, and before leaving the room. All supplies brought in and out of resident rooms should be sanitized with a sani-wipe and should be allowed to air dry prior to using them again. During an interview on 12/13/24, at 12:47 P.M., the DON said staff are expected to perform hand hygiene in between residents, when going from a dirty to clean surface, and after care. The DON expected staff to be performing glove changes along with the hand hygiene. All supplies brought in and out of resident rooms should be sanitized before and after going into resident rooms. During an interview on 12/13/24, at 1:00 P.M., the Administrator he expected staff to follow policy regarding hand hygiene and infection control. 11. Review of the facility's policy titled "Cleaning and Disinfecting," undated, showed the following: -The glucometer should be cleaned and disinfected between each patient; -The following products have been approved for cleaning and disinfecting of the meter: Medline Micro-Kill Bleach germicidal bleach wipes and Clorox Healthcare Bleach germicidal and disinfectant wipes; -Staff should wash hands with soap and water; -Put on single-use medical protective gloves; -Inspect for blood, debris, or lint anywhere on the meter; -Blood and bodily fluids must be thoroughly cleaned from the surface of the meter.	F 880		

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F 880	Continued From page 76 Review of the facility's policy titled "Diabetic Infection Control," undated, showed the following information: -Enviromental surfaces such as glucometer will be decontaminated anytime contamination with blood or body fluids occurs or is suspected using an Environmental Protection Agency (EPA) registered disinfectant; -Multiple resident use glucometers will be cleaned and disinfected after each use using an EPA registered disinfectant wipe according to container label; -Annual training on diabetic infection control and glucometer use procedure will be completed. Review of the glucometer's manufactures instructions, undated, showed the following information: -The meter should be cleaned and disinfected between each patient; -Wash hands with soap and water, put on single use medical protective gloves, inspect or blood, debris, dust, or lint anywhere on the meter. Blood and bodily fluids must be thoroughly cleaned from the surface of the meter; -Approved disinfection products included Dispatch Hospital Cleaner Disinfectant Towels with Bleach, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes, and Midline Micro-Kill Bleach Germicidal Wipes; -To clean the meter, use a moist, lint free cloth dampened with a mild detergent. Wipe all external areas of the meter including both back and the front until visibly clean; -To disinfect the meter, clean the meter surface with one of the approved disinfecting wipes. Wipe all external areas of the meter including both front	F 880		

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F 880	Continued From page 77 and back surfaces until visibly wet; -Wipe meter dry, or allow to air dry, remove gloves, dispose of infectious material. Observation on 12/11/24, at 11:21 A.M., showed LPN D sanitized his/her hands, donned gloves, obtained a glucometer from inside of the medication cart. After LPN D obtained the glucometer, he/she laid the glucometer down on top of the medication cart. LPN D did not disinfect the glucometer again. He/she obtained a glucose test strip, obtained the glucometer, and entered Resident #42's room. LPN D obtained the resident;s blood sugar reading, exited the room, obtained a sani-wipe and placed the glucometer inside of it and placed it on the med cart. The LPN did not wipe/clean the glucometer. Observation on 12/11/24, at 11:30 A.M., showed LPN D sanitized his/her hands, donned gloves, and obtained a glucometer from inside of a sani-wipe on top of the medication cart. The LPN D entered Resident #3's room and attempted to collect glucose level. The glucometer read error. LPN D exited the resident's room and did not disinfect the glucometer. He/she laid the glucometer down onto the medication cart. LPN removed his/her gloves, sanitized hands, and donned clean gloves. The LPN obtained the glucometer and test strip and entered the resident's room for a second attempt, the glucometer read error. LPN D exited the resident's room, did not disinfect the glucometer, and laid the glucometer down onto the medication cart. The LPN removed his/her gloves, sanitized hands, and donned clean gloves. He/she obtained glucometer and test strip and entered the resident's room for a third attempt and was successful. LPN D exited the resident's room and	F 880		

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F 880	Continued From page 78 laid the glucometer inside of a sani-wipe on top of the medication cart. The LPN did not wipe/clean the glucometer. During an interview on 12/13/24, at 11:02 A.M., LPN D said glucometers should be wiped clean and kept covered with a sani-wipe. There is a required dry time of two to three minutes. During an interview on 12/13/24, at 11:18 A.M., LPN E said glucometers should be sanitized with a sani-wipe and then kept covered with a sani-wipe and let sit. During an interview on 12/13/24, at 12:19 A.M., the ADON said glucometers should be cleansed with a sani-wipe and then be allowed to air dry. During an interview on 12/13/24, at 1:00 P.M., the Administrator said staff should follow infection control policies.	F 880		

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A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: 1. Please refer to F880.	A4031		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F755. 2. Please refer to F759. 3. Please refer to F760.	A4055		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For	A4074		

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A4074	Continued From page 1 residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F689.	A4074		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F678. Please refer to F684.	A4075		
A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II	A4083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09512A	A. BUILDING: _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN NURSING & REHAB	3405 WEST MT VERNON SPRINGFIELD, MO 65802

(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
A4083	Continued From page 2 1. Please refer to F686.	A4083		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F880.	A4086		
A5003	19 CSR 30-85.052(3) Foods-Nutritive Value/Flavor/Appearance Foods shall be prepared and served using methods that conserve nutritive value, flavor and appearance. II/III This regulation is not met as evidenced by: Class III 1. Please refer to F804.	A5003		
A5005	19 CSR 30-85.052(5) Hot Food Hot, Cold Food Cold Provision shall be made to assure that hot food is served hot and cold food is served cold. II	A5005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A5005	Continued From page 3 This regulation is not met as evidenced by: 1. Please refer to F804.	A5005		
A7086	19 CSR 30-87.030(84) Equip/Utensils Air Dried, Self-Drain Utensils After mechanical or manual sanitization, all equipment and utensils shall be air dried. All utensils shall be stored in a self-draining position. III This regulation is not met as evidenced by: 1. Please refer to F880.	A7086		

PLAN OF CORRECTION

Provider/Supplier Name:	Brookhaven Nursing and Rehab
Street Address, City, Zip:	3405 West Mt. Vernon Springfield, MO 65802
Date of Survey:	12.8.2024-12.13.2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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F-645	Facility will continue to maintain that preadmission screening for individuals with a mental disorder and individuals with intellectual disabilities with be conducted for all residents that meet these qualifications.	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-Resident 5 still resides in the facility. All current and future residents will have preadmission screening conducted for all residents with mental disorders and individuals with intellectual disabilities. All residents that qualify for a level to screening and PASRR will have one on file during the duration of stay at the facility.	
2	**The facility identifies that all residents could potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-Not all residents will be affected, only the residents with mental disorders or intellectual disabilities and trigger a level two	

	screening. -The facility will ensure that all residents receive preadmission screening to ensure that the facility is within compliance of state and federal regulations	
3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-Administrator will in-service Social Service and BOM designee on importance of making sure that preadmission screening is being conducted on all residents moving forward -Social Service or designee will audit all resident to ensure that all screen and documentation that is necessary is in each resident electronic file for the facility weekly x4 week then monthly ongoing. -Training to be completed by January 27, 2025.	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	

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PLAN OF CORRECTION

Provider/Supplier Name:	Brookhaven Nursing and Rehab
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F-678	Facility will continue to maintain and ensure that all resident code status are consistent throughout the facility and in the residents chart.	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-Resident 55 still resides in the facility and was assessed and interviewed. Corrected action will be taken to ensure that code status is consistent throughout the facility and consistent with the residents chart.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-All residents have the potential to be affected. -The facility will ensure and assess that code status is consistent on all resident charts and throughout the facility moving forward	

	to make sure the facility meets state and federal regulations.	
3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-Administrator will in-service Social Service or designee on importance of making sure code status are consistent throughout the facility as well within the each residents chart.	
	-Social Service or designee will audit all residents to ensure that all code status are consistent in each residents chart and throughout the facility weekly x4 week then monthly ongoing. -Training to be completed by January 27, 2025.	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4075	See F-678 for corrections	

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F-684	Facility will continue to maintain and ensure that residents receive treatments and care in accordance with professional standards of practice and will follow consistently document and physician orders and routinely document of notification of the physician and assessments.	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-All residents have the potential to be affected. Resident 60 was assessed and interviewed and corrections made to ensure the facility is in compliance with standard practicing procedures.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-The facility will ensure that all residents receive treatment and care in accordance with professional standards. -Facility will ensure to follow consistently document and physician orders and routinely document of notification of	

	physician and assessments.	
3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/ designee will in-service License Nursing staff on consistent documentation and treatments from physician's orders. -DON/ designee will in-service License Nursing staff on routinely documenting of notification of physician and assessments. -DON/ designee will audit License Nursing staff on consistent documentation and treatments from physician's orders weekly x4 weeks and then random audits monthly for 90 days and ongoing. -DON/ designee will audit License Nursing staff on routinely documenting of notifications of physician and assessments weekly x4 weeks and then random audits monthly for 90 days and ongoing. -Training to be completed by January 27, 2025.	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4075	See F684 for corrections	

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F-686	Facility will continue to maintain and ensure that residents with pressure ulcers receive services consistent with professional standards of practice and will document regular full wound assessments	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-All residents have the potential to be affected. Resident 60 was assessed and interviewed and corrections made to ensure the facility is in compliance with standard practicing procedures.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-Facility will ensure that all residents with pressure ulcers will receive services in accordance with professional standards. -Facility will ensure to document regular full wound assessments.	

3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/ designee will in-service License Nursing staff on residents receiving services with pressure ulcers consistent with standard of practice. -DON/ designee will in-service License Nursing staff on documenting regularly full wound assessments.	
	-DON/ designee will audit License Nursing staff on residents receiving services with pressure ulcers weekly x4 weeks and then random audits monthly for 90 days and ongoing. -DON/ designee will audit License Nursing staff on regularly documenting on full wound assessments weekly x4 weeks and then random audits monthly for 90 days and ongoing. -Training to be completed by January 27, 2025.	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4083	See F686 for corrections	

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F-689	Facility will continue to maintain and ensure that residents are free of accident hazards as possible. Facility will continue to ensure residents have smoking assessments completed and complete care plan for smoking. Facility will ensure that residents to store smoking supplies at the nurses' station.	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-Resident 268 was assessed and interviewed and corrections made to ensure facility is in compliance with policy and procedure. -Resident 48 and 67 were assessed and interviewed and corrections made to ensure facility is in compliance with policy and procedure. -Resident 27 no longer resides at this facility. -All residents have the potential to be affected.	

2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-Facility will ensure that all residents have a competed smoking assessment and care plans are updated for smoking purposes to be in compliance with policy and procedure. -Facility will ensure that all residents store smoking supplies at the nurses' station to be in compliance with policy and procedure.	
3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/ designee will in-service staff responsible for conducting smoking assessments on residents and updating care plans. -All staff will be in-serviced on residents storing smoking supplies at the nurses' station. -DON/ designee will audit nursing staff responsible for conducting smoking assessments and updating care plans weekly x4 weeks and then monthly ongoing. -DON/ designee will audit staff on residents storing smoking supplies at the nurses' station weekly x4 weeks and monthly ongoing. -Training to be completed by January 27, 2025	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4074	See F689 for corrections	

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F-755	Facility will continue to maintain and ensure that residents are provided pharmacy services to meet the needs of each resident and will have ordered medications on hand for administration.	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-Resident 49 and 13 were assessed and interviewed and no negative effects from not receiving ordered medications per standards of practice. -All residents have the potential to be affected.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-Facility will ensure that all residents are provided pharmacy services to meet the needs of every resident per standard of practice. -Facility will ensure that ordered medications will be on hand for	

	administration per standard of practice.	
3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/ designee will in-service License Nursing staff and CMTs on assuring all residents are provided pharmacy services. -DON/ designee will in-service License Nursing staff and CMTs on assuring all ordered medications are on hand for administration. -DON/ designee will audit License Nursing staff and CMTs on having ordered medications for every resident on hand and administrating medication weekly x4 weeks and then random audits monthly for 90 days and ongoing. -Training to be completed by January 27, 2025.	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4055	See F755 for corrections	

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F-759	Facility will continue to maintain and ensure that all resident are free from medication error rates of 5 percent that are outlined in CFR(s): 483.45 (f)(1).	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-All residents have the potential to be affected. Residents 13 and 42 were both assessed and interviewed and there were no negative side effects on the residents.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-Facility will ensure that all residents are free from any medication error rates of 5 percent.	

3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/designee will in-service License Nursing staff and CMTs on medication administration per standards of practice to ensure residents are free from medication error. -DON/designee will in-service License Nursing staff and CMTs on medication administration of insulin per standards of practice to ensure residents are free from medication error. -DON/ designee will in-service License Nursing staff and CMTs on medication administration and the importance to administer medication within the appropriate time frame. -DON/designee will audit License Nursing staff and CMTs on medication administration per standard of practice weekly x4 weeks and random audits monthly for 90 days and ongoing. -DON/designee will audit License Nursing staff and CMTs on insulin administration per standard of practice weekly x4 weeks and random audit monthly for 90 days and ongoing. -DON/ designee will audit License Nursing staff and CMTs on proper medication administration and to administer medication within the appropriate time frame weekly x4 weeks and then random monthly audits for 90 days and ongoing. -Training to be completed by January 27, 2025	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4055	See F759 for corrections	

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F-760	Facility will continue to ensure and maintain that all residents are free from significant med errors that is outlined in CFR(s): 483.45(f)(2).	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-All residents have the potential to be affected. Resident 42 was all assessed and interviewed and there were no negative side effects on the residents.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-The facility will ensure that all residents are free from any significant med error.	

3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/designee will in-service License Nursing staff and CMTs on medication administration of insulin per standards of practice to ensure residents are free from significant medication error. -DON/ designee will in-service License Nursing staff and CMTs on medication administration and the importance to administer medication within the appropriate time frame. -DON/designee will audit License Nursing staff and CMTs on insulin administration per standard of practice weekly x4 weeks and random audit monthly for 90 days and ongoing. -DON/ designee will audit License Nursing staff and CMTs on proper medication administration and to administer medication within the appropriate time frame weekly x4 weeks and then random monthly audits for 90 days and ongoing. -Training to be completed by January 27, 2025	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4055	-See F760 for corrections	

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F-804	Facility will continue to maintain and ensure that food prepared and served has Nutritive Value/Appear, Palatable/Prefer Temp outlined in CFR(s): 483.60 (d)(1)(2).	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-Residents 40,36,55,17, and 33 were assessed and interviewed and were no negative side effects on the residents. All residents have the potential to be affected.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-The facility will take the necessary steps to ensure that food prepared by the facility is palatable to the residents.	

3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-Administrator will in-service dietary manager to ensure that all food prepared by the facility meets the required standards for palatability and temperature. -Dietary manager will in-service dietary staff to ensure that staff understands and follows the required standards for food prepared by the facility and ensure they meet proper palatability and temperature. -Dietary manager will audit food prepared by the facility for palatability and temperature weekly x4 weeks and random monthly audits for 90 days and ongoing. -Training to be completed by January 27, 2025	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A5003	See F804 for corrections	
A5005	See F804 for corrections	

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PLAN OF CORRECTION

Provider/Supplier Name:	Brookhaven Nursing and Rehab
Street Address, City, Zip:	3405 West Mt. Vernon Springfield, MO 65802
Date of Survey:	12.8.2024-12.13.2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction ("POC") is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Brookhaven Nursing & Rehab (the "Facility") as to the accuracy of the surveyors' findings, nor the conclusions drawn therefrom. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Corrections on 1/27/2025.	
F-812	Facility does and will continue to ensure food safety requirement outline in CFR(s): 483.60 (i) are followed during storage, preparation, distribution, and service in accordance with professional standards.	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-All residents have the potential to be affected.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-The facility will keep food safe from potential contamination with food contact surfaces (wet dishes). The facility will put all equipment, eating equipment, and utensils in a self-draining position that allows air drying.	

3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-Administrator will in-service dietary manager to ensure that all equipment will be in self-draining position that allows air drying per facility policy and procedure. -Dietary manager will in-service dietary staff to ensure that all equipment will be in self-draining position that allows air drying per facility policy and procedure. -Dietary manager will audit dietary staff for proper air drying of all equipment, eating equipment, and utensils weekly x4 week, random audits monthly for 90 days and ongoing -Training to be completed by January 24, 2025	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	

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F-880	The facility does and will continue to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections per CFR(s): 483.80 (a)(1)(2)(4)(e)(f).	1/27/2025 and ongoing
1	**Corrective action will be accomplished for the residents found to be affected by the alleged deficient practice by:**	
	-All residents have the potential to be affected. Residents 14, 47, 24, 51, 227, 38, 60, 49, 42, and 3 were assessed and interviewed and were not harmed by the deficient practices.	
2	**The facility identifies all residents as potentially affected by this alleged deficient practice. The corrective action will be accomplished by:**	
	-The facility will maintain infection control and provide a safe, sanitary, and comfortable environment. All staff at time of hire will have two-step TB test. Staff will ensure catheter bags are properly being used. All staff will complete hand hygiene before, during, and after each task.	

	-The facility will maintain infection control and provide safe, sanitary, and comfortable environment. All License Nursing staff and CMTs will clean/disinfect glucometer and equipment items before and after each use.	
3	**The measures put in place and the systemic changes were made to ensure that alleged deficient practice does not recur:**	
	-DON/ designee will in-service all nursing staff on proper hand hygiene that needs to be performed before, during, and after all wound care, incontinent care and medication pass per standards of practice. -DON/ designee will in-service all License Nursing staff and CMTs on proper cleaning of glucometer and other equipment items per standards of practice. -DON/ designee will in-service all License Nursing staff and CMTs on ensuring new hires have two step TB test conducted per standards of practice. -DON/ designee will in-service all nursing staff ensuring catheter bags are being used properly per standards of practice. -DON/ designee will audit nursing staff on proper hand hygiene for wound care, incontinent care and medication pass weekly x4 weeks and random audits monthly for 90 days and ongoing. --DON/ designee will audit License Nursing staff and CMTs on proper cleaning of glucometer and other equipment items weekly x4 weeks and random audits monthly for 90 days and ongoing. -DON/designee will audit to maintain that all new hires have the two step TB test conducted per standards of practice. -Training to be completed by January 27, 2025	
4	**The facility plans to monitor its performance to make sure that solutions are achieved and sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All findings of the audits will be documented and submitted to the monthly Facility Quality Assurance Committee for review and additional interventions will be made as needed.	
A4031 A4086 A7086	-See F880 for corrections	

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