STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265799	A. BUILDING _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOODS AT QUAIL CREEK, THE	1514 WEST LARK SPRINGFIELD, MO 65810

(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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse and neglect policy regarding screening staff members when the facility failed to complete an Employee Disqualification List (EDL - a list that lists staff who are unable to work in long-term care in the	F 607		

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

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

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F 607	Continued From page 1 state) check and a Nurse Aide (NA) Registry (registry which shows if someone has a Federal Indicator (indicates individuals the person cannot work in long-term care)) check for one employee (Registered Nurse (RN) A). The facility had a census of 99. Review of the facility's policy titled "Abuse, Neglect, and Exploitation Policy and Procedure," updated 07/2022, showed the following: -The names of all potential employees will be checked against the list maintained by the state of persons who may not be eligible for employment within a long-term care facility; -CNA registry will be checked on all new hires. Staff will print a copy for employee file prior to employment and according to state law; -Facility's are prohibited from employing individuals who have been found guilt of abuse, neglect, mistreatment or exploitation of residents or misappropriation of a resident's property by a court of law; -Any person investigated and found to be on the EDL, or who is found guilty of any A or B felony violation, in accordance to chapter 565,566 or 569 RSMO will be allowed to maintain employment; -The EDL is checked on a quarterly basis for all employees; -Any person whose name appears on the EDL will be terminated upon notification 1. Review of RN A's personnel file showed the following: -Hire date on 11/27/22; -Staff documented an EDL check on 08/15/24 (over 20 months after hire/start date);	F 607		

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F 607	Continued From page 2 -Staff documented a NA Registry check on 08/15/24 (almost 20 months after hire/start date). During an interview on 08/15/24, at 2:15 P.M., Licensed Practical Nurse (LPN) B said the following: -He/she assisted with hiring and orientation/training of new employees; -He/she is responsible to ensure criminal background checks and EDL checks have been completed; -He/she also will look at the NA check for licensure and a letter from the Family Care Registry; -He/she ensures all of this is done with all new staff; -RN A was already hired with the company and transferred from another state. That state did not require an EDL or NA registry check as far as he/she was aware; -He/she is unsure why an EDL/ NA registry was not completed once RN A transferred to the facility; -He/she added the EDL check and NA registry check today; -He/she said an EDL and NA registry check should be done for all new employees; -Checking the EDL and NA registry is required before the employee can have contact with residents. During an interview on 08/15/24, at 2:50 P.M., the Director of Nursing (DON) said the following: -LPN B did the background checks and the EDL and NA registry would be included; -He/she will assist at times, but LPN B was primarily the one who does this;	F 607		

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F 607	Continued From page 3 -He/she is unsure why this was overlooked, but said it would have been an oversight; -Completing the EDL and NA registry check should be done prior to the hiring of new staff. During an interview on 08/16/24, at 3:15 P.M., the Administrator said the following: -During covid, he/she brought RN A over from a sister-facility in another state; -RN A stayed on as a as needed employee and also worked in another town full-time; -LPN B is the one who will ensure staff are cleared through all background checks prior to being hired; -The other state does not require an EDL or NA registry check, so this is where the process was not followed-through on he/she suspects; -The EDL and NA registry should have been checked, according to Missouri code.	F 607		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide all necessary activities of daily living (including assistance with meals) to all residents ensure good nutrition when facility staff failed to assist one resident (Resident #17) with eating in a timely fashion. The facility census was 99. 1. Review of Resident #17's face sheet (brief	F 677		

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F 677	Continued From page 4 resident profile sheet) showed the following information: -Admission date of 11/07/22; -Diagnoses included unspecified protein-calorie malnutrition (a wasting condition resulting from a diet inadequate in either protein or calories or both). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument filled out by facility staff), dated 05/10/24, showed the following: -Moderate cognitive impairment; -Dependent with eating; -At risk for malnutrition. Review of the resident's Nutrition Diagnosis Criteria, dated 05/13/24, showed the resident at risk for malnutrition. Review of the resident's care plan, last revised on 08/14/24, showed the following information: -On 11/22/22, staff care planned to serve regular diet as ordered; -On 11/22/22, staff care planned to offer substitutions if resident was not eating and/or did not like something; -On 11/22/22, staff care planned notify physician if resident gained/lost five percent in a month; -On 05/22/23, staff care planned to offer a fork and spoon with each meal; -On 05/22/23, staff care planned to cut food into bite size pieces. (Staff did not care plan regarding assistance needed from staff to eat.)	F 677		

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F 677	Continued From page 5 Observation on 08/12/24 of the noon meal showed the following: -At 11:55 A.M., the resident sat at the dining room table with his/her eyes closed and head down. The staff placed the resident's plate, with plate guard attached and consisting of a regular diet of pork fritter, scalloped potatoes, and green beans in front of the resident. The staff did not attempt to wake the resident. -At 12:21 P.M., the staff started serving room trays and the resident sat at the table with eyes closed and head down not eating. -At 12:23 P.M. (28 minutes after the resident's meal was served), a staff member woke the resident up and began cueing the resident to eat. After the resident began to put green beans on his/her fork and attempted to start eating, the staff member left the table. -At 12:34 P.M., the resident had green beans on his/her fork, but was unable to bring them to his/her mouth. The resident sat at the table holding the fork with the green beans. -At 1:15 P.M. (over an hour after the resident's meal was served), a staff member sat down and began assisting the resident to eat. Observation on 08/13/24, of the noon meal, showed the following: -At 12:13 P.M., staff placed a plate, with a plate guard attached, consisting of a regular diet of fried chicken (on the bone), mashed potatoes, corn, roll and pears in front of the resident. Staff opened the resident's silverware, but did not assist with removing the chicken from the bone. The resident picked up the chicken leg and began chewing on the end of the leg. The resident continued to eat the backside of the	F 677		

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F 677	Continued From page 6	F 677		

chicken leg and could not get the leg turned around to get to the meat.
-At 12:25 P.M., the resident continued to attempt to find the meat on the chicken leg and was not attempting to feed him/herself any of the side items on the plate.
-At 12:41 P.M. (28 minutes after them meal was served to the resident), Certified Nursing Assistant (CNA) CC knelt on the floor beside the resident and began to assist the resident to eat.
-At 1:12 P.M., the CNA asked if the resident was finished with his/her meal, then rolled the resident to the television room. The resident ate 25% of the meal.

During an interview on 08/15/24, at 9:11 A.M., CNA T said the resident used a plate guard and special utensils. He/She has good days and bad days, so some days the resident required more help than others. The resident did better in the middle of the day, but the staff watch him/her throughout the meal to see if the resident needed assistance. He/she would not wait longer than five to ten minutes before encouraging or assisting the resident to eat.

During an interview on 08/15/24, at 10:05 A.M., CNA U said the resident did well with finger foods, but would need assistance with food that required a fork or spoon. The resident used a plate guard. Once the plate was put in front of the resident, if there was enough staff, he/she would expect staff to start assisting the resident to eat immediately. But, if there was not enough staff, staff should finish serving trays and then sit and start assisting the residents to eat. The residents should not have to wait longer than five minutes. A resident waiting 15 to 20 minutes would not be acceptable.

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F 677	Continued From page 7 During an interview on 08/16/24, at 9:03 A.M., MDS Coordinator X said independent residents are served their trays first so that staff can immediately sit down and help provide meal assistance to those who need help. The resident eats well some days and other days he/she is sleepy and needs help, but staff can tell quickly, within a couple minutes, if the resident is awake and talkative or sleepy and groggy. The resident always needed setup help and would require meat to be torn off the bone of chicken and silverware to be setup. He/she would not consider the resident to be at risk for weight loss. During an interview on 08/16/24, at 9:51 A.M., the Clinical Dietary Nurse said the resident was at risk for weight loss and is monitored. The resident eats by him/herself and does not need assistance beyond the setup of silverware. Even if staff encouraged a resident to eat by themselves, staff should still sit with the resident. If the resident did not eat, staff should offer other foods or a shake. The resident had orders for mighty shakes with medication pass and for a bedtime snack. During an interview on 08/16/24, at 12:35 P.M., the Director of Nursing (DON) said she would not consider the resident at risk for weight loss. The resident had his/her days and could take bites on his/her own, but needed encouragement. Staff should not make the resident wait longer than five to ten minutes before assisting him/her with eating.	F 677		
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 -	F 689		

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F 689	Continued From page 8 §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 review, the facility failed to maintain the hot water temperatures at sinks at a temperature to prevent that reduced the possibility of burns when hot water in multiple resident access areas measured in access of 120 degrees Fahrenheit (F). The facility had a census of 99. Review of the the US Consumer Product Safety Commission (CPSC) document "Avoiding Tap Water Scalds," dated 03/2012, showed the following: -The majority of injuries involving tap water scalds are to the elderly and children under the age of five; -The CPSC urges all users to lower their water heaters to 120 degrees F; -Most adults will suffer third-degree burns if exposed to 150 degreed F water for two seconds; -Burns will also occur with a six-second exposure to 140 degreed F water or with a thirty second exposure to 130 degree F water; If the temperature is 120 degrees F, a five minute exposure could result in third-degree burns Review of a facility policy entitled "Safe Water Temperatures," dated 01/01/24, showed the following: -It is the policy of the facility to maintain	F 689		

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F 689	Continued From page 9 appropriate water temperatures in resident care areas; -Water temperatures will be set to a temperature of no more than 120 degrees F, or the state's allowable maximum water temperature; -Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed; -Documentation of testing will be maintained for three years and kept in the maintenance office. 1. Review of the facility's hot temperature logs showed staff documented checking the hot water reading in two residents rooms per hall per week, the hall's water tank, and the dishwasher. 2. Observations on 08/15/24, at 3:39 P.M., showed the following:: -The hot water in the hall/public bathroom #1, located across from the kitchen door, (unlocked and accessible to residents) measured 130.1 degrees F; -The hot water in the hall/public bathroom #2, located across form the kitchen door, (unlocked and accessible to residents) measured 132.8 degrees F. Observations on 08/16/24 showed the following: -At 11:22 A.M., the hot water in the hall/public bathroom #1 measured 134.1 degrees F; -At 11:24 A.M., the hot water in the hall/public bathroom, near the Cedars neighborhood living room (accessible to residents), measured 122.0 degrees F; -At 11:27 A.M., the hot water in hall/public bathroom #2 measured 130.2 degrees F.	F 689		

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F 689	Continued From page 10 3. Review of Resident #37's face sheet (gives basic profile information) showed the following: -Admission date of 07/18/24; -Diagnoses included metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood), type 2 diabetes with peripheral angiopathy (nerve pain in the extremities), peripheral vascular disease (poor blood circulation), and osteoarthritis. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 07/25/24, showed the following: -Severely impaired cognition; -Functional limitation in range of motion to one lower extremity; -Utilized a walker or wheelchair for mobility. Review of the resident's care plan, last updated 08/01/24, showed the following: -May have difficulty remembering due to decreased cognitive status; -Memory and decision-making process may not be as reliable as it used to be. Resident might forget safety factors, so caregivers need to help stay as safe as possible Observation on 08/16/24, at 1:25 A.M., showed the hot water temperature in the resident's bathroom measured 132.3 degrees F. 4. Review of Resident #255's face sheet showed the following:	F 689		

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F 689	Continued From page 11 -Admission date of 08/05/24; -Diagnoses included hip fracture and late onset Alzheimer's disease. Review of the resident's admission MDS, dated 08/12/24, showed the following: -Severely impaired cognition; -Functional limitation in range of motion to one lower extremity; -Utilized a wheelchair for mobility. Review of the resident's care plan, last updated 08/14/24, showed the resident had difficulty remembering and becomes easily confused related to Alzheimer's. Observation on 08/16/24, at 11:32 A.M., showed the hot water temperature in the resident's bathroom measured 134.6 degrees F. 5. During an interview on 08/16/24, at 11:32 A.M., Maintenance Staff P said they check the water temperatures of two resident rooms per hall daily. The Maintenance Director is usually the person who does the checks and records them in a logbook. 6. During an interview on 08/16/24, at 11:50 A.M., the Maintenance Director said they randomly select two resident rooms per hall per week and check the water temperatures daily, along with the hall's water tank and dishwasher. They did not currently include the hall/public bathrooms in the temperature checks. 7. During an interview on 08/16/24, at 1:22 P.M., the Administrator said the maintenance	F 689		

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F 689	Continued From page 12 department should routinely check the water temperatures in resident rooms and the hall/public access bathrooms.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure diets were provided as ordered when staff failed to to care plan and provide physician ordered dietary supplements to one resident (Resident #54) who experienced weight loss and one resident (Resident #67) at risk for weight loss. The facility census was 99.	F 692		

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F 692	Continued From page 13 Review of the facility's policy titled "SNAR (Skin, Nutrition, And At Risk) Policy and Procedure, dated 12/23, showed the following information: -The facility will ensure that the resident maintains, to the extent possible, acceptable parameters of nutritional status to refuse risk of weight loss; -If weight loss/gain of five percent in thirty days is noted on monthly weights, the resident will be added to the weekly SNAR meeting for review; -The dietary manager will bring the list of residents on fluid restrictions, supplements ordered/furnished, and any recommendations that the registered dietician may have made; -The physician will be notified of recommendations made by the registered dietician or observations from the inter-disciplinary team (IDT) and then the interdisciplinary team will note any new orders received from the physician; -The resident's care plan will be revised at this time of any changes and interventions. 1. Review of Resident #54's face sheet (brief look at resident information) showed the following: -Admission date of 11/18/21; -Diagnoses include Parkinson's disease (a disorder of the central nervous system that affects movement), dysthymic disorder (a mental health disorder that involves long-term, mild to moderate depression), chronic kidney disease, and high blood pressure. Review of the resident's electronic medical record (EMR) showed the following:	F 692		

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F 692	Continued From page 14 -On 02/12/24, the resident weighed 154.4 pounds; -On 05/13/24, the resident weighed 144.6 pounds (loss of 9.8 pounds or 6.3 percent in three months). Review of the resident's current care plan showed staff did not address the weight loss, or add new intervention to address the weight loss. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 05/27/24, showed the following: -Moderate cognitive impairment; -Required supervision or touching assistance for eating; -No swallowing difficulty; -Had not had weight loss of five percent or more in the last month, or more than ten percent in the past six months. Review of the resident's EMR showed on 07/12/24, the resident weighed 139.6 pounds (a loss of 5 pounds or 3.4 percent in two months). Review of the resident's current care plan showed staff did not address the weight loss, or add new intervention to address the weight loss. Observation on 08/12/24, at 12:05 P.M., of the meal showed the resident in the dining room with food, water, and juice in front of him/her. Staff did not provide the resident with a mighty shake or ice-cream. Observation on 08/14/24, at 11:48 A.M., showed the resident in the dining room with food, water,	F 692		

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F 692	Continued From page 15 and juice in front of him/her. Staff did not provide a mighty shake or ice-cream. Review of the resident's Medication Administration Records (MAR) and Treatment Administration Record, dated 05/01/24 to 08/14/2024, showed staff did not document providing a nutritional supplement to the resident. Review of the document titled, "Resident's Diets-Willows," dated 08/15/24, placed on the back side of the Willows kitchen door, showed the following information for the resident: -Regular Diet; -Cut up meats, likes peanut butter, mashed potatoes, eggs, milk, vanilla ice cream, and coffee with lots of cream/sugar. (The document did not list the resident was to receive mighty shakes.) Observation on 08/15/24, at 12:08 P.M., of the meal showed the resident in the dinning room with food, water, and juice in front of him/her. Staff did not provide a mighty shake or ice-cream. During an interview on 08/15/24, at 2:44 P.M., Registered Nurse (RN) M said checking for daily weight loss is the charge nurse's responsibility. Weekly weights are the responsibility of the Dietary Consultant Nurse. If there was an issue with the weekly weights, the Dietary Consultant Nurse would place the resident on the SNAR list and the resident would most likely be provided supplements. These supplements should populate on the MAR. That is how the staff would know what the resident should be receiving. RN M looked in the resident's EMR and said he/she saw the order for a supplement, but also saw the	F 692		

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F 692	Continued From page 16 order was put in incorrectly and it did not populate over to the MAR. The order was put into the system in May of 2024. During an interview on 08/15/24, at 2:53 P.M., the Dietary Consultant Nurse said he checked weights of at-risk resident's every week. He then tracks the weights for four weeks. If there is a loss or gain, he contacts the resident's physician and facility dietician. The dietician will usually prescribe supplements and the physician will prescribe any medication needed. He is responsible for entering these orders into the EMR. He believed the resident has had a weight loss of three percent this month and that he was on a supplement three times a day. The Dietary Consultant Nurse reviewed the resident's EMR and the order was entered into the EMR in May 2024, but it appears the order was revised this day. He believed that dining services was who passed out the supplements, but the CMT's are supposed to chart it within the MAR. He expected any weight loss issues and or supplements to be seen in the care plan. During an interview on 08/16/24, at 10:47 A.M., the Dietary Manager said the Dietary Consultant Nurse let him and his department know what needed to be done for the residents regarding weight loss or gain. Him and the Dietary Consultant Nurse fill out the "Resident's Diets-Willows" document and ensure correct documentation is within it. Dietary Staff/Homemakers are supposed to give the residents the mighty shakes. The nurses and CMTs document it in the resident's MAR. He had not been made aware of any weight loss and or supplements needed for the resident, so his staff would not know to be giving the resident the	F 692		

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F 692	Continued From page 17 supplement. Review of the resident's care plan, dated 08/16/24, showed the following information: -At risk for weight loss; -On regular diet. Meal intake had been good since admission and resident was able to eat unassisted, but required assistance opening packages and cutting up foods; -Staff to notify physician if there is a weight loss/gain of five percent or more in a month; -Staff to provide mighty shakes as ordered; -Monitor intake, weight, and healing. Staff to provide supplements per orders, and refer to registered dietician as indicated. During an interview on 08/15/24, at 12:28 P.M., Certified Medication Technician (CMT) L said he/she was not sure if the resident was supposed to be getting mighty shakes and ice cream. This would populate on his/her MAR if the resident had an order for it. CMT L double checked the MAR and said he/she did not see mighty shakes and ice cream populating for the resident. During an interview on 08/14/24, at 12:50 P.M., Licensed Practical Nurse (LPN) J said he/she thought the CMTs were responsible for ensuring supplements were given. There is a Dietary Consultant Nurse that monitors dietary needs and weights as well as manages all feedings and supplements. During an interview on 08/16/24, at 12:35 P.M., the Director of Nursing (DON) said residents with nutritional risk for weight loss should be on the SNAR list and the dietician would look at them and make recommendations. The Dietary	F 692		

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F 692	Continued From page 18 Consultant Nurse would put those orders into the EMR and he should also update the "Residents Diets-Willows" document. Some of the supplements were not populating on the MAR, such as for this resident. During an interview on 08/16/24, at 1:46 P.M., the Administrator said for residents at risk for weight loss, he expected staff to be following through with supplement/medication orders and updating the care plan. 2. Review of Resident # 67's face sheet showed the following: -Admission date of 06/02/24; -Diagnoses included anorexia (anorexia is a significant loss of appetite which may be induced by a variety of causes including advanced dementia, changes in taste and smell, tooth loss or edentulism, and delayed gastric (stomach) emptying), dementia, abnormal weight loss, and hypothyroidism (a condition in which the body's tissues are exposed to a subnormal concentration of thyroid hormone). Review of the resident's Nutrition Risk Evaluation, dated 06/05/24, showed the following: -Resident's most current weight was 85 pounds; -Resident added to the high risk roster; -Resident had low body mass index (BMI - a calculation that used a person's weight and height to categorize them as underweight, normal weight, overweight, or obese); -Admit with hospice services; -Offer mighty shake; -Mechanical soft diet (a texture-modified diet that	F 692		

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F 692	Continued From page 19 makes foods easier to chew and swallow by pureeing, blending, finely chopping, or grinding food). Review of the resident's physician order sheet (POS), dated 08/16/24, showed an order, dated 06/07/24, for mighty shakes after meals. Review of the resident's quarterly MDS, dated 06/09/24, showed the following information: -Severely cognitively impaired; -Partial to moderate assistance with eating; -Has had weight loss of five percent or more in the last month, or more than ten percent in the past six months; -Complaints of difficulty or pain with swallowing. -Resident is on hospice services. (Staff did not care plan the intervention of mighty shakes.) Review of the resident's care plan, last revised on 07/03/24, showed the following information: -Admitted to hospice on 06/14/24; -Offer substitutions if resident is not eating and/or does not like something; -Offer supplements as directed; -Let the physician know if resident gained/lost five percent in a month; -Serve diet as ordered, now a regular diet (risk versus benefit form signed by family). Review of the resident's July 2024 MAR showed staff did not have a place to document administration of the mighty shake. Observation on 08/12/24, beginning at 11:57 A.M., of the noon meal showed staff did not	F 692		

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F 692	Continued From page 20 provide or offer a mighty shake to the resident. Observation on 08/13/24, beginning at 12:17 P.M., of the noon meal showed staff did provide or offer a mighty shake to the resident. Observation on 08/14/24, beginning at 11:57 A.M., of the noon meal showed staff did not provide or offer a mighty shake to the resident. Review of the resident's care plan showed the following information: -On 08/14/24, staff added the intervention to offer mighty shakes after meals; -On 08/14/24, staff added intervention to assist with meals. Resident may forget to eat or not use silverware. During an interview on 08/15/24, at 9:11 A.M., CNA T said he/she did not know for sure if the resident got a mighty shake. The kitchen usually handled that. During an interview on 08/15/24, at 11:13 A.M., Dietary Aide DD said the resident got mighty shakes at the table after meals. Review of the resident's diet on the back of the unit's kitchen door on 08/15/24 showed the following: -Cut food into bite size pieces; -No crispy food; -Mighty shakes after meals only. During an interview on 08/15/24, at 11:19 A.M., CMT V said the mighty shakes show up on the MAR. Sometimes the MAR will ask for a	F 692		

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F 692	Continued From page 21	F 692		

percentage and sometimes the MAR will ask if the resident received the shake. If CMT V knows the aides are busy he/she will give the shakes him/herself. He/she had not seen an order for the resident to have a mighty shake, but if the resident does not eat, the CMT recommends that he/she gets one. The mighty shakes do not show up on the MAR at times.

During an interview on 08/15/24, at 2:31 P.M., LPN W said he/she considered the resident someone at risk for weight loss. The resident's mighty shakes should show up on the MAR for the CMT. The resident had no other specific recommendations. The Clinical Dietary Nurse and the Dietary Manager make the recommendations for the residents. The Clinical Dietary nurse is responsible for updating the care plans regarding weight loss and weight loss interventions.

During an interview on 08/16/24, at 9:03 A.M., MDS Coordinator X said he/she could not find the resident's mighty shake on the MAR as it did not have a specific time to be charted. Sometimes, the homemakers give the mighty shakes, sometimes CNA or CMT will give it.

During an interview on 08/16/24, at 9:51 A.M., the Clinical Dietary Nurse said he considered the resident at risk for weight loss. His/her Mighty Shake should be documented on the MAR. He had found some that have not flowed to the MAR. He thought when the order was put in, the order did not get linked to the MAR. The resident had an order for Mighty Shakes, dated 06/07/24. Since it did not get linked to the MAR, there is no way to tell if the resident received his/her Mighty Shake since 06/07/24. He did not know if the care plan would be updated for Mighty Shakes.

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F 692	Continued From page 22 Review of the resident's MAR, dated 08/01/24 through 08/15/24, showed staff did not have a place to document administration of the Mighty Shake. During an interview on 08/16/24, at 12:35 A.M., the DON said the resident was at risk for weight loss. The resident was on weekly SNAR and weekly weight. The resident has an order for mighty shakes. If the resident ate good, staff might wait to give him/her the mighty shake. If not, it may be given while the resident is still at the table.	F 692		
F 755 SS=E	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 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	F 755		

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F 755	Continued From page 23 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 observation, interview, and record review, the facility failed to provide a safe and effective medication administration system for all residents when staff failed to maintain an accurate reconciliation and accounting for controlled medications (substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) for one resident (Resident #356) and when staff failed to destroy expired or unused medications for Willows and Chestnut Neighborhoods. The facility census was 99. 1. Review of a facility policy entitled "Medication Storage," dated 01/01/24, showed the following: -Any discrepancies which cannot be resolved must be reported immediately. Staff to notify the Director of Nursing (DON), charge nurse, or designee and the pharmacy and complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted; -The DON, charge nurse, or designee must also	F 755		

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report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators;
-Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies.

Review of Resident #356's face sheet (brief look at resident information) showed the following information:

-Admission date of 08/06/24;
-Diagnoses included drug induced polyneuropathy (when multiple peripheral nerves become damaged), anorexia (an eating disorder that causes people to obsess about their weight and food), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and diabetes.

Review of the resident's care plan, initiated on 08/10/24, showed the following information:

-Staff to administer diuretics, opioids, and diabetic medication as prescribed and monitor for any adverse side effects;
-Staff to give anti-diarrheal medications as prescribed.

Review of the resident's Physician Order Sheet (POS), dated 08/01/24 through 08/31/24, showed the following orders:

-A current order for diphenoxylate-atropine (an antidiarrheal medication, controlled substance),

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F 755	Continued From page 25 2.5-0.025 mg (milligram), give one tablet by mouth every four hours as needed, for diarrhea. Observation on 08/14/24, at 3:12 P.M., showed Willows neighborhood controlled medication lock box contained the following: -One bottle of diphenoxylate atropine containing two tablets; -The count sheet showed three tablets remaining. Review of the resident's Medication Administration Record (MAR), dated 08/01/24 through 08/31/24, showed diphenoxylate-atropine 2.5-0.025 mg had not been administered since 08/08/24 at 12:07 P.M. During an interview on 08/14/24, at 3:12 P.M. Certified Medication Technician (CMT) L said he/she believed the night shift nurse gave the medication, so CMT L wrote the date and time down and added a sticky note on the page to remind the night shift nurse to sign out the medication. When asked if CMT L typically takes the keys to the controlled substance box if the count is off, he/she said yes, all he/she does is leave a sticky note for the staff member to sign. He/she believed the night nurse must have gotten busy with morning report and simply forgot, because the two of them discussed it prior to CMT L taking the keys. During an interview on 08/14/24, at 4:34 P.M., Willows Neighborhood Charge Nurse/ Licensed Practical Nurse (LPN) J said he/she was not aware that there was a discrepancy in the controlled count. The CMT for that hall was CMT L and that was who took the count today and did not notify LPN J of any discrepancy. If LPN J had	F 755		

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F 755	Continued From page 26	F 755		

known about the discrepancy, he/she would have reported it to the nurse on call, or the Director of Nursing (DON). The nurse on call or DON would have come in and resolved the discrepancy prior to the count being signed over to CMT L. LPN J said if he/she ever noticed a discrepancy, he/she reported it to the nurse on call, or DON and does not accept the count until it's been resolved.

During an interview on 08/14/24, at 4:42 P.M., Willows Neighborhood Supervisor/Registered Nurse (RN) M said he/she, the nurse on call, or the DON should have been notified of the discrepancy. Once they are notified of such, they immediately begin investigating and no oncoming staff is to accept the count and no off going staff is to leave the facility until the discrepancy has been resolved. He/she was not aware there was a current discrepancy. It is never acceptable to place a sticky note for someone else to eventually sign, it needs to be taken care of immediately.

During an interview on 08/14/24, at 4:48 P.M., the DON said RN M had just let her know about the discrepancy. The DON, Assistant Director of Nursing (ADON) and RN M were currently investigating the discrepancy. The DON said if the oncoming staff is aware of whom did not sign a medication out, they could "flag" the medication to be signed, however they should still let the DON and RN M know what is going on. The DON said she was currently calling the night shift nurse who was responsible for signing out the medication to get it corrected immediately. The DON said she believed she knew what happened, She believe the night shift nurse accidentally signed off the wrong medication. She does expect staff to ensure they know where the error is coming from prior to any shift leaving the

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NEIGHBORHOODS AT QUAIL CREEK, THE	**1514 WEST LARK SPRINGFIELD, MO 65810**

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F 755	Continued From page 27 building. During an interview on 08/15/24, at 4:34 P.M., CMT N said if the shift count of the narcotics and controlled medications is off, staff shouldn't accept the keys or sign off on the log. If the previous shift cannot resolve a discrepancy, staff should tell the charge nurse or the DON. During an interview on 08/15/24, at 12:26 P.M., CMT O said he/she would not accept the keys from the previous shift staff if the narcotic shift count was off. Staff should get it resolved first. During an interview on 08/15/24, at 4:48 P.M., the DON said if the shift count of controlled medications is off (count doesn't match the logbook documentation), staff should let the Mentor/Unit Manager or the DON or Assistant Director of Nursing (ADON) know immediately. There would have to be an investigation to resolve the discrepancy. The medication administration record showed the nurse documented administration on the wrong medication, causing a discrepancy on the logbook. The nurse should have resolved the issue and corrected documentation before the next shift staff accepted the keys to the medication cart and locked cabinet and box 2. Review of a facility policy entitled "Medication Storage," dated 01/01/24, showed the following: -The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused	F 755		

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F 755	Continued From page 28 Drugs Policy. Observation on 08/14/24, at 3:02 P.M., of the Willows Neighborhood overstock and wound supplies cart showed the following: -A strip pack that contained fourteen tablets of dexamethasone (a corticosteroid that helps relieve inflammation) with an expiration date of 07/30/24 that belonged to a deceased/discharged resident. Observation on 08/14/24, at 3:12 P.M., of the Willows Neighborhood controlled medication lock box showed the following: -Fifty-six tablets of OxyContin (opioid analgesic, schedule II-controlled substance with abuse potential, used to treat pain) 20 mg with a note on the count sheet that said "do not use" for Resident #356; -One bottle that contained seventeen tablets of OxyContin 20 mg with a note on the count sheet that said "do not use" for Resident #356; -One bottle that contained fifty-nine and a half tablets of Percocet (opioid analgesic, schedule II-controlled substance with abuse potential, used to treat pain) 5/325 with a note on the count sheet that said "do not use" for Resident #356; -Fifty-three tablets of Oxycodone (opioid analgesic, schedule II-controlled substance with abuse potential, used to treat pain) 5 mg for a deceased/discharged resident; -One bottle containing 21 ml (milliliters) of morphine solution (opioid analgesic, schedule II-controlled substance with abuse potential, used to treat pain) for a deceased/discharged resident; -One full/unopened bottle containing 30 ml of Morphine Solution for a deceased/discharged	F 755		

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F 755	Continued From page 29 resident. Observation on 08/15/24, at 12:35 P.M., of the Chestnut Neighborhood medication cart showed the following: -One bottle of Systane (relieves dry eyes) eye drops belonging to Resident #34 expired on 07/22; -One bottle of acetaminophen (nonsteroidal anti-inflammatory - NSAID drug used to relieve pain) 500 mg belonging to Resident #58, expired on 06/30/24; -One card of Hyoscyamine (central muscarinic antagonist used to treat muscle cramps in the bowels and bladder) 0.125 mg belonging to Resident #71, expired on 08/06/24; -One bottle of ibuprofen (NSAID used to relieve pain) 200 mg belonging to Resident, #61 expired on 01/23; -One bottle of Colace (stool softner) 100 mg belonging to Resident #62, expired on 03/24; -One bottle of milk of magnesia (laxative) belonging to Resident #62, expired on 07/23; -One bottle of stock geri-lanta (antacid), expired on 04/24; -One box of Daytime Cold and Flu belonging to Resident #71, expired on 10/21; -One box of Metamucil (fiber supplement) packets belonging to Resident #50, expired on 02/24. During an interview on 08/14/24, at 4:42 P.M., RN M said expired medications and medications from deceased or discharged residents destroyed and not used. During an interview on 08/16/24, at 9:38 A.M., LPN J the protocol for expired medications is to	F 755		

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F 755	Continued From page 30 pull it from the cart, don't use it, and destroy it. LPN's can destroy anything that is not a narcotic. If the medication is a narcotic, there must be two RNs to destroy. If he/she found medications from deceased or discharged residents, he/she would notify a manager and take it out of the cart. During an interview on 08/16/24, at 11:28 A.M., the DON said expired and medications from deceased or discharged residents should be destroyed and not used. During an interview on 08/16/24, at 1:46 P.M., the Administrator said medications from deceased or discharged residents and/or expired medications should not be used. The staff should let RN M or DON know so they can destroy the medication.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		

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F 761	Continued From page 31 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all medications were stored and labeled in accordance with standards of practice when staff failed to store controlled substances under two locks, when medication carts were left unlocked when unattended, when staff left medications on the nightstand of one resident (Resident #70), and when staff removed prescription labels from medications. The facility census was 99. Review of a facility policy entitled Medication Storage, dated 01/01/24, showed the following: -It is the policy of the facility to ensure all medications housed on the premises are stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security; -All drugs and biologicals will be stored in locked compartments (such as medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls; -Only authorized personnel will have access to the keys to locked compartments; -During a medication pass, medications must be under the direct observation of the person administering medications or locked in the	F 761		

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F 761	Continued From page 32 medication storage area/cart; -Narcotics and Controlled Substances: Schedule II drugs and back-up stock of Schedule III, IV, and V medications are stored under double-lock and key; -Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator. 1. Observation and interview on 08/15/24, at 12:26 P.M., on the Dogwood hall with Certified Medication Technician (CMT) O showed the following: -The door to nurses' office was open with no staff was present in the room; -CMT O entered the office and indicated a cabinet door was where the narcotics and controlled substances were kept. The CMT grasped the cabinet handle and opened the door without using a key. -The CMT then used a key to unlock the narcotic/controlled substance box located within the cabinet. Multiple pharmacy packaged medications were present. -CMT O said other medications were also stored in the cabinet, such as medications brought in by residents from home and not currently in use. -CMT O verified that the cabinet door was not locked when he/she opened it and said staff was expected to lock both the narcotics box and the cabinet door after its use. During an interview on 08/15/24, at 4:34 P.M., CMT N said staff should always lock the cabinet where the narcotics locked box is kept and should ensure the locked box is also secured.	F 761		

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F 761	Continued From page 33 During an interview on 08/16/24, at 12:35 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said having medication cabinets unlocked is not acceptable. During an interview on 08/16/24, at 1:46 P.M., the Administrator said medication cabinets should be locked at all times. 2. Observation on 08/12/24, at 9:19 A.M., showed the Willows hall medication cart contained several medication cards, over the counter medications, and supplies. The cart was unlocked and faced the nurses' station. Several residents were in the living room adjacent from the medication cart. At 9:21 A.M., a staff member came by and locked the cart. Observation on 08/14/24, at 9:47 A.M., showed the Willows hall medication cart contained several medication cards, over the counter medications, and supplies. The cart was unlocked and faced the nurses' station and adjacent from the living room. The medication cart was out of sight of CMT L who was in the dining room. Several residents in the living room area, next to the medication cart. At 9:51 A.M., CMT L walked up to the cart and locked it. During an interview on 08/16/24, at 9:38 A.M., Licensed Practical Nurse (LPN) J said medication carts should be locked at all times. During an interview on 08/16/24, at 11:28 A.M., Registered Nurse (RN) M said medication carts should be locked at all times unless it is in use by a certified medication technician or nurse. During an interview on 08/16/24, at 12:35 P.M.,	F 761		

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F 761	Continued From page 34 the DON and ADON said having medication carts unlocked is not acceptable. During an interview on 08/16/24, at 1:46 P.M., the Administrator said medication carts should be locked at all times. 3. Review of Resident #70's face sheet, showed the following information: -Admission date of 07/07/24 -Diagnoses include emphysema (a condition in which the air sacs of the lungs are damaged and enlarged, causing breathlessness), chronic obstructive pulmonary disease (COPD - a lung disease that blocks airflow and makes it difficult to breathe), hypercapnia (an increase in partial pressure of carbon dioxide), and high blood pressure. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/31/24, showed the following information: -Cognitively intact; -Did not receive any high-risk drug class medications. Review of the resident's care plan, revised on 06/12/24, showed staff did not care plan self-administration of medications. Review of the resident's Physician Order Sheet (POS), dated 08/01/24 through 08/31/24, showed staff did not note an order for keeping medications at bedside or self-administration. Review of the resident's Medication	F 761		

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F 761	Continued From page 35 Administration Record (MAR), dated 08/01/24 through 08/31/24, showed staff did not note an order for the resident to keep medications at bedside or self-administration. Observation on 08/12/24, at 9:10 A.M., showed the resident in his/her room, laying on the bed. Two inhalers, labeled fluticasone propionate (treats allergy symptoms by decreasing inflammation in the nose) and one bottle labeled echinacea (a dietary supplement for the common cold and other infections) were on top of the resident's bedside table. During an interview on 08/13/24, at 9:04 A.M., The resident said he/she no longer used those medications that are on top of his/her bedside table. The medications were only used by him/her when he/she was sick a while back. Observation on 08/13/24, at 2:09 P.M., showed the resident in his/her room, laying on the bed. Two inhalers, labeled fluticasone propionate and one bottle labeled echinacea were on top of the resident's bedside table. Observation on 08/14/24, at 8:49 A.M., showed the resident in his/her room, laying on the bed. Two inhalers labeled fluticasone propionate and one bottle labeled echinacea were on top of the resident's bedside table. Observation on 08/15/24, at 9:26 A.M., showed the resident in his/her room, laying on the bed. Two inhalers labeled fluticasone propionate and one bottle labeled echinacea were on top of the resident's bedside table. During an interview on 08/16/24, at 9:38 A.M.,	F 761		

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F 761	Continued From page 36 LPN J said medications should never be left on a resident's bedside table. The only reason that would happen is if they have a physician's order to do so. During an interview on 08/16/24, at 11:28 A.M., RN M said he/she is not aware wether or not the resident had a physician's order for his/her medications to be at bedside. If the resident did have an order, that would also be in the care plan. If the resident does not have an order, leaving any medications at bedside would not be acceptable. During an interview on 08/16/24, at 12:35 P.M., the DON and ADON said leaving medications at bedside without a physician's order was not acceptable. The DON said that there must be a physician's order for leaving medications at bedside, and that information should also be found in the care plan. During an interview on 08/16/24, at 1:46 P.M., the Administrator said it was not acceptable to leave medications at bedside without a physician's order. 4. Observation on 08/14/24, at 3:02 P.M., inside of the treatment and overflow cart inside the nursing station on the Willows neighborhood showed the following medication with prescription labels removed: -One Santyl (a Federal and Drug Administration (FDA) approved medication that removes dead tissue from wounds); -One Diclofenac 3% cream (a nonsteroidal anti-inflammatory drug used to treat mild to moderate pain);	F 761		

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F 761	Continued From page 37 -One Mometasone Furoate 0.1% cream (a corticosteroid ointment used to treat skin conditions such as eczema, and psoriasis); -One Ketoconazole 2% (an antifungal medicine that is used to treat skin infections caused by yeast); -One Diclofenac 1% cream. During an interview on 08/14/24, at 3:02 P.M., LPN J said creams are sometimes unlabeled because other staff use those medications for other residents as the needs arise, especially Santyl as it is expensive. During an interview on 08/16/24, at 11:28 A.M., RN M said it would not be acceptable to tear off prescription labels with the purpose of using the medications for other residents. During an interview on 08/16/24, at 12:35 P.M., the DON said it would not be acceptable to tear off prescription labels with the purpose of using the medications for other residents. During an interview of 08/16/24, at 1:46 P.M., the Administrator said it would not be acceptable to tear off prescription labels with the purpose of using the medications for other residents.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		

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F 812	Continued From page 38 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 all food safe from potential contamination at all times when staff failed to where hairnets properly while in working in the facilities kitchens. The facility census was 99. Review of the facility's policy titled "Dietary Employee Personal Hygiene," dated 01/01/24, showed the following information: -The purpose was to prevent contamination of food by food service employees; -All dietary staff must wear hair restraints (e.g., hairnet, hat and/or beard restraint) to prevent hair from contacting food; -Head coverings must be clean. Review of the Food and Drug Administration (FDA) 2013 Food Code showed the following: -Consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. -A hair restraint keeps dislodged hair from ending	F 812		

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F 812	Continued From page 39	F 812		

up in the food and may deter employees from touching their hair.
-Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and lines; and unwrapped single-service and singled-use articles.

1. Observation on 08/14/24, at 1:38 P.M., showed Homemaker Q walked through the kitchen. He/she was not wearing a hairnet and his/her hair hung below his/her shoulders.

Observation and interview on 08/14/24, at 1:44 P.M., with Baker D showed the following:

-Baker D was in the kitchen with out a hair or beard net. He/she then walked over next to the kitchen door, put on the beard net over his/her facial hair, but did not put on a hair net covering his/her hair on his/her head;
-He/she said hairnets should be put on when entering the kitchen, but he/she had forgotten to do so today.

Observation on 08/16/24, at 12:24 P.M., in the Redbud neighborhood, Homemaker D wore a hairnet, but failed to ensure all his/her hair was secured. The hairnet was not covering his/her long hair pieces on the front, sides, or back.

During an interview on 08/16/24, at 12:24 P.M., Homemaker D said the following:

-Everyone who does anything with food should be wearing a hairnet;
-He/she knows that his/her hair won't stay in very

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F 812	Continued From page 40 well; -He/she only the roots of the hair must be covered and it is okay for the loose hairs to be outside of the hairnet. Observation on 08/16/24, at 12:30 P.M., in the Dogwood neighborhood, showed Homemaker F wore a hairnet that did not secure his/her hair. His/her hair came out from under the hair net. During an interview on 08/16/24, at 12:24 P.M., Homemaker F said the following: -He/she said everyone should be wearing hair nets; -He/she does wear hairnets as staff are supposed to be doing, but they do not stay on well. During an interview on 08/16/24, at 1:05 P.M., Homemaker G said hairnets and any face covering should be covering all hair and worn anytime working in the kitchen or around food. During an interview on 08/14/24, at 1:40 P.M., Chef C said everyone working in the kitchen is required to wear a net, covering all hair. During an interview on 08/14/24, at 1:45 P.M., the Dietary Manager, said he/she expects anyone working behind the kitchen doors to have a hair net covering all hair. During an interview on 08/16/24, at 2:50 P.M., the Administrator said any staff working in the kitchen is expected to be wearing a hairnet.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 41 §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 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:	F 880		

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F 880	Continued From page 42 (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, interview, and record review, the facility failed to implement an effective program of infection control when staff failed to communicate an infection control plan to all staff and implement a consistent infection control plan for one resident (Resident #17) who had a current diagnosis of Clostridium difficile (C. Diff - a highly contagious germ that causes diarrhea and inflammation of the colon). Facility staff also failed to perform hand hygiene per standards of practice when providing cares to two residents	F 880		

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F 880	Continued From page 43 (Resident #17 and Resident #67) and when administering medication per a feeding tube for one resident (Resident #2). Facility staff also failed to use infection control practices per standards of practice when completing accuchecks (a meter that measures glucose in whole blood) and failed to properly disinfect glucometers (measures how much sugar is in the blood sample) for one resident (Resident #22). The facility census was 99. Review of the facility's policy titled "Hand Hygiene," revised January 2024, showed the following: -Staff will perform hand hygiene when indicated. Using proper technique consistent with accepted standards of practice; -Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations; -Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. 1. Review of the facility's policy titled "Management of C. Difficile Infection," revised January 2024, showed the following information: -All staff are to wear gloves and gown upon entry into the resident's room and while providing care of the resident with C. difficile infection; -Hand hygiene shall be performed by hand washing with soap and water in accordance with facility policy for hand hygiene; -Maintain on contact precautions for the duration of illness, but no less than 48 hours after diarrhea has resolved.	F 880		

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F 880	Continued From page 44 Review of the facility's policy titled "Enhanced Barrier Precautions (EBP)," revised April 2024, showed the following information: -The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an Multi-Drug Resistant Organism (MDRO) that is not currently targeted by Centers for Disease Control (CDC), but may be considered epidemiologically important; -Make gowns and gloves available in designated area of the resident's room; -Position a trash can inside the resident room and near the exit for discarding PPE (personal protective equipment - protective clothing such as gowns, gloves, goggles or other garments designed to protect workers from infection or injury) after removal, prior to exit of the room or before providing care for another resident in the same room; -High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device use, and/or wound care. Review of the CDC Implementation of PPE Use in Nursing Homes to Prevent Spread of MDROs, dated 04/02/24, showed the following: -EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO; -When implementing contact precautions or enhanced barrier precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove	F 880		

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F 880	Continued From page 45 use; -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE; -For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves; -Make PPE, including gowns and gloves, available immediately outside of the resident room; -Contact precautions are recommended for all residents who have another infection (such as C-diff) or condition. Review of Resident #17's face sheet (brief resident profile sheet) showed the following information: -Admission date of 11/07/22; -Diagnoses included metabolic enterocolitis (enterocolitis- inflammation of the small intestine) due to clostridium difficile. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/10/24, showed the following information: -Moderately cognitively impaired; -Dependent on staff for toileting, bathing, dressing, and mobility; -Frequently incontinent of bowel and bladder. Observation on 08/12/24, at 3:42 P.M., showed the resident sat in a wheelchair in the room. There were no isolation sign on the door or PPE supplies observed in or near the room. Observation on 08/13/24, at 9:25 A.M., showed	F 880		

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the resident in the bed sleeping and an EBP sign on the door.

Review of the resident's care plan, revised 08/14/24, showed the following information:

-Contact precautions;
-Provide PPE equipment per protocol;
-Provide peri care with each incontinent episode;
-Evidence based precautions;
-Please wear a gown and gloves (and mask if indicated) when providing direct care.

Observation on 08/14/24, at 2:30 P.M., showed the following:

-Certified Nursing Assistant (CNA) R and CNA S entered the resident's room;
-CNA R and CNA S washed their hands and applied gowns and gloves;
-CNA S observed the mechanical lift (sit to stand lift - helps transfer a resident with limited mobility from a seated position to a standing position) did not have a battery. He/she removed the PPE and left the room;
-When CNA S returned with the battery, he/she did not perform hand hygiene. The CNA reapplied gown and gloves with no hand hygiene and attached the battery to the sit to stand lift;
-CNA R and CNA S transferred the resident to the toilet with the mechanical lift. The resident's brief was saturated with urine;
-CNA R gave the resident toilet paper to wipe him/herself. CNA R then assisted resident's with cleaning his/her peri area. CNA R then took the dirty toilet paper from the resident and placed the toilet paper in the trash. The CNA did not remove his/her gloves;
-The staff stood the resident back up with the

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F 880	Continued From page 47 mechanical lift; -While the resident stood, CNA S wiped the resident twice with clean wash cloths. The CNA removed his/her gloves and did not perform hand hygiene; -CNA R and CNA S pulled up the resident's brief and clothes, rolled the resident back to the wheelchair, and sat him/her down in the wheelchair; -CNA R and CNA S hooked the resident back up to the sit to stand. CNA S did not have gloves on and CNA R continued to wear the same contaminated gloves while operating the lift; -The CNAs transferred the resident into the bed with the sit to stand lift. CNA S, without washing hands and with no gloves, and CNA R while continuing to wear the same contaminated gloves, placed a pillow under his/her legs to float the resident's heels, and pulled up the covers over the resident; -CNA R handed the resident his/her call light and then removed the contaminated gloves, CNA S gathered the trash. CNA S and CNA R washed their hands. CNA R lowered the bed and wheeled out the sit to stand into the hall and to the shower room; -CNA R placed the sit to stand in the shower room and did not clean it. Observation on 08/15/24, at 9:09 A.M., showed CNA T and CNA U in the resident room unhooking the resident's sling from the mechanical lift. The resident sat in the wheelchair. Staff did not have gowns or gloves on. During an interview on 08/15/24, at 10:00 A.M., CNA T said he/she and CNA U had changed the resident in the bed, sat him/her up, and	F 880		

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F 880	Continued From page 48 transferred the resident to the wheelchair with the sit to stand mechanical lift. Both CNAs had gown and gloves on during the provision of peri care and had removed the gown and gloves after placing the sling behind the resident and attaching it to the sit to stand lift. During an interview on 08/15/24, at 10:05 A.M., CNA U said he/she and CNA T went into the room and applied gown and gloves and provided peri care for the resident. The CNAs applied the sling, connected the sling to the sit to stand lift, removed their gowns and gloves, rolled the resident to his/her wheelchair, and sat the resident in his/her wheelchair. CNA U and CNA T washed their hands and then washed the resident's face. Observation on 08/15/24, at 11:53 A.M., showed the following: -CNA T entered the resident's room, washed his/her hands, and applied gown and gloves; -The resident sat in his/her wheelchair; -CNA U entered the resident's room and did not perform hand hygiene. The CNA applied gown and gloves; -CNA T placed the sit to stand sling behind the resident and connected it to the sit to stand lift. He/she then raised the resident into a standing position; -CNA T and CNA U rolled the resident in the lift to the bathroom and lowered him/her onto the toilet; -CNA U removed the resident's brief. The brief contained semi formed, yellow stool with mucus and a strong odor; -CNA U unhooked the resident from the sit to stand so brief could be placed. CNA U hooked the resident back to the sit to stand lift. The	F 880		

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resident had a bowel movement while sitting on the toilet. CNA U cleansed the resident and pulled up his/her brief;
-CNA U removed gown and gloves and helped roll the resident back to his/her wheelchair, then washed his/her hands;
-CNA T removed the gown and gloves. The CNA put on new gloves, did not perform hand hygiene, and wiped down the lift with bleach wipes;
-CNA U put on new gloves, did not put on a gown, and cleaned loose fecal material off the toilet with bleach wipes;
-CNA U gathered the trash and left the room with the bag containing contaminated trash and took it down the hall to the main trash can.

During an interview on 08/15/24, at 9:11 A.M., CNA T said the resident was on EBP because he/she had C. diff but they took the resident off because he/she was not having many loose bowel movements.

During an interview on 08/15/24, at 10:05 A.M., CNA U said the following:

-EBP signs are different from contact isolation signs. Contact isolation signs have a stop sign and say to check with the nurse;
-Contact isolation would also have a three-tier drawer system outside of the room;
-The resident is on EBP. This would require gown and gloves before providing direct care such as transfers or peri care;
-Transfers to wheelchair would count as direct care.

During an interview on 08/15/24, at 11:19 A.M., Certified Medical Technician (CMT) V said the following:

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F 880	Continued From page 50 -The resident was on contact isolation; -There should be a sign on the door for this; -There should be PPE in the hallway and staff should be putting this on before entering the room; -There should be two different trash cans in the resident's room, one for regular trash and one for the biohazard trash. During an interview on 08/15/24, at 2:31 P.M., Licensed Practical Nurse (LPN) W said the following: -The resident generally still has one or two loose bowel movements a day and still currently has C. diff; -Staff should be wearing gown and gloves throughout care with residents on isolation; -The resident is on contact isolation, but can come out of the room, once he/she has a brief on because the bowel movement is contained; -The contact isolation sign is different from the EBP sign and staff should ask the nurse who is on isolation based on the sign on the door directing them too; -When questioned about the difference in the EBP sign versus the contact isolation sign, the LPN realized the resident only had an EBP sign on his/her door. The LPN asked the MDS coordinator what type of isolation the resident was on. The MDS coordinator was unsure also.; -The LPN placed a contact isolation sign on the resident's door; -The isolation supplies are on the back of the resident's door; -The contaminated trash goes straight to the hamper room and should be placed in a biohazard bag.	F 880		

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F 880	Continued From page 51 During an interview on 08/15/24, at 2:56 P.M., the Director of Nursing (DON) said the following: -The medical director is aware of the resident having loose bowel movements and C. diff positive status; -The medical director did not feel the resident needed to be on contact isolation as he/she may always have loose bowel movements; -The DON made the decision to place the resident on EBP as a precaution not a requirement. During an interview on 08/16/24, at 11:29 A.M., the facility's Medical Director said several weeks ago, he discussed the situation with the facility staff and determined they could just do universal precautions for the resident's care. Staff should wear gloves and wash their hands. He was not sure if staff should wear gowns or not when providing care for the resident. If handling body fluids, staff should wear gloves. During an interview on 08/16/24, at 12:35 P.M., the DON said gown and gloves would be expected to be put on before care for anyone on EBP and to be worn all throughout care. Hand hygiene should be performed when finished. During an interview on 08/16/24, at 1:30 P.M., MDS Coordinator X said the resident's care plan should reflect that the resident is on EBP not contact isolation. During an interview on 08/16/24, at 1:46 P.M., the Administrator said he would expect staff to update care plans as needed.	F 880		

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F 880	Continued From page 52 2. Review of Resident # 67's face sheet (brief resident profile sheet) showed the following information: -Admission date of 06/02/24; -Diagnoses included dementia. Review of the resident's admission MDS, dated 06/09/24, showed the following information: -Severely cognitively impaired; -Dependent on staff for toileting, bathing, dressing, and mobility; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, revised 07/03/24, showed the following information: -Apply barrier cream after each incontinence; -Assist resident to toilet upon rising, before and after meals, at HS (bedtime), and throughout the night as needed; -Check on resident frequently to ensure he/she is clean and dry; -Provide peri care with each incontinent episode; -One to two staff assistance with toileting. Observation on 08/12/24, at 1:22 P.M., showed the following: -LPN Y and CNA Z enter the resident's room to change the resident; -The LPN and CNA washed their hands and applied gloves. The staff then removed the resident's pants; -The CNA took one wet wipe and wiped down one side of the resident's peri-area, took another wipe and wiped down the other side, and took a third wiped and wiped down the middle of the	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53 peri-area; -The staff rolled the resident onto his/her side and the CNA began wiping the resident's bottom with multiple wipes. Bowel movement was visible on the wipes; - The CNA rolled up the soiled brief and removed it and then placed a clean brief under the resident; -The CNA took a wipe and cleaned the resident's perineal area from the front to the back, while continuing to wear the same contaminated gloves (potentially introducing bacteria into the urethal tract); -The CNA removed his/her gloves and took off the resident's glasses, covered the resident up, placed a pillow between his/her legs, lowered the bed, moved resident's wheelchair against the wall and placed the fall mat back down on the floor; -The LPN performed hand hygiene; -The CNA gathered trash and then washed his/her hands. During an interview on 08/15/24, at 9:11 A.M., CNA T said hands should be washed before and after incontinence care, or anytime during care if they become dirty. Staff should wash their hands after removing gloves, after providing care, and before handling personal items. During an interview on 08/15/24, at 10:05 A.M., CNA U said hands should be washed before and after incontinent care or if gloves get contaminated. After providing care, staff should wash their hands before touching personal items. During a interview on 08/15/24, at 2:31 P.M., LPN W said hands should be washed before and after peri care. They should also be washed immediately after peri care and before touching	F 880		

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F 880	Continued From page 54 personal items. During an interview on 08/16/24, at 12:35 P.M., the DON said the following: -Hands should be washed before and after peri care; -Gloves are a layer of protection and hands should not have to be immediately washed once gloves are taken off before touching personal items; -If a staff member's hands are not visibly soiled and they did not leave the room after removing the gloves, then they should not have to wash their hands until all care is finished. During an interview on 08/16/24, at 1:46 P.M., the Administrator said when gloves are removed hands should be washed. 3. Review of the facility policy titled "Flushing/verifying Placement with a Feeding Tube," undated, showed the following: -Wash hands prior to the procedure according to the facility policy; -Put on clean gloves; -Flush utilizing the 60 milliliter (ml) catheter tip syringe with the prescribed amount of water as ordered, before and after feedings and medications or as directed by the physician; -Wash hands after the procedure. Review of Resident #2's face sheet (brief resident profile sheet), showed the following information: -Admission date of 02/23/24; -Diagnoses included other diseases of the pharynx (diseases that affect the throat),	F 880		

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F 880	Continued From page 55 protein-calorie malnutrition (a wasting condition resulting from a diet inadequate in either protein or calories or both), and gastrostomy status (tube that is inserted through the stomach wall and into the stomach). Review of the resident's care plan, revised 02/12/24, showed the following information: -Currently receiving Isosource (nutritional supplement) 1.5 percutaneous endoscopic gastrotomy (PEG) tube feedings throughout the day via boluses (method of feeding liquid nutrition through a feeding tube at mealtimes); -Administer feedings and free water flushes as ordered; -Crush medications and administer them via PEG tube. Review of the resident's quarterly MDS, dated 05/31/24, showed the following information: -Moderate cognitive impairment; -Independent with ADLs (activities of Daily Living-bathing, dressing, grooming); -Always continent; -Resident has a feeding tube. Review of the resident's Physician's Order Sheet (POS), dated 08/14/24, showed the following: -Nothing by mouth diet (NPO); -Flush PEG tube with water before and after each bolus; -Administer 120 ml before and after each bolus; -Give 240 ml Isosource 1.5 four times a day; -Flush PEG tube with 30 ml of water before and after meds.	F 880		

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F 880	Continued From page 56 Observation on 08/13/24, at 9:38 A.M., showed the following: -LPN W sat at the nurses' station and said it was time to administer the resident's tube feeding bolus and medications. He/she walked to the resident's room; -The LPN then entered the resident's bathroom and open the locked bathroom cabinet to remove his/her medications; -The LPN placed each medication into separate cups and took them back to the resident's dresser and crushed each one separately in the plastic bag; -The nurse placed 425 ml of tap water into the graduate container and carried it to the bedside; -The LPN applied gown and gloves, The LPN did not perform hand hygiene; -The LPN diluted all the medications with 30 ml of water; -The LPN connected a 60 ml syringe to the resident's PEG tube and flushed it with approximately 125 ml of tap water; -The nurse administered each medication separately followed with a 30 ml flush that was poured directly into the syringe; -Once the LPN gave the last medication, the LPN administered the 240 ml feeding bolus. -When the LPN completed the bolus he/she flushed the tube with the remaining water, which was approximately 60 ml; -The LPN removed his/her PPE and performed hand hygiene. During an interview on 08/15/24, at 2:31 P.M., LPN W said staff should wash their hands before and after medications and tube feeding boluses. During an interview on 08/16/24, at 12:35 P.M.,	F 880		

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F 880	Continued From page 57 the DON said staff should be washing their hands before doing anything with a feeding tube. 4. Review of the facility's policy titled "Glucometer Sampling Policy and Procedure," dated 01/01/24, showed the following information: -Wash hands, explain procedure, apply gloves, and clean glucometer with sani-wipe. Allow glucometer to air dry. Remove and discard gloves and sani-wipe. Provide a clean surface for glucometer and supplies; -Apply gloves, wipe area to be lanced with an alcohol wipe, and allow to dry; -Obtain blood sample, apply blood sample to glucometer according to direction specific to glucometer used, and discard lancet in the sharps container; -Read glucometer, clean glucometer with sani-wipe and allow to dry, remove gloves, and place gloves and sani-wipe in an appropriate receptacle; -Wash hands and record glucometer reading. Review of Resident #22's face sheet showed the following information: -Admission date of 07/17/24; -Diagnoses included type II diabetes. Review of the resident's admission MDS, dated 07/24/24, showed the following information: -Severe cognitive impairment; -Received insulin injections seven days a week. Review of the resident's care plan, revised on 08/16/24, showed the following information:	F 880		

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F 880	Continued From page 58 -Educate regarding medications and importance of compliance; -Administer diabetic medication as ordered by doctor, monitor, and document side effects and effectiveness. Review of the resident's POS, dated 08/01/24 through 08/31/24, showed the following: -A current order for insulin lispro (rapid acting insulin) subcutaneous (under the skin) solution 100 unit/ml (milliliter), inject as per the following sliding scale subcutaneously before meals and at bedtime: -If blood sugar is 131 milligrams/deciliter (mg/dL) to 180 mg/dL, administer 4 units of insulin; -If blood sugar is 181 mg/dL to 240 mg/dL, administer 8 units of insulin; -If blood sugar is 241 mg/dL to 300 mg/dL, administer 10 units of insulin; -If blood sugar is 301 mg/dL to 350 mg/dL, administer 12 units of insulin; -If blood sugar is 351 mg/dL to 400 mg/dL, administer 16 units of insulin; -If blood sugar is 401 mg/dL to 500 mg/dL, administer 30 units of insulin; -If blood sugar is 501 mg/dL or greater, contact physician. Observation on 08/13/24, at 8:52 A.M., showed the following: -LPN K previously obtained another resident's blood sugar. He/she sanitized his/her hands and donned gloves. While donning gloves, he/she dropped one glove onto the ground in the hallway. -LPN K picked up the glove and placed it onto the clean box of gloves. LPN K doffed gloves, sanitized hands, donned new gloves, and	F 880		

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F 880	Continued From page 59 obtained the resident's blood sugar with a result of 291 mg/dL. LPN K said the resident would be receiving 10 units of insulin. -Upon exiting the resident's room, LPN K disposed of lancet and glucose strip and placed the used glucometer on top of the glove box that was on the medication cart. -LPN K doffed gloves, sanitized hands, donned new gloves, and retrieved the used glucometer from on top of the glove box, wrapped it inside of a Sani-wipe (without wiping it down), and sat it onto the medication cart. -LPN K obtained the resident's insulin pen, attached needle, primed needle with 2 units of insulin, and dialed the dose to 10 units. -LPN K administered insulin to the resident in the left lower quadrant. LPN K exited the resident's room, doffed gloves, and disposed of needle and trash. During an interview on 08/16/24, at 9:38 A.M., LPN J said glucometers should be disinfected before and after every use. Staff must wipe the down the glucometer with a Sani-cloth, dispose of the Sani-wipe, and then let the glucometer dry on a clean barrier prior to the next use. He/she said it would not be acceptable to lay the glucometer down on the cart after obtaining a blood sample. That would be considered cross contamination or an infection control issue. Staff should immediately disinfect the glucometer. He/she said it would not be appropriate to drop something on the floor and place it somewhere for continued use. The dropped item should be thrown away and should not touch other clean items. During an interview on 08/16/24, at 11:28 A.M., RN M said he/she expects glucometers to be disinfected by wiping it down with a Sani-wipe,	F 880		

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F 880	Continued From page 60 wrap the glucometer in the wipe for two minutes, then dispose of the wipe. It should be allowed to air dry before use. He/she said it would not be acceptable to lay the glucometer down onto the medication cart, after use and prior to disinfection. It was not acceptable to drop something onto the floor and then place it somewhere for continued use. The dropped item should be thrown away and should not touch other clean items. During an interview on 08/16/24, at 12:35 P.M., the DON and Assistant Director of Nursing (ADON) said glucometers must be disinfected between each use. The DON said staff are expected to take Sani-wipe, wipe the glucometer, then take another Sani-wipe and wrap it around the glucometer for two minutes before each use. The DON was not sure if the glucometer needed to dry to be considered disinfected. The ADON said there was a dry time and the glucometer should be allowed to air dry prior to use. Both ADON and DON said it was not acceptable to pick up an item off the floor and place it somewhere for continued use. The dropped item should be thrown away and should not touch other clean items. During an interview on 08/16/24, at 1:46 P.M., the Administrator said he expected staff to follow policy regarding glucometer disinfection. It is not acceptable to pick up dirty item off the floor and put back with the clean items. The dirty item should be thrown away.	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		

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F 921	Continued From page 61 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide a sanitary environment for all residents and staff when staff failed to ensure ceiling vents, light covers, walls, and non-contact food surfaces were clean. The facility census was 99. Review of the facility's policy titled "Standard Operating Procedure, Cleanliness and Sanitation of the Dining Room," dated 01/01/24, showed staff to routinely clean all areas of the dining room, including equipment such as service refrigerators, etc. Review of the facility's policy titled "Equipment Cleaning and Sanitizing," dated 01/01/24, showed the following: -Equipment is washed, rinsed and sanitized after each use to ensure the safety of food served to residents; -Employees who use equipment will be responsible for washing and sanitizing after each use; -The food service manager will conduct a visual inspection of all equipment to be certain that it is being cleaned properly. 1. Observation on 08/12/24, at 8:52 A.M., ice machine in the main kitchen showed the following: -Dark smear marks across the front of the ice machine;	F 921		

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F 921	Continued From page 62 -Lime build-up, about ½ inch in length, on the rubber lining where the door closes. Observation on 08/12/24, at approximately 9:00 A.M., of the kitchen in the Chestnut neighborhood showed the following: -The ceiling vent, over ice machine station, was dirty with a fuzzy lint that visibly moved when the air was on; -The light fixture above the ice machine had a multiple dead bugs inside; -The front of freezer was dirty with splatter stains and smear marks. Observation on 08/16/24, at approximately 12:35 P.M., of the kitchen in the Chestnut neighborhood showed the following: -The light fixture over sink had several dead bugs inside; -The ceiling vent remained dirty; The front of the freezer remained dirty. Observation on 08/12/24, at approximately 9:10 A.M., of the kitchen in Willows neighborhood showed the following: -The ceiling vent, over ice machine station, was dirty with a fuzzy lint that visibly moved when the air was on; -The front of the refrigerator was dirty; -The front of the freezer was dirty with dark smear marks and food splatters. Observation on 08/16/24, at approximately 12:45 P.M., of the kitchen in Willows neighborhood showed the following:	F 921		

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F 921	Continued From page 63 -The front of the refrigerator remained dirty; -The ceiling vent remained dirty; -The front of the freezer remained dirty. Observation on 08/12/24, at approximately 9:20 A.M., of the kitchen in Cedars neighborhood showed the following: -The ceiling vent, over ice machine station, was dirty with a fuzzy lint that visibly moved when the air was on; -The ice machine had brown smear marks on the right side; -The wall behind ice machine and near the ceiling was dirty and had cobwebs present; -The light over sink had dead bugs laying in the light fixture; -The front of the freezer was dirty with food platters. Observation on 08/16/24, at approximately 12:55 P.M., of the kitchen in Cedars neighborhood showed the following: -The ceiling vent, over ice machine station, remained dirty; -The ice machine remained dirty; -Cobwebs remained on the wall behind ice machine; -The light over the sink had dead bugs present in the light fixture; -The front of freezer remained dirty. Observation on 08/12/24, at approximately 9:40 A.M., of the kitchen in the Redbud neighborhood showed the following: -The ceiling vent, over ice machine station, was dirty with a fuzzy lint that visibly moved when the	F 921		

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F 921	Continued From page 64 air was on; -The front of freezer had splatter stains and smear marks. Observation on 8/16/24, at approximately 12:15 P.M., of the kitchen in the Redbud neighborhood showed the following: -The ceiling vent remained dirty with lint; -The dishwasher remained dirty with splatter stains and smears. Observation on 08/12/24, at 9:50 P.M., of the kitchen in the Dogwood neighborhood showed the following: -Cobwebs present on the back wall, near the ceiling; -The front of freezer was dirty with splatter stains and smear marks. Observation on 08/16/24, at approximately 12:25 P.M., of the kitchen in the Dogwood neighborhood showed the following: -Cobwebs remained on the back wall; -The front of freezer remained dirty with splatter stains and smear marks. During an interview on 08/16/24, at approximately 12:20 P.M., Homemaker D said he/she used to use a checklist to clean everything, but now he/she just knows what to do and does it on his/her own. During an interview on 08/16/24, at approximately 12:30 P.M., Homemaker E said the following: -He/she used to use a list for all cleaning chores,	F 921		

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F 921	Continued From page 65	F 921		

but now just knows what to do;
-He/she is not sure who is responsible for cleaning the ceiling vents and/or walls behind the ice machine;
-He/she is the one who does the wiping down of all the appliances and counters.

During an interview on 08/16/24, at approximately 12:40 P.M., Homemaker F said it was the homemaker's job to do the cleaning in the kitchen/dining room areas. He/she did the cleaning of these areas and tried to get them looking good, but there are quite a few stains.

During an interview on 08/16/24, at approximately 12:50 P.M., Homemaker G said the following:

-He/she knew from when they went through training and did their orientation how to clean the kitchen area;
-He/she made sure to clean the kitchen/dining area following each meal;
-Maintenance or housekeeping will do the cleaning of the walls behind the sink and the ceiling vents.

During an interview on 08/16/24, at approximately 1:00 P.M., Homemaker H said the following:

-He/she did all the cleaning of the kitchen and dining room area;
-He/she thought maintenance or housekeeping did the ceiling vents, but he/she was not sure;
-He/she was taught what to do when he/she was trained as a new employee.

During an interview on 08/16/24, at approximately 2:00 P.M., the Dietary Manager said the following:

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F 921	Continued From page 66 -The homemakers are expected to keep all of their kitchens and serve-out areas clean and well sanitized; -Each homemaker had been trained through orientation and follow-up in-services regarding how to keep the kitchens in clean, working order; -There would be no reason for ice machines or the surfaces of any appliances, such as freezers or refrigerators, to be dirty; -The homemakers would be responsible for all surface areas in the kitchen where they are able to reach; -Maintenance would be responsible for the ceiling vents and light fixtures. During an interview on 08/16/24, at approximately 2:50 P.M., the Administrator said the following: -It is the housekeeping department that is responsible for cleaning the walls behind the ice machine and the ceiling vents; -The homemakers should be cleaning most of the kitchen and serve-out areas. FACILITY	F 921		

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	24701	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOODS AT QUAIL CREEK, THE	1514 WEST LARK SPRINGFIELD, MO 65810

(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
A1104	19 CSR 30-85.012(97) Hot Water 105-120 Degrees F Plumbing fixtures that require hot water and are resident-accessible shall be supplied with water thermostatically controlled to provide a water temperature of between one hundred twenty degrees Fahrenheit (120°F) (49°C) and one hundred five degrees Fahrenheit (105°F) (41°C) at the fixture or faucet. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F689.	A1104		
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 F761.	A4055		
A4062	19 CSR 30-85.042(53) Medication Labeling All prescription medications shall be supplied as individual prescriptions. All medications, including over-the-counter medications, shall be packaged and labeled in accordance with applicable professional pharmacy standards and state and federal drug laws and regulations. The United States Pharmacopoeia (USP) labeling shall include accessory and cautionary instructions as	A4062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24701	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOODS AT QUAIL CREEK, THE	1514 WEST LARK SPRINGFIELD, MO 65810

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A4062	Continued From page 1 well as the expiration date, when applicable, and the name of the medication as specified in the physician's order. Over-the-counter medications for individual residents shall be labeled with at least the resident's name. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F761. *The higher classification merited due to the extent of the violation.	A4062		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III 1. Please refer to F761.	A4064		
A4065	19 CSR 30-85.042(56) Schedule II Meds-Storage Facilities shall store Schedule II medications, including those in the emergency drug supply, under double lock separately from noncontrolled medication. Schedule II medications may be stored and handled with other noncontrolled medication if the facility has a single unit dose	A4065		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOODS AT QUAIL CREEK, THE	**1514 WEST LARK SPRINGFIELD, MO 65810**

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A4065	Continued From page 2 drug distribution system in which the quantity stored is minimal and a missing dose can be readily detected. II This regulation is not met as evidenced by: 1. Please refer to F761.	A4065		
A4080	19 CSR 30-85.042(71) Mealtime Assistance/Supervision All residents who require assistance at mealtimes, whether it be preparation of the food items or actual feeding, shall be provided the assistance upon delivery of the tray. Facilities shall provide dining room supervision during meals. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F677. *The higher classification is merited due to the extent of the violation and impact when combined with other deficiencies.	A4080		
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	A4086		

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A4086	Continued From page 3 This regulation is not met as evidenced by: Class II 1. Please refer to F880.	A4086		
A5001	19 CSR 30-85.052(1) Nutritional Needs Met, Assess Res, Inform Dr Each resident shall be served nutritious food, properly prepared and appropriately seasoned, taking into consideration resident food preferences, to provide an adequate diet in accordance with the physician ' s order and as recommended by the National Research Council. Nutritional needs of residents shall be met and shall be based on the individual ' s circumstances, medical condition and goals of treatment as determined and justified by the physician. A qualified professional, such as a dietitian or registered nurse, shall regularly assess these needs and shall keep the physician informed of the nutritional status of the resident. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F692.	A5001		
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean Walls and ceilings, including doors, windows and skylights, shall be clean and maintained in good repair. III This regulation is not met as evidenced by:	A6015		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOODS AT QUAIL CREEK, THE	1514 WEST LARK SPRINGFIELD, MO 65810

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A6015	Continued From page 4 1. Please refer to F921.	A6015		
A6019	19 CSR 30-87.020(19) List Fixtures, Vent Covers, Décor Cleanable Light fixtures, vent covers, wall-mounted fans, decorative materials and similar equipment attached to walls and ceilings shall be easily cleanable and shall be maintained clean and in good repair. III This regulation is not met as evidenced by: 1. Please refer to F921.	A6019		
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints The outer clothing of all employees shall be clean and employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. III This regulation is not met as evidenced by: 1. Please refer to F812.	A7003		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: 1. Please refer to F921.	A7067		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies	A8023		

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	24701	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORHOODS AT QUAIL CREEK, THE	**1514 WEST LARK SPRINGFIELD, MO 65810**

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A8023	Continued From page 5 The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class III 1. Please refer to F607.	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	The Neighborhoods at Quail Creek
Street Address, City, Zip:	1514 West Lark St, Springfield, MO 65810
Date of Survey:	8/16/24

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265799

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under state and federal law. The submission of this plan of correction does not constitute an admission on the part of The Neighborhoods at Quail Creek as to the accuracy of the surveyor's findings no conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of the facility that findings are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.	9/29/24
F 607	**Develop/Implement Abuse/Neglect Policies**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification that RN A did not have an EDL and NA registry completed, the staff development nurse immediately ran both.	
	How we will identify other practices having potential to be affected by the same deficient practice: All employees that have transferred from a sister-facility have the potential to be affected. Staff Development nurse completed an audit to ensure every transfer had the required background screenings.	
	Systemic changes to ensure practice does not reoccur: Admin, Staff Development Nurse, Employee Experience Officer and Assistant Bookkeeper; staff that complete onboarding were reeducated on the abuse, neglect, and exploitation policy and completed a Relias competency.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 677	**ADL Care Provided for Dependent Residents**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification that resident #17 did not have an updated care plan reflecting the amount of assistance needed from staff to eat, the MDS Coordinator updated the care plan to reflect the current needs at weekly SNAR meeting.	

	How we will identify other practices having potential to be affected by the same deficient practice: All residents that are at risk for weight loss have the potential to be affected. DON and/or Designee will conduct an audit of all resident's care plans that are at risk for weight loss.	
	Systemic changes to ensure practice does not reoccur: All staff were reeducated on facilities weight loss and assistance policy by Staff Development Nurse and/or Designee. All new staff will be educated in orientation by Staff Development Nurse. DON and/or Designee will conduct weekly audits x 4, then monthly to ensure compliance.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 689	**Free of Accident Hazards/Supervision/Devices**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification that the water in the public bathrooms were temping over 120 degrees Fahrenheit, the Maintenance Director immediately turned down the hot water heater and then called Connelly Plumbing who replaced the sensor. Staff were educated to make sure the water was within temp prior to Resident's #255 and #37 using the sink by Administrator.	
	How we will identify other practices having potential to be affected by the same deficient practice: Maintenance Director added the public bathrooms to the list of rooms on TELS to be checked.	
	Systemic changes to ensure practice does not reoccur: Maintenance Director will randomly select and check the temperature of two rooms per hall per week along with the hall's water tank and dishwasher.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 692	**Nutrition/Hydration Status Maintenance**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification that resident's #67 and #54 were not given might shakes nor their care plan updated to reflect current interventions, nursing staff immediately made sure the residents were given a might shake and that their care plans were updated to reflect current interventions.	
	How we will identify other practices having potential to be affected by the same deficient practice: All resident's that are at risk for weight loss have the potential to be affected. DON	

	and/or Designee immediately conducted an audit to ensure that all resident's weight loss interventions were followed and their care plans updated.	
	Systemic changes to ensure practice does not reoccur: All nursing staff were reeducated on the facilities SNAR and weight loss policies by Staff Development Nurse. All new nursing staff will be educated in orientation by the staff development nurse. Mighty shake orders will now be put into the TAR and also input under the Table Side profile on each resident. Care plans will be updated in weekly SNAR meeting for new interventions. DON and/or Designee will conduct weekly audits x 4 and then monitor monthly for compliance.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 755	**Pharmacy Services/Procedures/Pharmacist/Records**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification of the discrepancy on the medication count, the DON immediately investigated and determined that the nurse accidentally signed off the wrong medication. The correct medication had been administered. Residents #356, #34, #58, #61, #62, #71, and #50 expired medications were destroyed by DON and Designee.	
	How we will identify other practices having potential to be affected by the same deficient practice: All areas where medications are stored have the potential to be affected. Nurse managers audited all storage areas to ensure that no expired medications were present.	
	Systemic changes to ensure practice does not reoccur: All current licensed nurses were reeducating on the facilities medication administration policy by Staff Development Nurse. New licensed nurses will be educated on above policy during orientation by Staff Development Nurse. Nurse and Med Tech's were reeducated to check expired medications prior to administering any medications. DON and/or Designee will conduct weekly audits x4 and then monitor monthly for compliance. DON and/or Designee will conduct medication administration competency on all nurses and med techs.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 761	**Label/Store Drugs and Biologicals**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon	

	notification that the medications were not locked up, the DON immediately locked the medications on the med cart and med storage area per the facilities policy. Resident #70's medication were removed from bedside and placed in medication cart and the medication with the label removed was immediately destroyed.	
	How we will identify other practices having potential to be affected by the same deficient practice: Residents that administer their own medications and all medication storage areas have the potential to be affected. DON and/or Designee conducted an audit to ensure that no medications were left bedside and no other medications had the label torn off. All nursing staff were reeducated by Staff Development Nurse and/or Designee on the facilities medication administration policy, resident self-administration policy, and the facilities medication storage policy.	
	Systemic changes to ensure practice does not reoccur: DON and/or Designee will conduct weekly audits x 4 and then monitor monthly for compliance. All licensed nurses were educated on the medication administration and storage policy by Staff Development Nurse and/or Designee. New licensed nurses will be educated on the above policies during orientation by Staff Development Nurse and/or Designee.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 812	**Food Procurement, Store/Prepare/Service-Sanitary**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification that dietary staff were not wearing hear nets, the Dietary Manager immediately reeducated the staff on the facilities personal hygiene policy and had staff put on a hair net.	
	How we will identify other practices having potential to be affected by the same deficient practice: All areas where food is prepared and served have the potential to be affected. Dietary manager and/or designee audited areas to ensure that all dietary staff were wearing a required hair net.	
	Systemic changes to ensure practice does not reoccur: Dietary Manager and/or designee will conduct weekly audits x 4 and then monitor monthly for compliance. The Cook and/or Designee was educated to round during meal service times to ensure that all appropriate staff are wearing hair nets in food service areas. All dietary staff were educated on the personal hygiene policy by Dietary Manager. All new dietary staff will be educated on the facilities hygiene policy during orientation by Staff Development Nurse.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The	

	results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 880	**Infection Prevention & Control**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification that resident #17 had the incorrect isolation, the DON immediately implemented contact isolation until directed otherwise by a physician. When notified of staff not performing hand hygiene on residents #17, #67 and #2, the Staff Development nurse immediately reeducated the staff. Staff Development nurse also reeducated the nurse on the facilities policy on disinfecting glucometers.	
	How we will identify other practices having potential to be affected by the same deficient practice: All residents that are on any precautions, receive blood sugar checks, or receive any care from facility staff have the potential to be affected. Nursing leadership conducted an audit on each neighborhood to ensure that all precautions were correct, staff understood proper hand washing technique, and that each nurse knew how to disinfect and clean a glucometer before and in-between residents.	
	Systemic changes to ensure practice does not reoccur: Nursing leadership to audit each system weekly x4 and then monthly to ensure compliance. All facility employees were reeducated on proper handwashing and demonstrate competency by Staff Development Nurse and/or Designee. All new employees will be educated on proper handwashing during orientation and demonstrate upon hire by Staff Development Nurse and/or Designee. All licensed nurses were reeducated on the facilities glucometer policy by Staff Development Nurse and/or Designee. All new nurses will be educated on the facilities glucometer policy during orientation by Staff Development Nurse and/or Designee. All current staff were educated on differences of contact isolation and EBP by Staff Development Nurse and/or Designee. All new employees will be educated on the differences of isolation precautions by Staff Development Nurse and/or Designee. Facility has implemented precaution signs with instructions of what to wear prior to entering the room.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	
F 921	**Safe/Functional/Sanitary/Comfortable Environment**	9/29/24
	Corrective Actions for Alleged Deficient Practice: Upon notification of the ceiling vents, ice machines, refrigerators, and the light fixtures needing cleaned; the Dietary Manager and Maintenance Director immediately cleaned each individual unit.	
	How we will identify other practices having potential to be	

	affected by the same deficient practice: All food service areas have the potential to be affected. Dietary Manager and Maintenance Director audited each area together.	
	Systemic changes to ensure practice does not reoccur: Dietary Manager and Maintenance Director will audit each neighborhood kitchenette weekly x 4 and then monitor monthly for compliance. All dietary staff and housekeeping staff were educated on facilities standard operating procedure, cleanliness and sanitation of the dining room by Dietary Manager. All new dietary/housekeeping staff will be educated during orientation by Staff Development Nurse. A cleaning checklist was added to the homemaker's clipboard. Cooks and/or Designee educated to round on satellite kitchens each shift to ensure cleaning checklist is completed.	
	Monitoring to ensure practice does not reoccur: To assure compliance Administrator and or Designee will review the above system Monthly over the next 90 days. Issues or concerns will be immediately addressed and the Administrator notified. The results of the above monitoring process will be reported to the IDT at our monthly QAPI meeting. Additional interventions will be made as indicated by the QAPI committee and acted upon as assigned to assure compliance is maintained. The Administrator and/or Designee will be responsible.	

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

PLAN OF CORRECTION

Provider/Supplier Name:	The Neighborhoods at Quail Creek
Street Address, City, Zip:	1514 West Lark, Springfield, MO 65810
Date of Survey:	08/16/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265799

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A1104	**Hot Water 105-120 Degrees F**	9/29/24
	Refer to F689	
A4055	**Safe/Effective Medication System**	9/29/24
	Refer to F755 & F761	
A4062	**Medication Labeling**	9/29/24
	Refer to F761	
A4064	**Medication Storage**	9/29/24
	Refer to F761	
A4065	**Schedule II Meds-Storage**	9/29/24
	Refer to F761	
A4080	**Mealtime Assistance/Supervision**	9/29/24
	Refer to F677	
A4086	**Infection Control/Communicable Disease**	9/29/24
	Refer to F880	
A5001	**Nutritional Needs Met, Assess Res, Inform Dr**	9/29/24
	Refer to F692	
A6015	**Walls/Ceilings/Doors/Windows Clean**	9/29/24
	Refer to F921	
A6019	**List Fixtures, Vent Covers, Décor Cleanable**	9/29/24
	Refer to F921	
A7003	**Clean Clothing, Hair Restraints**	9/29/24
	Refer to F812	
A7067	**Nonfood Contact Surfaces, Cleaned as Needed**	9/29/24
	Refer to F921	
A8023	**Develop/Implement A/N Policies**	9/29/24
	Refer to F607	

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