STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265535	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW GARDENS	100 AUDSLEY DRIVE GLASGOW, MO 65254

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sabrina Crowder — TITLE: Administrator — (X6) DATE: 5/2/2025

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive, person centered care plan for two residents (Resident #35 and #89), in a review of 15 sampled residents. The facility census was 36. Review of the facility's undated policy Care Plan Comprehensive, showed the following: -An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental and psychosocial well-being; -Assessment of each resident is ongoing and the care plan will be revised as changes occur in the resident's condition; -The comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment; -Periodic review and updating of care plans will occur: a. When a significant change in the resident's condition has occurred; b. At least quarterly; c. when changes occur that impact the resident's care (i.e. change in diet, change in care areas). 1. Review of Resident #35's face sheet showed	F 656		

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F 656	Continued From page 2 the following: -He/She admitted to the facility on 11/04/24; -Diagnoses included unspecified dementia, unspecified severity, with agitation (a type of dementia-a progressive decline in cognitive function, including memory, thinking, and reasoning, severe enough to affect a person's daily life-where the specific cause is unknown or unspecified, and where the individual experiences agitation) and unspecified atrial fibrillation (an irregular heartbeat that can be intermittent or persistent, whose cause is unknown). Review of the resident's Continuity of Care Document (CCD), showed the following medication orders: -Citalopram (an antidepressant medication), 20 milligrams (mg) by mouth daily for a diagnosis of unspecified dementia, start date 12/04/24; -Eliquis (a blood thinner used to help prevent blood clots and stroke), 2.5 mg by mouth two times daily, for a diagnosis of unspecified atrial fibrillation, start date 11/04/24; -Seroquel (an antipsychotic medication used to treat several kinds of mental health conditions), 25 mg by mouth daily in the evening, for a diagnosis of unspecified dementia, start date 12/17/24. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/07/25, showed the following: -The resident was rarely understood; -Dependent for toileting; -Substantial to maximum assistance for mobility; -Received an antipsychotic and an antidepressant medication routinely; -No evidence facility staff documented the	F 656		

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F 656	Continued From page 3 resident received an anticoagulant medication routinely. Review of the resident's care plan, last reviewed/revised on 04/14/25, showed the following: -Problem: Cognitive loss/dementia: impaired neurological status related to dementia; -Long-term goal: the resident will maintain activities of daily living (ADL's) through the next review on 07/31/25; -No evidence facility staff identified the problem, long-term goals, or interventions related to the resident's use of an antidepressant for a diagnosis of unspecified dementia in the resident's care plan; -No evidence facility staff identified the problem, long-term goals, or interventions related to the resident's diagnosis of unspecified atrial fibrillation and the use of an anticoagulant medication in the resident's care plan; -No evidence facility staff identified the problem, long-term goals, or interventions related to the resident's use of an antipsychotic medication for a diagnosis of unspecified dementia in the resident's care plan. Observation on 04/14/25 at 2:50 P.M. showed the following: -The resident moved himself/herself about the facility in his/her wheelchair using his/her feet; -The resident did not answer verbal questions; -The resident was calm. During an interview on 04/15/25 at 9:05 A.M., the resident's family member said the following: -The resident had a lot of behaviors when he/she first arrived at the facility, but was better the last few months;	F 656		

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F 656	Continued From page 4 -He/She knew the facility had used some medications to help with the behaviors, but he/she wasn't sure what they were. During an interview on 04/16/25 at 10:55 A.M., the Director of Nursing (DON) said the following: -The resident was placed on an antipsychotic when he/she first arrived due to behaviors such as wandering in and out of certain rooms, urinating in the hall, being aggressive towards staff and difficult to redirect; -The resident had a diagnosis of dementia with agitation; -She was responsible for the residents' care plans; -She was not aware Resident #35's care plan did not reflect the use of an antipsychotic or anticoagulant; she may have just forgotten to add it; -The resident has had pharmaceutical evaluation of the antipsychotic medication with dose changes made based on behaviors; -The MDS should indicate the resident's use of an antipsychotic medication. 2. Review of Resident #89's Face Sheet showed following: -He/She admitted to the facility on 03/21/25; -Diagnoses included dyspnea (shortness of breath). Review of the resident's Physician's Order, dated 03/28/25, showed to administer oxygen via nasal cannula at bedtime as needed for oxygen saturation level (measures oxygen level in) below 90%. Review of the facility's undated list of residents who smoke showed the resident was a smoker.	F 656		

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F 656	Continued From page 5 Review of the resident's smoking assessment, dated 04/11/25, showed he/she was to be supervised while smoking. Observation on 04/14/25 at 1:15 P.M. showed the resident smoked with supervision. Review of resident's Care Plan, last reviewed/revised on 04/14/25, showed the following: -The care plan did not include documentation to show the resident may require oxygen as needed to maintain oxygen saturation levels above 90%; -The care plan did not include documentation to show the resident smoked and required supervision while smoking. During an interview 4/16/25 at 2:06 P.M., the DON said the following: -The resident was a smoker; -The resident had orders for PRN oxygen; -The resident's smoking status and oxygen use should be documented on the resident's care plan; -She was responsible for developing the care plans and missed adding smoking and oxygen use to the resident's care plan; -She found it difficult at times to complete/update care plans as needed as she had several duties. During an interview on 04/17/25 at 3:30 P.M., the Administrator said the care plans should reflect all of a resident's care areas.	F 656		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary	F 661		

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F 661	Continued From page 6 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a comprehensive discharge summary and recapitulation of stay for one resident (Resident #38), in a review of one closed records. The facility census was 36. Review of the facility's undated policy for discharge/transfer showed the following: -Purpose of the policy was to provide safe departure from the facility and provide sufficient	F 661		

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F 661	Continued From page 7	F 661		

information for after care of the resident;
-Complete a discharge summary and post discharge plan of care form which included:
a. List of medications with instructions in simple terms;
b. Instructions for post discharge care and explain to the resident and/or representative;
c. Have resident and/or representative responsible for care sign the discharge summary and post discharge care form;
d. Give a copy of the form to the resident and/or representative responsible for care;
e. Place signed original form in the medical record.

1. Review of Resident #38's undated face sheet showed the following:
-He/She was admitted on 3/10/25;
-The resident was his/her own responsible party.

Review of the resident's Physician Orders, dated 3/10/25 through 3/11/25, showed the following:
-Diagnoses of acute embolism (blockage of a blood vessel) and thrombosis (the formation of a blood clot inside a blood vessel) of deep veins of the left lower extremity, acute kidney failure, abnormalities of gait and mobility, pain, edema, hypertension, pulmonary heart disease, chronic diastolic congestive heart failure, iron deficiency anemia, and type 2 diabetes;
-Physical therapy order for five times per week for 30 days to include therapeutic exercises, gait training, and neuromuscular re-education (a technique to restore normal movement patterns);
-Occupational therapy order for five times per week for four weeks for therapeutic exercises, self care management, and neuromuscular re-education with hot and cold packs as needed.

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F 661	Continued From page 8	F 661		

Review of the resident's progress notes, dated 3/10/25, showed the resident was admitted for chronic back pain.

Review of the resident's progress notes, dated 3/12/25, showed the resident was expected to be a short stay and return home as condition improves. Spouse will be assisting resident to appointments as needed.

Review of the resident's progress notes, dated 3/16/25, showed the resident's leg began to weep (the release of liquid). Orders were received to cleanse with normal saline, apply gauze and secure with kling wrap (soft, stretching, rolled gauze) and tape, change as needed.

Review of the resident's Physician Note, dated 3/17/25, showed the resident was admitted for management of chronic conditions, functional status, and symptom management related to blood clot and pain.

Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/17/25, showed the following:
-Admission date 3/10/25;
-The resident was cognitively intact;
-He/She had no impairment in range of motion of upper or lower extremities;
-He/She was dependent on a wheelchair for mobility;
-He/She required set up assistance for oral hygiene;
-He/She required moderate assistance for personal hygiene, rolling left and right in bed, lying to sitting on the side of the bed, sitting in a

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F 661	Continued From page 9	F 661		

chair or on the side of the bed to standing, chair/bed to bed transfers, toilet transfers, and tub/shower transfers;
-He/She required maximum assistance for upper body dressing;
-He/She was dependent for toilet hygiene, lower body dressing, and putting on and taking off footwear;
-He/She was continent of bowel and bladder;
-Diagnoses included heart failure (a chronic condition in which the heart can't pump enough blood to meet the body's needs for blood and oxygen), hypertension (elevated blood pressure), gastroesophageal reflux disease (a chronic condition involving the digestive system, when stomach acid or bile irritates the esophagus, or food pipe, lining), diabetes (a disease that results in too much sugar in the blood), chronic obstructive pulmonary disease (a group of chronic lung disease that block airflow and make it difficult to breathe).

Review of the resident's progress notes, dated 3/20/25, showed the resident had a pain clinic appointment. The clinic called the facility and reviewed the current and discontinued medications. The resident also saw cardiology and was told to return for a yearly office visit, as well as an oncology visit and was told to return to clinic in three months.

Review of the resident's progress notes, dated 3/24/25, showed the physician was at the facility and gave orders for the resident to discharge home with medications and remaining narcotics.

Review of the resident's physician orders showed an order to discharge to home with medications, dated 3/24/25.

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F 661	Continued From page 10 Review of the resident's Physical Therapy Discharge Summary, signed 3/25/25, showed the following: -The resident was seen for acute embolism and thrombosis of unspecified deep veins of the left lower leg and weakness; -The resident had made consistent progress and reached maximum potential; -Discharge recommendations of assistive device for safe functional mobility and home health services. Review of the resident's Licensed Practical Nurse (LPN) B progress note, dated 3/25/25 at 11:17 A.M., showed the resident was discharged home with his/her spouse. He/She took all medications and belongings. The pharmacy was sending medication refills later this day and the resident's spouse will return in the morning to pick them up. Review of the resident's Occupational Therapy Discharge Summary, signed 3/26/25, showed the following: -The resident was seen for acute embolism and thrombosis of unspecified deep veins of the left lower leg and weakness; -The resident had made consistent progress with skilled interventions and throughout the plan of treatment; -Discharge recommendations of grab bars and assistance from spouse as needed. Review of the resident's electronic medical record (EMR) showed no documentation staff completed a comprehensive discharge summary or discharge recapitulation of stay. During an interview on 4/15/25 at 3:05 P.M. the	F 661		

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F 661	Continued From page 11 Social Services Director (SSD) said the following: -He/She was responsible for scheduling appointments and services, and notifying the resident or responsible party of those; -The resident had an upcoming appointment for chemotherapy that the resident's spouse was aware of; -The nurses were responsible for completing the discharge paperwork. During an interview on 4/15/25 at 4:32 P.M. LPN A said he/she had not completed many discharges and was not sure what documentation was required. During an interview on 4/16/25 at 9:11 A.M., the Director of Nursing (DON) said the following: -The charge nurses were responsible for completing the discharge paperwork; -The charge nurses should complete a recapitulation of stay document (the document was built into the EMR). The resident or responsible party should sign the document, staff should provide the resident or responsible party with a copy, and keep a copy for the resident's medical record; -The charge nurse should also make a detailed progress note in the resident's chart; -She had provided the charge nurses with a discharge checklist to follow as well as a template to follow for the detailed progress note; -She reviewed Resident #38's medical record and found staff did not complete a discharge recapitulation. Staff should have completed the discharge recapitulation. During an interview on 4/17/25 at 11:50 A.M., LPN B said the following: -At discharge, he/she completed the pharmacy	F 661		

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F 661	Continued From page 12 discharge and provided a medication list to the resident or responsible party. He/She ensured the resident had all belongings, including durable medical equipment. After the resident was discharged, he/she made a detailed progress note and discharged the resident from the EMR system; -He/She did not complete a discharge summary or recapitulation of stay, and did not complete any forms or observation tasks in the EMAR for discharge; -He/She was not familiar with a discharge checklist or detailed progress note template that he/she was to use at discharge. During an interview on 4/17/25 at 9:56 A.M., the resident's spouse said facility staff provided him/her with a medication review and some discharge paperwork, but he/she could not remember what was included in the discharge paperwork. During an interview on 4/17/25 at 3:30 P.M. the Administrator said she would expect for a discharge summary and recapitulation of stay to be completed by the charge nurse at the time of discharge for all discharged residents.	F 661		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility	F 727		

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must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This had the potential to affect all residents. The facility census was 36.

Review of the facility's policy, Staff Scheduling, dated April 2015, showed an RN must work eight consecutive hours on the day shift every day, seven days a week.

1. Review of the facility's RN daily staffing sheets and time-clock data, dated December 2024, showed the facility did not have documentation to show an RN (including the Director of Nursing (DON)) worked on 12/01/24, 12/07/24, 12/13/24, and 12/26/24.

Review of the facility's RN daily staffing sheets and time-clock data, dated January 2025, showed the facility did not have documentation to show an RN (including the DON) worked on 01/13/25, 01/19/25, and 01/27/25.

Review of the facility's RN daily staffing sheets and time-clock data, dated March 2025, showed the facility did not have documentation to show an RN (including the DON) worked on 03/23/25.

During an interview on 04/17/25 at 9:50 A.M., the Director of Nursing (DON) said the following:

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F 727	Continued From page 14 -There were some days when there was no RN coverage in the facility; -She was the only full-time RN employed at the facility; -The facility had advertised to hire another RN for several months but had not found anyone to fill this role; -When she was working as the facility RN, it took her away from her administrative duties. During an interview on 04/17/25 at 3:30 P.M., the Administrator said the following: -The DON was the only full-time RN at the facility; -The facility had advertised for several months to hire another RN but was unable to fill this role; -The facility used agency staff in the past, but they were not available for the facility's needs and were not reliable; -The corporate office was aware of this issue but had not offered any solutions.	F 727		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		

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F 880	Continued From page 15 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 16 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 complete or maintain documentation of a two-step or prior two step Tuberculin Skin Tests (TST), or a chest x-ray in the last year, as required to rule out Tuberculosis (TB) (a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing), and failed to complete annual TB screening as required for three residents (Resident #17, #239, and #15), in a review of five sampled residents evaluated for immunization status. The facility failed to ensure there was a complete water management program in place to reduce the risk of legionellosis (any disease caused by Legionella (a bacteria which people can breathe in without knowing, sometimes causing infection in the lungs)) in the facility. The facility census was 36. Review of the facility's Tuberculosis Control Plan, dated May 2015, showed the following: -All residents new to long-term care who do not have documentation of a previous skin reaction less than 10 millimeter (mm) or a history of adequate treatment of tuberculosis infection or disease, should have the initial test of a Mantoux PPD two-step test to rule out tuberculosis within	F 880		

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F 880	Continued From page 17 one month prior to or one week after admission. If the initial result is 0-9 mm, the second test, which can be given after admission, should be given at least one week and no more than three weeks after the first test. The results of the second test should be used as the baseline; -Documentation of a chest x-ray ruling out active pulmonary tuberculosis within one month prior to admission along with an evaluation to rule out signs and symptoms of tuberculosis, may be acceptable by the facility on an interim basis until the Mantoux PPD two-step test is completed; -Annual skin tests for residents with documented results greater than 10 mm are not required nor annual chest x-rays for residents with documented skin tests results greater than 10 mm; (The policy did not identify how staff were to routinely monitor residents for signs and symptoms of TB (i.e. annual evaluation).) Review of the TB Screening for Long-Term Care Residents (a document provided by the Department of Health and Senior Services to long-term care facilities), updated 3/11/24, showed to conduct an annual evaluation to rule out signs/symptoms of TB. 1. Review of Resident #17's undated face sheet showed the following: -He/She admitted on 06/03/24; -He/She was not his/her own responsible party for decision making. Review of the resident's Medication Administration Record (MAR), dated June 2024, showed the following: -A first-step TST administered on 6/3/24, and the results read on 6/6/24;	F 880		

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F 880	Continued From page 18 -The resident refused the second-step TST on 6/13/25. Review of the resident's medical record showed no documentation staff attempted to administer the second-step TST at another time or notified the resident's responsible party or physician of the resident's refusal. During an interview on 4/17/25 at 10:18 A.M., the Director of Nursing (DON) said the following: -The resident refused the second-step TST; -Staff should have tried again and contacted the responsible party; -If the resident continued to refuse the TST, staff should have documented the refusal and notified the physician for an order for a chest x-ray. During an interview on 4/17/25 at 11:11 A.M., the facility Nurse Practitioner said she was not notified of the resident refusing to complete the two-step TST. 2. Review of Resident #239's undated face sheet showed the following: -The resident admitted on 4/11/25; -The resident was his/her own responsible party; -The resident was unable to have TB testing due to receiving Bacillus Calmette-Guerin (BCG) treatment (an immunotherapy used to treat bladder cancer) related to history of bladder cancer. Review of the resident's electronic medical record showed no documentation of a chest x-ray completed in the last year. During an interview on 4/17/25 at 9:56 A.M., the resident's family member said the following:	F 880		

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F 880	Continued From page 19 -The resident could not have TB testing due to his/her history of bladder cancer and the treatment the resident received; -The facility did not ask about obtaining a copy of a chest x-ray or getting a new chest x-ray. During an interview on 4/17/25 at 10:18 A.M., the DON said the following: -The resident was unable to receive TB testing; -A chest x-ray should have been obtained through records, if possible, or a new chest x-ray should have been requested, ordered, and completed. 3. Review of Resident #15's undated face sheet showed the following: -He/She admitted on 05/11/23; -He/She was not his/her own responsible party for decision making. Review of the resident's electronic medical record showed no documentation staff completed an annual TB signs and symptoms evaluation on the resident's anniversary of admission. During an interview on 4/17/25 at 10:18 A.M., the DON said the resident should have received an annual evaluation to rule out signs and symptoms of TB on the anniversary of his/her admission and did not not. 4. During an interview on 4/17/25 at 11:11 A.M., the facility Nurse Practitioner said the following: -The facility was responsible for the admission TB testing as well as the annual signs and symptoms evaluation; -If a resident had a positive TST result, refused, or was unable to have the TB testing for any reason, the facility should notify the medical team and they could order an x-ray.	F 880		

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F 880	Continued From page 20 During an interview on 4/17/25 at 3:30 P.M., the Administrator said the following: -The two-step TST should be started on admission, unless contraindicated; -Staff should complete an evaluation to rule out signs and symptoms of TB every year on the resident's anniversary of admission; -The charge nurse should complete both the two-step TST and the annual evaluation to rule out signs and symptoms of TB. 5. Review of the facility's undated policy, Water Management Program to Reduce Legionella Growth, showed the following: -Our facility will develop and implement a Water Management Program to inhibit microbial growth in building water systems that reduce the risk of growth and spread of legionella and other opportunistic pathogens in water; -Legionella Infections: the bacterium Legionella can cause a serious type of pneumonia called Legionnaires' Disease in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devises such as showerheads, cooling towers, hot tubs, and decorative fountains; -Purpose: to 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 disease and infections;	F 880		

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F 880	Continued From page 21 -The facility will create a water management committee which will consist of the Administrator, Director of Nursing, and the Maintenance Director; -The water management committee will conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system; -The water management commit will implement a water management program that considers the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard and the Centers for Disease Control and Prevention (CDC) toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; -The water management committee will specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's undated Annual Water Management Checklist, showed the following: -Acceptable hot water range of 110 to 120 degrees Fahrenheit; -Acceptable cold water range of 50 to 68 degrees Fahrenheit. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F	F 880		

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F 880	Continued From page 22 and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F. 6. Review of the facility's water management program binder on 4/16/25, showed the facility only checked and documented the temperature of the hot water temperatures weekly. There was no documentation to show the facility checked the temperature of the cold water temperatures in the facility. During an interview on 4/17/25 at 11:57 A.M., the Maintenance Director said the following: -He was on the water management committee, but did not know who else was on the committee; -He checked the temperature of the hot water weekly on Mondays. He did not check the temperature of the cold water; -He checked the water temperature in the kitchen, laundry and two resident rooms on each hall. He had not checked the temperature in either shower room; -He did not keep track of when a room sat empty for a period of time to know if the water fixtures needed to be flushed prior to using the room again. During an interview on 4/17/25 at 3:30 P.M., the Administrator said the following: -She expected the facility's water management program to follow the ASHRAE guidelines; -She expected maintenance staff to complete water temperature checks, flush the lines, and check for leaks every month; -She was not aware staff should check and monitor the temperature of the cold water.	F 880		

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F 881	Continued From page 23	F 881		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to follow the facility's policy for the antibiotic stewardship program by not reporting infections to the infection preventionist as directed in policy, and failed to timely track infections and review antibiotic use following initiation of the medications. The facility census was 36. Review of the facility's undated policy, Surveillance: Antibiotic Stewardship Program, showed the following: -Measures of Antibiotic Prescribing, Use, and Clinical Outcomes: -The Infection Preventionist/designee will be responsible to audit the clinical assessment documentation at the time of the antibiotic prescription; -The Infection Preventions/designee will be responsible for auditing the completeness of antibiotic prescribing documentation to include dose, route, start date, end date, days of therapy, and indication; -The Infection Preventionist/designee will monitor antibiotic imitation. This is done by taking	F 881		

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the number of new antibiotic starts for a single indication (Urinary Tract Infection, etc), dividing by total number of resident-days, and multiplying by 1,000;

-The infection Preventionist/designee will track C. difficile and antibiotic resistant infections. The facility will work with the consultant laboratory personnel to develop a quarterly report of any instances of C. difficile or antibiotic resistant infections, such as methicillin-resistant staphylococcus aureus (MRSA) or E. coli. This report will be discussed with the Medical Director, Pharmacist Consultant, and Lab Consultant during the quarterly Quality Assurance meeting;

-Antibiotic Utilization: All residents transferred to or from the facility who are on an antibiotic will have adequate documentation of dose, duration, and indication for the antibiotic. This will aid in determining the appropriateness of treatment based on additional laboratory/clinical data and resident response to treatment. This will also ensure discontinuation in a timely manner;

-Broad Interventions to Improve Antibiotic Use:

-Residents with a change in condition (symptoms of infection) should be identified with the Stop and Watch Tool;

-Licensed nurses should complete the Situation-Background-Assessment-Recommendation (SBAR) to ensure a comprehensive assessment of the resident suspected of having an infection;

-The Infection Preventionist/designee will initiate an antibiotic "time-out" three days after an antibiotic is initiated. The team will review all clinical findings, diagnostic findings, and resident response to answer the following questions:

1. Does the resident have a bacterial infection that will respond to antibiotic treatment?

2. Is the resident on the most appropriate

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F 881	Continued From page 25 antibiotic, including dose and route of administration? 3. Can the spectrum of the antibiotic be narrowed of the during of therapy be shortened? 4. Does the resident need additional infectious disease expertise to ensure optimal treatment? -The facility will reduce prolonged antibiotic treatment courses for common infections by requesting the shortest duration of efficacy or the specific infection. Best evidence has shown that short courses of antibiotics are effective for common infections and may reduce adverse events and complications associated with antibiotic use; Review of the facility's undated policy, Antibiotic Stewardship Program, showed the following: -The antibiotic stewardship program is designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use; -The goal of the facility will be to monitor infections and antibiotic usage by having a designated individual to track, monitor, trend and evaluate the monthly infections This individual will be known as the infection prevention coordinator; -The Director of Nursing (DON) will set the standard for assessment, monitoring and communication changes in a resident's condition to the front-line nursing staff; -The leadership team will include the charge nurses and the nursing assistants in the decision-making process for stating an antibiotic; -The infection prevention coordinator will play a key role in the stewardship program by performing the tracking, monitoring, trending and evaluating of antibiotic usage. The infection	F 881		

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F 881	Continued From page 26 prevention coordinator will identify education needs of the facility staff and will communicate needs with the DON, medical director and charge nurses as needed; -The nursing home will utilize specific forms to identify the three most common infections: 1. Urinary tract infection (UTI) 2. Skin and soft tissue 3. Respiratory; -The facility will utilize the SBAR forms available in the electronic medical record (EMR) system for suspected UTI, suspected lower respiratory and suspected soft skin tissue prior to calling the attending physician; -The facility will utilize the Event-Infection Report in EMR system; -The facility will attach the nursing progress note to the event form; -The facility will utilize the following reports in the EMR system for review and monitoring of infections: 1. Antibiotic Medication Report - Utilization Report 2. Infection Summary Report 3. Current Resident Infection by infection type 4. Resolved Resident Infection by infection type; -The infection prevention coordinator will track the adverse outcomes and costs from antibiotic usage including: C. difficile infections, antibiotic-resistant organisms or adverse drug events to analyze whether or not the stewardship is successful in improving resident outcomes; -The facility will provide reporting related to antibiotic usage, tracking, and trending trough the Quality Assurance and Performance Improvement and Quality Assurance Agency process; -The facility will provide antibiotic stewardship	F 881		

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education to clinicals, nursing staff, residents and families;
-There should be a minimum of two individuals to serves as the champions of the facility infection prevention plan. There should be a designated Infection Prevention Coordinator as well as team members to assist with the infection program.

1. Review of Resident #35's Physician Order Sheet, dated April 2025, showed the following:
-An order for Bactrim DS (an antibiotic) 800-160 milligrams (mg), one tablet twice a day, for a diagnosis of urinary tract infection (order dated for 3/31/25 to 4/3/25);
-An order for cefuroxime axetil (an antibiotic) 250 mg, one tablet twice a day, for a diagnosis of urinary tract infection (order dated for 4/3/25 to 4/8/25).

2. Review of Resident #26's Physician Order Sheet, dated January 2025, showed the following:
-An order for azithromycin (an antibiotic) 250 mg, one tablet daily, for a diagnosis of bacterial pneumonia (order dated for 1/24/25 to 1/29/25);
-An order for amoxicillin-potassium clavulanate (an antibiotic) 875-125 mg, one tablet twice a day, for a diagnosis of bacterial pneumonia (order dated for 1/24/25 to 1/30/25).

3. Review of the resident's progress note, dated 12/31/24 at 9:06 A.M., showed physician orders were received to start amoxicillin (oral antibiotic) 875 milligrams (mg)/125 mg for treatment of pneumonia.

Review of resident's progress notes, dated 01/27/25 at 3:38 P.M., showed new orders were received to start Augmentin (oral antibiotic) 875 mg/125 mg due to abnormal CT scan (a

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	265535	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW GARDENS	100 AUDSLEY DRIVE GLASGOW, MO 65254

(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 881	Continued From page 28	F 881		

diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) with diagnosis of possible pneumonia.

4. During interviews on 4/16/25 at 9:11 A.M. and 1:57 P.M. and 4/17/25 at 10:18 A.M. the Director of Nursing (DON) said the following:
-She was the Infection Preventionist and was responsible for the antibiotic stewardship program;
-She completed the tracking and trending reports for infections and antibiotics at the end of every month;
-She tried to complete the tracking and trending reports in real time, but due to staffing, hours worked, and other assigned duties, she was not able to do that;
-The nurses did not notify her when a resident had signs/symptoms of infections;
-The charge nurses did not use the SBAR or event infection reports;
-She tried to review progress notes and new orders daily; this is how she was made aware of new infections and antibiotics;
-She tried to use McGreer criteria (a set of clinical and laboratory findings used to define and track infections in long-term care facilities) if she could capture the symptoms in the nursing progress notes.

During an interview on 4/17/25 at 11:11 A.M., the facility Nurse Practitioner said she expected the facility to use and follow the McGreer criteria as much as possible.

During an interview on 4/17/25 at 3:30 P.M., the Administrator said the following:
-She expected the DON to track and monitor all

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F 881	Continued From page 29 infections and antibiotics; -She expected the DON to follow the McGreer criteria; -She expected for all nurses to use the SBAR and event infection reports in the resident's chart.	F 881		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		

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F 883	Continued From page 30 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the pneumococcal vaccinations (a vaccine that can protect against pneumococcal disease) as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines for four residents (Residents #15, #25, #6, and #34), of five five residents reviewed for immunization status. The facility census was 36. Review of the facility's undated policy, Immunization, showed the following: -Pneumococcal vaccination in persons age 65 and older years, unless contraindicated, would be administered according to the following guidelines when determining the vaccination status;	F 883		

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F 883	Continued From page 31 -Adults 65 years or older who have not already received a pneumococcal conjugate vaccine should receive either a single dose of PCV15 followed by a dose of PPSV23 one year later, or a single dose of PVC20. If PCV20 is administered, a dose of PPSV23 is not indicated; -Adults 65 or older who have only received PPSV23 should receive a single dose of PCV15 or PCV20. The PCV 15 OR PVC20 dose should be administered at least one year after the most recent PPSV23. Regardless whether PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it; Review of the CDC's Pneumococcal Vaccine Timing for Adults, updated October 2024, showed the following: -For adults 50 years or older who have never received any pneumococcal vaccine or whose previous vaccination history is unknown, administer PCV15, PCV20, or PCV21; -If PCV15 is administered, administer a dose of PPSV23 at least one year after the dose of PCV15. If the PPSV23 is not available, the PCV20 or PCV21 may be used; -If PCV20 or PCV21 is administered, regardless of which vaccine is used, their pneumococcal vaccinations are complete; -For adults 50 years or older who received the PPSV23 only at any age, administer the PCV15, PCV20 or the PCV 21 at least one year after the PPSV23 was administered; -For adults 50 years or older who received the PCV13 only at any age, administer the PCV20 or PCV21 at least one year after the PCV13 was administered; -For adults 50 years or older who received the PCV13 at any age and the PPSV23 when less than 65 years of age, administer the PCV20 or	F 883		

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F 883	Continued From page 32 PCV21 after at least five years after the last pneumococcal vaccine dose; -For adults 65 years or older who received the PCV13 at any age and the PPSV23 at 65 years or older, the individual and their vaccination provider may choose to administer the PCV20 or PCV21 after at least five years after the last pneumococcal vaccine dose. (Refer to the CDC's Shared Clinical Decision-Making PCV20 or PVC21 Vaccination for Adults 65 Years or Older for additional information on clinical decision making.) 1. Review of Resident #15's undated face sheet showed the following: -He/She was greater than 50 years of age; -He/She admitted on 05/11/23; -He/She was not his/her own responsible party for decision making. Review of the resident's admission packet, dated 3/14/23, showed the resident's pneumococcal vaccination consent was left blank. Review of the resident's significant change MDS, dated 2/10/25, showed he/she was up to date with pneumococcal vaccinations. Review of the resident's medical record showed no documentation the resident received or declined any pneumococcal vaccinations prior to admission or while a resident at the facility. (The resident's vaccination status was not up to date in accordance with the CDC guidelines and recommendations.) During an interview on 4/23/25 at 11:11 A.M., the resident's responsible party said he/she wanted the resident to be up to date on vaccinations,	F 883		

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F 883	Continued From page 33	F 883		

including the pneumococcal vaccination. He/She would consent to the pneumococcal vaccination if it was offered.

2. Review of Resident #25's face sheet showed the following:
-He/She was greater than 50 years of age;
-He/She admitted to the facility on 11/01/23;
-He/She had a power of attorney (POA) for health care;
-Diagnoses included congestive heart failure (a condition where the heart muscle is weakened and can't pump enough blood to meet the body's needs; this lead to buildup of fluid in the lungs, legs, and other parts of the body), cough and dyspnea (shortness of breath).

Review of the resident's admission packet, dated 11/01/23, showed the resident provided consent for the pneumococcal vaccinations on 11/01/23.

Review of the resident's quarterly MDS, dated 01/10/25, showed he/she was up to date with pneumococcal vaccinations.

Review of the resident's Continuity of Care Documentation (CCD), dated 04/16/25, showed no documentation the resident received any pneumococcal vaccinations prior to or after admission.

3. Review of Resident #6's immunization record showed the resident received the PPSV 23 vaccination on 06/14/17.

Review of the resident's undated face sheet showed the following:
-He/She was greater than 50 years of age;
-He/She admitted on 11/21/22;

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F 883	Continued From page 34 -He/She had a guardian. Review of the resident's admission packet, dated 11/17/22, showed the resident's guardian consented to the pneumococcal vaccinations on 11/17/22. Review of the resident's quarterly MDS, dated 2/21/25, showed the resident's pneumococcal vaccine was up to date. Review of the resident's Continuity of Care Document, dated 04/17/25, showed no documentation the resident received any pneumococcal vaccinations after admission. (The resident's vaccination status was not up to date in accordance with the CDC guidelines and recommendations.) 4. Review of Resident #34's face sheet showed the following: -He/She was greater than 50 years of age; -He/She admitted to the facility on 11/02/23; -He/She was not his/her own responsible party for decision making. Review of the resident's admission packet, dated 11/02/23, showed the resident's responsible party consented to the pneumococcal vaccinations on 11/02/23. Review of the resident's quarterly MDS, dated 02/07/25, showed he/she was up to date with pneumococcal vaccinations. Review of the resident's Continuity of Care Document, dated 04/17/25, showed no documentation the resident received any pneumococcal vaccinations prior to or after	F 883		

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F 883	Continued From page 35 admission. 5. During an interview on 4/16/25 at 9:11 A.M. and 1:57 P.M. the Director of Nursing (DON) said the following: -The facility gave the immunization consents to the resident/responsible party upon admission. These should be completely filled out; -With the new regulations and changes in pneumococcal vaccinations, it was confusing to determine which pneumococcal vaccinations the residents needed; -She and the medical director worked together to determine which pneumococcal vaccination to order; -She or the charge nurses were responsible for administering the pneumococcal vaccinations as ordered; -Most of the residents were not up to date with their pneumococcal vaccinations. During an interview on 4/17/25 at 3:30 P.M., the Administrator said the following: -It could be difficult to obtain a resident's vaccination history on admission; -She was aware of the issues with the residents' pneumococcal immunizations. The process was overwhelming but needed more attention; -She expected the pneumococcal vaccinations to be given following the CDC guidelines.	F 883		

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	01659	A. BUILDING: _____ B. WING _____	04/17/2025

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A4040	19 CSR 30-85.042(35)(B) SNF RN-Day Shift, LPN/RN eve/nights Licensed Nursing Requirements; Skilled Nursing Facility. (B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II This regulation is not met as evidenced by: Class II Refer to F727.	A4040		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Refer to F880, F881, and F883.	A4086		

PLAN OF CORRECTION

Provider/Supplier Name:	Glasgow Gardens
Street Address, City, Zip:	100 Audsley Drive, Glasgow, Missouri 65254
Date of Survey:	04/17/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. This submission of the POC does not constitute an admission on the part of Glasgow Gardens ("the facility") as to the accuracy of the surveyor findings, nor the conclusions drawn there from. The facility's submission of the POC does not constitute an admission on the part of the facility that the findings cited are accurate, or that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction.	
F656 **SS=D**	**Develop/Implement Comprehensive Care Plan** **1. Corrective Action for Residents Affected by the Deficient Practice:** • Resident #35's care plan was immediately updated to reflect: o The diagnosis of dementia with agitation and corresponding use of antipsychotic (Seroquel) and antidepressant (Citalopram) medications, including goals for behavior management and monitoring for adverse effects.	**05/28/2025**

	○ The diagnosis of atrial fibrillation and use of anticoagulant therapy (Eliquis), with related interventions such as fall precautions, bleeding risk assessments, and vital sign monitoring. • Resident #89's care plan was updated to include: ○ PRN oxygen use based on oxygen saturation thresholds, with monitoring parameters and reassessment protocols. ○ The resident's smoking status, supervision requirements, and fire safety precautions, including coordination with staff scheduling and smoking area documentation. **2. Identification of Other Residents with Potential to be Affected:** • A comprehensive audit of all resident care plans was conducted to ensure that each reflects all active diagnoses, ordered treatments, and risk factors. • Special focus was given to residents receiving psychotropics, anticoagulants, PRN oxygen, or those identified as smokers. • Any omissions were corrected, and updated care plans were verified by the MDS Coordinator/DON and/or designee. **3. Systemic Changes to Prevent Recurrence:** • The facility's care planning policy was revised to mandate interdisciplinary verification of care plans within 72 hours following each MDS assessment. • A standardized care plan quality assurance checklist was implemented to ensure inclusion of all clinically relevant data, including high-risk medications and resident-specific lifestyle risks.	

	• All members of the IDT—including the DON, MDS Coordinator, Social Services, and Nursing staff—were re-educated on comprehensive care planning requirements and CMS expectations for measurable, person-centered goals. **4. Monitoring to Ensure Ongoing Compliance:** • The DON or designee will conduct weekly audits of all new and revised care plans for four consecutive weeks, transitioning to biweekly audits for two months, followed by monthly audits for an additional three months. • Findings will be reviewed at each QAPI meeting and documented in the committee's minutes. • Any deviations from care planning standards will trigger immediate corrective training and root cause analysis by the QAPI team. • Date of Compliance: May 28, 2025	
F661 **SS=B**	**Discharge Summary** **1. Corrective Action for the Resident Affected by the Deficient Practice:** • Resident #38's medical record was reviewed in its entirety. A complete discharge summary and recapitulation of stay was generated post-discharge, including: o Summary of diagnoses and clinical course; o Summary of therapy provided and outcomes; o Medication reconciliation from pre-admission through discharge;	**05/28/2025**

	○ Post-discharge plan of care, including follow-up appointments, home support services, and care instructions. • The documentation was signed by the appropriate clinical personnel and retained in the medical record. A copy was forwarded to the resident's authorized representative. **2. Identification of Other Residents with Potential to be Affected:** * Responsible staff members were re-educated on 4/17/2025 . • A concurrent review of all current residents with anticipated discharge orders was initiated to ensure pending documentation requirements are completed proactively. **3. Systemic Changes to Prevent Recurrence:** • Nursing staff were re-trained by the DON on: 4/17/2025 ○ The regulatory requirements for discharge documentation; ○ Use of the EMR templates for discharge; ○ Resident and representative notification and education at discharge. • Social Services and Nursing were trained to collaborate on post-discharge planning to ensure accurate reflection of services, location, follow-up, and resident preferences. **4. Monitoring to Ensure Ongoing Compliance:** • The DON or designee will perform weekly audits of 100% of discharge records for four weeks to ensure all required discharge documentation is completed and properly filed.	

	• Thereafter, 25% of discharges will be reviewed monthly for three months. • Audit results will be reviewed in monthly QAPI meetings, and any identified deficiencies will result in immediate corrective action and staff re-education. • Compliance trends will be analyzed to determine if additional process changes or training are necessary. • Date of Compliance: May 28, 2025	
F727 **SS=F** **A4040**	**RN 8 Hours/7 Days a Week; Full-Time Director of Nursing** **1. Corrective Action for the Deficient Practice:** • The facility immediately initiated interim coverage solutions to ensure a Registered Nurse (RN) is present for at least 8 consecutive hours per day, 7 days a week. • On days the Director of Nursing (DON) is unavailable or off duty, an RN from a contracted staffing agency or a qualified part-time RN was scheduled to provide coverage. **2. Identification of Other Residents with Potential to be Affected:** • All residents were identified as potentially affected due to the systemic nature of the deficiency. • The Administrator and DON reviewed all resident care documentation from affected days to ensure no delay or deficiency in care was noted due to the absence of RN coverage. • Resident status changes, assessments, and medication administration records were closely reviewed for accuracy and timeliness. **3. Systemic Changes to Prevent Recurrence:**	**05/28/2025**

	• The facility's staffing and scheduling procedure was updated to include a contingency plan for unexpected RN absences, requiring pre-identified backup RNs or agency personnel usage. • The DON's job description was reaffirmed to reflect full-time administrative duties. The DON will not be assigned as the charge nurse unless in emergency coverage situations permitted under §483.35(b)(3). • The corporate HR department was engaged to expand recruitment efforts regionally, including RN sign-on bonuses, and part-time-to-full-time conversion incentives. • The facility implemented a "weekend RN rotation incentive" to attract PRN or part-time RNs for weekend shifts. **4. Monitoring to Ensure Ongoing Compliance:** • The Administrator or designee will audit the RN daily staffing logs weekly to ensure 8-hour RN coverage is met every day. • Results of these audits will be presented in monthly QAPI meetings for review and follow-up. • Any days lacking documented RN coverage will be investigated, corrective action taken immediately, and staffing logs corrected with verified time records. • Date of Compliance: May 28, 2025	
F880 **SS=E** **A4086**	**Infection Prevention & Control** **1. Corrective Action for the Residents Affected by the Deficient Practice:**	**05/28/2025**

	• **Resident #17**: Resident consented to the 2-step TB test completed on 4/18/2025- results 0mm and 4/28/2025- results 0 mm. • **Resident #239**: Medical records were reviewed to confirm BCG treatment history. Laboratory test for Quantiferon Level. The result will be reviewed by the Nurse Practitioner and filed in the resident's record. • **Resident #15**: An annual TB evaluation was completed by the licensed nurse and documented, confirming no signs or symptoms of TB were present. **2. Identification of Other Residents with Potential to be Affected:** • A facility-wide audit was completed of all current residents to verify: o Completion of a two-step TST or documented chest x-ray at admission; o Annual TB symptom evaluations were completed on the anniversary of admission. • All discrepancies were corrected, and physicians or responsible parties were contacted as needed. Missed evaluations were completed and documented. **3. Systemic Changes to Prevent Recurrence:** • The facility's **Tuberculosis Control Policy** was reviewed ensure it includes: o Clearly require documentation of second-step TST follow-up, refusal, and escalation to the physician/responsible party;	

	○ Mandate annual TB symptom evaluations for all residents and define responsible personnel and documentation process. • Nursing staff were retrained on TB screening procedures, documentation expectations, and timelines for annual reviews. • The DON implemented a **TB Evaluation Tracking Log**, reviewed monthly, to ensure timely completion of admission and annual evaluations. • The **Water Management Policy** was revised to reflect full compliance with **ASHRAE 188** and **CDC guidelines**, including: ○ Routine checks of both **hot and cold water** temperatures; ○ Monitoring water outlets, including **shower rooms**, for temperature and stagnation risks; ○ Flushing of water systems in unused rooms prior to reoccupation. • The Maintenance Director received training on Legionella risk factors, cold water temperature monitoring, and documentation protocols. • A **Water Management Log** was developed to include: ○ Weekly monitoring of hot and cold water temperatures; ○ Documentation of outlets tested, results, and corrective actions taken if control limits are not maintained; ○ Monthly review of any unoccupied rooms and flushing records. **5. Monitoring to Ensure Ongoing Compliance:**	

	• The **DON or designee** will conduct monthly audits of TB records for all new admissions and annual evaluations, with immediate remediation of deficiencies. • The **Infection Preventionist or designee** will present a quarterly report to the QA Committee, including TB tracking, refusals, follow-ups, and x-ray documentation. • The **Maintenance Director or designee** will submit monthly water temperature logs to the Administrator. A random review of cold and hot water outlets will be conducted monthly by the Administrator or designee to ensure compliance. • Deficiencies will be discussed during monthly **QAPI meetings**, with corrective actions initiated as needed. Date of Compliance: May 12, 2025 • Date of Compliance: May 28, 2025	
F881 **SS=E** **A4086**	**Antibiotic Stewardship Program** **1. Corrective Action for Residents Affected by the Deficient Practice:** • All antibiotic orders and infection-related documentation for **Residents #35 and #26** were reviewed by the Infection Preventionist (IP)/designee and Medical Director. • Missing documentation related to antibiotic start/stop dates, indications, clinical assessments and treatment evaluations were added to the medical record based on clinical evidence and provider verification. • SBAR and infection event reports were retrospectively completed where appropriate and	**05/28/2025**

attached to the relevant progress notes and EMR documentation.

2. Identification of Other Residents with Potential to be Affected:

- A facility-wide review was conducted of all current residents receiving antibiotics.
    - Accurate and complete documentation of dose, route, duration, and clinical indications.
    - Infection event reports were completed as indicated.
    - Antibiotic time-out evaluations at 72 hours were completed.
- Any missing elements were promptly corrected. Responsible nurses and providers were contacted for clinical justification as needed.

3. Systemic Changes to Prevent Recurrence:

- The **Antibiotic Stewardship Program policy** was reviewed to include:
    - Mandatory notification to the IP or designee upon initiation of any antibiotic therapy.
    - Required use of infection event forms for suspected infections, integrated into the EMR workflow.
    - A revised time-out process at 72 hours post-antibiotic initiation with checklist prompts for clinical reassessment and antibiotic adjustment.

	• The **DON / Infection Preventionist** provided in-service training to all licensed nurses, charge nurses, and nursing assistants on:
	  ○ Use of infection event documentation, and McGeer criteria.
	  ○ Proper reporting of suspected infections to the IP.
	  ○ Role expectations in antibiotic stewardship, including communication protocols and EMR usage.
	• Monthly collaboration between the IP, Medical Director, Consultant Pharmacist, and Lab Consultant, if indicated, will now occur consistently through documented Quality Assurance and Performance Improvement (QAPI) meetings.
	4. Monitoring to Ensure Ongoing Compliance:
	• The IP or designee will audit all new antibiotic orders weekly to verify:
	  ○ Documentation of indication, route, dose, and start/stop dates.
	  ○ Completion of infection event report.
	  ○ Completion of 72-hour antibiotic time-out evaluations.
	• Audit results will be reviewed monthly during QAPI meetings with tracking logs maintained and trended to identify improvement areas or recurring noncompliance.
	• Corrective actions will be taken for any missed documentation or reporting failures, including follow-up education and staff counseling as necessary.
	• Date of Compliance: May 28, 2025	

F883 SS=E A4086	**Influenza and Pneumococcal Immunizations** **1. Corrective Action for the Residents Affected by the Deficient Practice:** • **Residents #15, #25, #6, and #34**: Each resident's immunization status will be reviewed and collaborated with the physician and responsible party. o Orders will be obtained for pneumococcal vaccines as indicated by current CDC guidelines (e.g., PCV15 followed by PPSV23 or PCV20 as appropriate). o Consents will be reaffirmed or newly obtained from residents or their representatives. o Vaccines will be administered or scheduled promptly, and documentation will be entered into the EMR, including vaccine type, date, lot number, and manufacturer. o Educational materials on vaccine benefits and side effects will be provided and documented. **2. Identification of Other Residents with Potential to be Affected:** • A facility-wide audit was conducted for all residents aged 50 and older to verify pneumococcal and influenza immunization status. • Residents with incomplete, missing, or unclear immunization documentation were flagged for immediate follow-up. • Physicians and responsible parties were contacted to obtain history, verify prior vaccinations, or obtain consent for updated immunization per CDC guidelines.	05/28/2025

	3. Systemic Changes to Prevent Recurrence:
	• The **Immunization Policy** was reviewed to ensure:
	  o Integration of CDC's current pneumococcal vaccine recommendations into admission and annual immunization protocols.
	  o Clear step-by-step guidance for determining vaccine eligibility based on age, prior immunization, and shared decision-making standards.
	• An **Immunization Tracking Tool** was implemented to:
	  o Prompt staff on required vaccines upon admission.
	  o Track due dates for follow-up doses (e.g., PPSV23 after PCV15).
	  o Alert nursing staff and IP when documentation is incomplete or consent is pending.
	• The Director of Nursing provided re-education to licensed nursing staff and admission coordinators on:
	  o CDC pneumococcal vaccine guidelines.
	  o Proper documentation of education, consent, administration, or refusal.
	  o Importance of ensuring immunization status accuracy for regulatory compliance and resident safety.
	• **Facility Director of Nursing/IP or designee** is responsible for reviewing vaccination status monthly and ensuring follow-through on due or overdue immunizations.	

4. Monitoring to Ensure Ongoing Compliance:

- The DON or designee will conduct monthly audits of all newly admitted and long-stay residents to verify:
    - Proper vaccine type and timing per CDC guidelines.
    - Documentation of education, consent, and administration.
- Results will be reviewed in **QAPI** meetings, and missed or delayed immunizations will trigger immediate follow-up.
- Trends or repeated omissions will be addressed through corrective training or process revision.
- Date of Compliance: May 28, 2025

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