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A2204	19 CSR 30-86.022(2)(F) Exterior Premises-Fire Safety General Requirements. (F) The facility shall maintain the exterior premises in a manner as to provide for fire safety. II This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed maintain the outdoor areas to maintain fire safety by not doing the following: preventing the presence of three sandbags outside the exit door from the basement; failed to maintain the exit discharge (the portion of the means of egress between the building exit and the public way, street, alley, or other similar parcel of land essentially open to the outside air deeded, dedicated, or otherwise permanently appropriated for public use) from the stairwell from the basement to the public way (that portion of a means of egress between the termination of an exit and a public way) free of slipping hazards; failed to install a gradual decline from two exit discharges from the east side of the facility to the public way; and failed to maintain the exit discharge from the first floor west , free of slipping hazards after a rainstorm occurred and finished. This practice potentially affected all residents. The facility census was 41 residents. 1. Observation with the Maintenance Director on 6/12/25 at 10:34 A.M. showed: -Three bags of sandbags located outside of the exit door from the basement and in front of the stairwell from the basement. -An 11 feet (ft.) 8 inches (in.) length of that exit discharge from the stairwell to the public way was wet and slippery.	A2204		

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A2204	Continued From page 1 During an interview on 6/12/25 at 10:39 A.M., the Maintenance Director said there was a sump pump (a device, typically found in basements or crawl spaces, that removes accumulated water from a pit (called a sump pit) and pumps it away from the building's foundation) in the basement which pumped water to a drainage pipe which places water on the walkway. 2. Observation with the Maintenance Director on 6/12/25 at 10:46 A.M. showed the curbs of two exit discharges from the East side of the facility which had a 6 in. height from the public way. During an interview on 6/12/25 at 10:48 A.M. the Maintenance Director said a gradual decline from the curb to the public way would help in the evacuation of residents with wheelchairs. 3. Observation on 6/13/25 at 8:50 A.M. showed a rainstorm in progress in the vicinity of the facility. Observation on 6/13/25 at 9:46 A.M., showed a 55 ft. 10 in. length section of the exit discharge from the West side of the facility to the public way with standing water on the sidewalk when other walkways were dry by that time after the rainstorm passed on. During an interview on 6/13/25 at 10:21 A.M., the Maintenance Director said he/she needed to improve the drainage of the water from the walkway into the grass and divert the waterflow from the gutter downspout from the sidewalk to a different areas. Record review of the 2012 National Fire Protection Association (NFPA) 101 Chapter: 7.1.10.1, showed the following: "Means of egress shall be continuously maintained free of all	A2204		

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A2204	Continued From page 2 obstructions or impediments to full instant use in the case of fire or other emergency."	A2204		
A3235	19 CSR 30-86.032(34) Hot Water 105-120 Degrees F Plumbing fixtures which are accessible to residents and which supply hot water shall be thermostatically controlled so that the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120°F) (49°C) and the water shall be at a temperature range between one hundred five degrees Fahrenheit (105°F) (41°C) and one hundred twenty degrees Fahrenheit (120°F) (49°C). I/II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to maintain the hot water at the faucets of the following resident rooms (Resident rooms 104,105, 106, 107, 108, 109, 110, 115, 103, 102, 102, 201, 202, 203, 205, 206, 208, and 210) at a temperature at or below 120 ºF (degrees Fahrenheit). This practice affected 16 residents who resided in those rooms. The facility census was 41 residents. Review of the Section for Long Term Care Policy entitled Maximum/ Minimum Water temperatures revised 10/1/98, showed: -State Regulations require that all facilities maintain water temperatures between 105 ºF -- 120 ºF at plumbing fixtures accessible to residents. -Department of Health and Senior Services (DHSS) staff shall use the dial or digital thermometers to measure water temperatures.	A3235		

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A3235	Continued From page 3 -In some situations, water temperatures may fluctuate significantly even at the same plumbing fixtures. Measurements at any water fixture should be taken for at least two minutes in order to determine fluctuation patterns or until the temperature has been constant for at least 30 seconds. Review of the facility's policy entitled Water Temperatures, Safety of Temperatures, revised December 2009, showed: Policy Statement: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120? F, or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. 4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. 1. Observation with the Maintenance Director on 6/11/25, showed: -At 1:54 P.M. the hot water temperature in resident room 104 was 121.8 ºF -At 1:56 P.M. the hot water temperature in resident room 105, was 127.9 ºF.	A3235		

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A3235	Continued From page 4 -At 2:00 P.M. the hot water temperature in resident room 106, was 126.5 ºF. During an interview on 6/11/25 at 2:02 P.M., the Maintenance Director said: -There were 4 hot water heaters which provide hot water to the Assisted Living Facility and the adjoining Skilled Nursing Facility. -When he/she checked hot water temperatures, he/she did not let the hot water run for 2 minutes. Observation with the Maintenance Director on 6/11/25 at 2:04 P.M., showed the hot water heaters were set at the following temperatures: -Hot Water Heater #1 was set between 132 and 133 ºF -Hot Water Heater #2 was set between 125 and 126 ºF. -Hot Water Heater #3 was set between 132 and 133 ºF. -Hot Water heater #4 was set between 132 and 133 ºF. -At 2:19 P.M. the hot water temperature in resident room 107 was 120.3 ºF. -At 2:21 P.M. the hot water temperature in resident room 108 was 123.6 ºF. -At 2:26 P.M. the hot water temperature in resident room 109 was 124.8.0 ºF. -At 2:29 P.M. the hot water temperature in resident room 110 was 125.9 ºF -At 2:33 P.M. the hot water temperature in resident room 112 was 121.6 ºF -At 2:34 P.M. the hot water temperature in resident room 115 was 122.3 ºF. -At 2:51 P.M. the hot water temperature in resident room 103 was 123.6 ºF -At 2:54 P.M. the hot water temperature in resident room 102 was 124.7 ºF -At 2:56 P.M. the hot water temperature in resident room 101 was 123.9 ºF.	A3235		

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A3235	Continued From page 5 -At 3:04 P.M. the hot water temperature in resident room 201 was 125.0 ºF -At 3:08 P.M. the hot water temperature in resident room 202 was 127.9 ºF -At 3:11 P.M. the hot water temperature in resident room 203 was 121.8 ºF. -At 3:13 P.M. the hot water temperature in resident room 204 was 122.5 ºF. -At 3:16 P.M. the hot water temperature in resident room 205 was 127.5 ºF. Observation on 6/11/25 at 3:16 P.M, showed the facility's thermometer measured the water in resident room 205 at 120 ºF after the water flowed for more than 2 minutes. -At 3:24 P.M. the hot water temperature in resident room 206 was 130.8 ºF. -At 3:26 P.M. the hot water temperature in resident room 208 was 128.8 ºF. -At 3:28 P.M. the hot water temperature in resident room 209 was 126.1 ºF. -At 3:30 P.M. the hot water temperature in resident room 210 was 126.4 ºF. -At 3:11 P.M. the hot water temperature in resident room 203 was 121.8 ºF. During an interview on 6/12/25 at 10:59 A.M. the Maintenance Director said he/she turned down the temperature of the hot water heaters and increased the amount of cold water which flowed into the system on the morning of 6/12/25. All hot water temperatures after the faucets were allowed to run for 2 minutes were within the range of state regulations.	A3235		
A4704	19 CSR 30-86.047(6) Operator/Administrator Responsibilities The operator shall be responsible to assure	A4704		

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A4704	Continued From page 6 compliance with all applicable laws and regulations. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator ' s responsibilities shall include oversight of residents to assure that they receive care as defined in the individualized service plan. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to comply with state regulation 11 Code of State Regulations (CSR)40-5.100 paragraph 2 by not obtaining and displaying the operating certificate for the elevator. The facility census was 41 residents. 1. Review of the State Regulations (CSR)40-5.100 paragraph 2 pertaining to displaying of State Operating Certificate and Local Operating Certificate, showed (2) Display of State Operating Certificate. The owner, operator, lessee or agent of either shall post the operating certificate in the elevator equipment room, in a noncombustible frame with a clear protective vision plate over it. For installations without an elevator room the state operating certificate shall be posted as directed by the chief elevator inspector. Review of the facility's inspection book showed the previous operating certificate expired on 11/15/24. -An inspection dated 11/8/24 which was required before a new operating certificate is issued. During an interview on 6/12/25 at 12:59 P.M. the	A4704		

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A4704	Continued From page 7 Maintenance Director said it was the responsibility of the Administrator to call the company about obtaining about the operating permit. During an interview on 6/13/25 at 10:03 A.M. the Director of Nursing (DON) said since November 2024, there has been 4 different Administrators at the facility and was which caused a delay in the facility obtaining an operating certificate for the elevator.	A4704		
A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure an individualized service plan (ISP- the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident) was updated for one sampled resident (Resident #1) out of four sampled residents. The facility census was 41 residents.	A4754		

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A4754	Continued From page 8 1. Review of Resident #1's Admission Record showed he/she admitted to the facility with a diagnosis of Parkinson's (a group of neurological conditions characterized by similar movement symptoms with Parkinson ' s disease (a progressive nervous system disorder that affects movement, often causing tremors, stiffness, and difficulty with balance and coordination) being the most common), Unspecified. Review of the resident's Physician Order Sheet (POS) dated June 2025 showed the resident had an order for the resident to admit to hospice care (end of life) which was ordered on 12/31/24. Review of the resident's individualized service plan on 6/12/24 showed the resident did not have an intervention in place to show the resident had been admitted to hospice. During an interview on 6/12/25 at 2:56 P.M. the Director of Nursing (DON) and the Regional Nurse said that they understood that the ISP's needed to be updated semi-annually and when there was a significant change. During an interview on 6/13/25 at 9:24 A.M. the DON said: -The resident had hospice services documented in multiple places outside of the ISP. -The resident's ISP should have been updated to show that the resident received hospice services.	A4754		
A4785	19 CSR 30-86.047(41)(C) Medication Storage-Separate, Not In Use All medication shall be safely stored at proper temperature and shall be kept in a secured location behind at least one (1) locked door or	A4785		

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A4785	Continued From page 9 cabinet. Medication shall be accessible only to persons authorized to administer medications. II/III (C) Medication that is not in current use and is not destroyed shall be stored separately from medication that is in current use. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview, and record review, the facility failed to ensure that medications were properly stored and destroyed after the discard date or expiration date. The facility census was 41 residents. Review of the facility's policy titled "Medication Labeling and Storage" dated from 2001 showed: -Medications and biological's were stored in the packaging, containers or other dispensing systems in which they are received. -The nursing staff were responsible for maintaining medication storage and preparation areas were in a clean, safe, and sanitary manner. -Each resident's medications were assigned to an individual cubicle, drawer, or other holding area. -Discharged/expired resident's and/or expired medications should be pulled and stored away from daily administration medications and could be locked in the medication cart of pharmacy/medication room closet to be destroyed weekly on Fridays by a licensed nurse. -Medication labels needed to include at a minimum the following information: --Medication name. --Prescribed dose. --Strength. --Expiration date, when applicable. --Resident's name.	A4785		

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A4785	Continued From page 10	A4785		

--Route of administration.
--Appropriate instructions and precautions.
-Medications were not to be transferred between containers.

1. Review on 6/12/25 at 1:09 P.M. of the 100-hall medication cart and pharmacy room showed:
-The pharmacy room contained a shelving storage system for resident medications in which each resident had a container where overflow medications could be stored.
-There was no specific area designated for expired medications or for medications no longer in use that needed to be destroyed.
-A bottle of Nortriptyline (can be used to treat nerve pain and depression) 10 milligrams (mg) with a discard date of 2/25/25.
-A bottle of Aspirin (used to relieve mild or chronic pain and to reduce fever and inflammation) 81 mg with a discard date of 2/5/25.
-A container of Pantoprazole (used to treat conditions involving excessive stomach acid production) 40 mg with a discard date of 5/4/25.
-A bottle of Acetaminophen (used to treat pain and a fever reducer) 250 mg that expired in March 2024.
-A container of Valacyclovir (an anti-viral medication) one gram (gm) with a discard date of 2/14/25.
-A bottle of Lisinopril (used to treat high blood pressure) 10 mg with a discard date of 10/23/20.
-A container of Jantoven (a brand name for warfarin sodium, used as a blood thinner) one mg with a use by date of 2/28/25.
-A bag of five pills that appeared to be ibuprofen (used to as a pain reliever and/or anti-inflammatory) that was not stored in its original container and did not have a label or expiration date.
-A bottle of Acetaminophen 500 mg that expired

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A4785	Continued From page 11 in June 2024. -A bottle of Nyamic (the brand name for nystatin topical powder, which is used as an anti-fungal) 100,000 United State Pharmacopeia (USP- sets standards for the quality of medications to ensure identity, strength, quality, and purity) units per gram that had expired in February 2025. -A bottle of Psyllium Fiber (a dietary supplement) sugar free powder 180 teaspoons (tsp) with an expiration date that was illegible. -A stapled package of pill capsules not in its original container and did not have a label. -Four boxes of Refresh Celluvisc eye gel (used to soothe and relieve eyes from moderate symptoms of eye dryness) that expired in March 2025. During an interview on 6/12/25 at 3:45 P.M. Level One Medication Aide (L1MA) B and C said: -Most of the medications that were expired or that needed to be discarded were from residents that had been transferred emergently to the facility. -The medications that those residents had come into the facility emergently were supposed to have their medications screened for expiration and labeling when they admitted to the facility. -There should be a designated area for expired medications and medications that needed to be discarded away from the rest of the medications. -Expired medications should not be stored in the medication cart or in the resident overflow bins. -Only nurses were able to destroy medications. -The Director of Nursing (DON) had been waiting on the pharmacist in order to destroy the expired medications. During an interview on 6/13/25 at 9:24 A.M. the DON said: -He/She expected the L1MAs to notify the nurses when a medication needed to be destroyed.	A4785		

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A4785	Continued From page 12 -He/She was aware that a family member had brought in expired medication. -Those medications had been brought to the facility one or two months prior. -The medications should have been reviewed by the receiving staff member and should not have been accepted. -He/She expected staff to follow the expiration dates for medications and not the discard date or use by date. -Medications that that have an illegible expiration date needed to be destroyed or clarified with family if the medication came in a pack. -Medications should stay in their original container with an appropriate label. -Any medications that were not labeled appropriately should be discarded. -He/She expected the staff to check the medication carts and pharmacy room weekly for appropriate medication storage. -There should not have been expired medications in the medication cart or resident over-flow and should have been stored separately and away from the other medications. -He/She would be the person responsible for ensuring that the weekly checks were completed. "The higher classification merited due to the extent of the violation.	A4785		
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable	A4797		

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A4797	Continued From page 13	A4797		

nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition and medication. Administration of medication shall mean delivering to a resident his or her
prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II

This regulation is not met as evidenced by:
Class II

Based on observation, interview, and record review, the facility failed to ensure that one sampled resident's (Resident #1) insulin was administered using acceptable nursing techniques out of four sampled residents. The facility census was 41 residents.

Review of the facility's policy titled "Insulin Administration" showed there was no specific policy or protocol related to the administration of insulin via an insulin pen.

1. Review of Resident #1's Admission Record showed he/she admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein

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metabolism that is primarily a result of a deficiency or complete lack of insulin (a hormone produced in the pancreas by the islets of Langerhans, which regulates the amount of glucose in the blood) secretion in the pancreas or resistance to insulin.

Review of the resident's Physician Order Sheet (POS) dated June 2025 showed an order for Novolog (insulin Aspart) FlexPen Subcutaneous Solution Pen-injector 100 Unit/milliliter (ml), inject three units subcutaneously three times a day.

Observation on 6/12/25 at 12:37 P.M. of the resident's insulin administration completed by Level One Medication Aide (L1MA) A showed:
-He/She gathered the supplies in order to administer the resident and wheeled the resident into a private area.
-He/She dialed the pen to three units and injected the insulin without priming the needle.
-He/She then wheeled the resident back to the dining area.

During an interview on 6/12/25 at 12:44 P.M. L1MA A said:
-He/She would not have done anything differently when he/she administered the insulin to the resident.
-He/She knew that the insulin pen needed to be primed before use.
-He/She had forgotten to prime the insulin pen because he/she had struggled pulling the residents' pants down in order to reach the appropriate spot to inject the insulin.
-He/She was unsure of the exact amount of insulin that was needed in order to appropriately prime the insulin pen.

During an interview on 6/12/25 at 3:35 P.M. L1MA

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A4797	Continued From page 15 B and L1MA C said: -They were unsure if an insulin pen needed to be primed before use. -They were unsure of the amount of insulin that was used to appropriately prime the insulin pen. During an interview on 6/13/25 at 9:24 A.M. the Director of Nursing (DON) said: -An insulin pen needed to be primed before use. -The amount of insulin to prime the pen with was per manufacturer's instructions. -L1MA A had not given the resident's insulin appropriately. -He/She would have expected L1MA A to have primed the insulin pen before use.	A4797		
A4837	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a reasonable likelihood of serious harm to himself or herself or others and accidents that potentially could result in injury or did result in injuries involving the resident; III	A4837		

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A4837	Continued From page 16 This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure a monthly review/summary of the resident's general conditions was completed for four sampled residents (Resident #1, Resident #2, Resident #3, and Resident #4) out of four sampled residents. The facility census was 41 residents. 1. Review of Resident #1's Admission Record showed he/she admitted to the facility with the following diagnoses: -Parkinsonism (a group of neurological conditions characterized by similar movement symptoms with Parkinson's disease (a progressive nervous system disorder that affects movement, often causing tremors, stiffness, and difficulty with balance and coordination) being the most common), Unspecified. -Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin (a hormone produced in the pancreas by the islets of Langerhans, which regulates the amount of glucose in the blood) secretion in the pancreas or resistance to insulin). -Congestive Heart Failure (CHF- a weakness of the heart that leads to the build-up of fluid in the lungs and surrounding tissues). Review of the resident's electronic medical record (EMR) on 6/12/25 showed the resident did not have any monthly summaries completed. Review of the resident's requested medical records on 6/12/25 at approximately 1:45 P.M. showed no monthly summaries had been received.	A4837		

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A4837	Continued From page 17 2. Review of Resident #2's Admission Record showed he/she admitted to the facility on 2/22/25. Review of the resident's face sheet on 6/12/25 showed: -The face sheet had been completed by the resident's previous facility. -The resident had the following diagnoses: --Atrial Flutter (a type of abnormal heart rhythm). --Chronic Kidney Disease (CKD- a long-standing kidney disease based on kidney damage or decreased kidney function for three or more months). --Brain aneurysm (a weakened area in the wall of a blood vessel in the brain that bulges or forms a sac-like structure). Review of the resident's EMR on 6/12/25 showed the resident did not have any monthly summaries completed. Review of the resident's requested medical records on 6/12/25 at approximately 1:45 P.M. showed no monthly summaries were received. 3. Review of Resident #3's Admission Record showed he/she was admitted on 2/22/25 with diagnoses that included risk for falls and stroke history. Review of the resident's EMR on 6/12/25 showed the resident did not have any monthly summaries. The monthly summaries were requested and not provided. 4. Review of Resident #4's Admission Record showed he/she was admitted on 9/25/23 with diagnoses that included rheumatoid arthritis (an inflammatory disease that may lead to serious joint damage and disability) and acquired	A4837		

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A4837	Continued From page 18 absence of right toes. Review of the resident's EMR on 6/12/25 showed the resident did not have any monthly summaries. The monthly summaries were requested and not provided. 5. During an interview on 6/13/25 at 11:08 A.M. the Director of Nursing (DON) said: -The facility did not have a process in place for completing monthly summaries. -The information that was needed to complete the monthly summaries were in the residents' charts, just not all in one place. -He/She was not aware that information needed to complete the monthly summaries had to be in one place.	A4837		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to maintain the floors of the walk-in refrigerator and the floors under the food preparation table, free from food debris and grime. The facility census was 41 residents.	A6012		

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A6012	Continued From page 19 1. Observations on 6/13/25 from 6:23 A.M., through 8:15 A.M., during the breakfast meal preparation, showed: -The presence of brown colored grime and broken eggshells and debris on the floor of the walk-in. -The presence of old French fry pieces and food debris from previous meals that were on the floor under the steam table. During an interview on 6/13/25 at 6:45 A.M. Dietary Cook (DC) A said the night shift employees should sweep and mop under the steam table and the facility needed a different broom, because the broom is soiled looking. During an interview on 6/13/25 at 6:57 A.M. the Assistant Dietary Manager (ADM). DM said he/she expected facility staff to sweep and mop the floor of the walk-in daily.	A6012		
A6032	19 CSR 30-87.020(32) Outside Dumpsters Cleanable/Covered Waste containers stored outside the establishment and dumpsters, compactors and compactor systems shall be easily cleanable, shall be provided with tight-fitting lids, doors or covers and shall be kept covered when not in actual use. In containers designed with drains, drain plugs shall be in place at all times, except during cleaning. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to keep the lid of the outdoor dumpster closed and failed to remove scattered debris from the ground around the outdoor dumpster. The	A6032		

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A6032	Continued From page 20 facility census was 41 residents. 1. Observations on 6/13/25 at 6:57 A.M. and 9:34 A.M., showed the outdoor dumpster with an open lid and various debris, including discarded gloves, paper, and food on the ground around the outdoor dumpster. During an interview on 6/13/25 at 9:33 A.M. the Assistant Dietary Manager (ADM) said he/she expected all departments whether dietary or some other department to close the dumpster lid and it is between housekeeping and the Maintenance department to clean the ground around the dumpster.	A6032		
A7066	19 CSR 30-87.030(64) Grills/Griddles/Microwaves/Other-Clean Daily The food-contact surfaces of grills, griddles and similar cooking devices and the cavities and door seals of microwave ovens shall be cleaned at least once a day, except that this shall not apply to hot oil-cooking equipment and hot oil-filtering systems. The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. III This regulation is not met as evidenced by: Based on observation and interview, the facility failed to clean the bread toaster on a regular basis as evidenced by a heavy buildup of breadcrumbs at the bottom of the toaster. The facility census was 41 residents. 1. Observation on 6/13/25 at 8:27 A.M. and 9:29 A.M., showed a heavy buildup of breadcrumbs at the bottom of the toaster.	A7066		

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A7066	Continued From page 21 During an interview on 6/13/25 at 9:34 A.M., the Assistant Dietary Manager said the toaster should be cleaned daily after breakfast.	A7066		

PLAN OF CORRECTION

Provider Name:	Jackson Creek Post Acute
Street Address, City, Zip:	3980 S Jackson Dr. Independence MO 64057
Date of Survey:	6/12/2025
Provider number:	25709N

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A2204	**Exterior Premises Fire Safety** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Sandbags were observed outside of the exit door from the basement and in front of the stairwell from the basement. • The maintenance director immediately removed the sandbags. 11 ft 8 in from stairwell to public way were observed to be Wet & Slippery • Addressed this issue by the contractor Two curbs measured at 6 in • The maintenance director formed a concrete ramp to ensure resident safety when evacuating Standing Water caused by Drainage issue in the public way • The Maintenance Director has sought and received multiple bids to fix the drainage issue. **How you will identify other residents having the potential to be affected by the same deficient practice;** • All Assisted Living residents have the potential to be affected by the alleged deficient practice.	7/01/25

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Sandbags located outside of the exit door from the basement and in front of the stairwell • In the event where sandbags are needed to reroute drainage from heavy rain the maintenance director, designee or team will immediately return sandbags to their designated location once inclement weather concludes. 11 ft 8 in from stairwell to public way were observed to be Wet & Slippery • The maintenance director or designee will use Adhesive Non-Slip Treads or Strips for the stairwells. Two curbs measured at 6 in • The maintenance director or designee will ensure each curb has a ramp and is maintained as needed. Water in the public way caused by lack of Drainage • The facility approved and has moved forward with a project to address the deficiencies noted. The project details are as follows with an estimated compliance date of 08/01/25 or earlier. • Project Details: Four downspouts will be buried and tied into the new drainage system. Two previously buried downspouts will also be tied into the new drainage system. All downspouts will outlet directly into the parking lot. A 3' wide rock bed will be installed along the designated sidewalk. A french drain will be installed in the middle of the new rock bed to help capture pooling surface water. Sod will be used to repair damaged turf areas. See design for details. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Sandbags located outside of the exit door from the basement and in front of the stairwell • In the event where sandbags are needed to reroute drainage the maintenance director, designee or team will immediately return sandbags to their designated location once inclement weather concludes. 11 ft 8 in from stairwell to public way were observed to be Wet & Slippery • The maintenance director or designee will conduct and log an evaluation on the Adhesive Non-Slip Treads/strips located on the stairwell annually then replace it as needed. Two curbs measured at 6 in • The maintenance director or designee will conduct and log an evaluation focused on ensuring that the area is properly maintained and in working condition.	08/01/25

	Standing Water in the public way caused by Drainage issue • The Maintenance Director or designee will conduct an annual evaluation of the location to ensure proper draining in that area.	
A3235	**<u>Hot water 105-120 Degrees F</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • The Maintenance director corrected the deficiency by adjusting the water mixing valves that control hot water temperature to ensure they were within the proper range. And the vendors conducting a replacement for high and low mixing valve to make sure the components are working properly. **How you will identify other residents having the potential to be affected by the same deficient practice;** • The Maintenance director or designee will conduct & log a weekly temperature check for AL rooms to ensure the temperature is within the proper range. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur.** • The Maintenance director or designee will conduct & log a weekly temperature check for all AL rooms to ensure the temperature is within the proper range. **How the facility plans to monitor its performance to make sure that solutions are sustained.** • The Maintenance director will Record water temperatures while his assistant or designee (CNA) monitors.	07/01/2025
A4704	**<u>Operator/Administrator responsibilities Elevator Permit Expired</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • The Administrator has made contact with the facilities account manager/rep who will help address the deficiency. We are waiting on the third party. **How you will identify other residents having the potential to be affected by the same deficient practice.** • Not Applicable	7/07/2025

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. • The Administrator will keep an Annual Log which will act as a reminder for administrator to contact OTIS for Elevator Permit Renewal. The log will be kept with the maintenance director. **How the facility plans to monitor its performance to make sure that solutions are sustained.** • The Administrator will keep an Annual Log which will act as a reminder for the administrator to contact OTIS for Elevator Permit Renewal. The log will be kept with the maintenance director.	
A6012	**<u>Failure to maintain Floor Surface of walk in refrigerator and the floors under the food preparation table in Kitchen</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • The Dietary director and assistant will ensure all floors are consistently maintained. **How you will identify other residents having the potential to be affected by the same deficient practice.** • Not Applicable **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The Dietary director and assistant will ensure all floors are consistently maintained and logged daily. **How the facility plans to monitor its performance to make sure that solutions are sustained.** • The Dietary director and assistant will ensure all floors are consistently maintained and logged daily.	7/01/2025

A6032	**<u>Outside Dumpsters Cleanable Covered</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • The maintenance, housekeeping & dietary departments will keep the lid of the outdoor dumpster closed. They will also remove scattered debris from the ground around the dumpster. Rotation… **How you will identify other residents having the potential to be affected by the same deficient practice.** • Not Applicable **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The maintenance and housekeeping director or designees will round at the end of their shift to ensure there are no pieces of debris around the dumpster. **How the facility plans to monitor its performance to make sure that solutions are sustained.** • The maintenance and housekeeping director or designees will log the completion of this task at the end of their shift.	7/01/2025
A7066	**<u>Heavy Buildup of Breadcrumbs at the bottom of the Toaster</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** • The Dietary Director, Supervisor and Designee will maintain cleanliness of toasters and continuously prevent buildup. **How you will identify other residents having the potential to be affected by the same deficient practice.** • Not Applicable **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The Dietary director will ensure the team consistently maintains cleanliness of toasters by using a daily cleaning log to track the completion of this task.	7/01/25

	How the facility plans to monitor its performance to make sure that solutions are sustained. • The Dietary director, supervisor and designee will ensure the cleanliness of the toaster by tracking the kitchen's cleaning log.	
A4754	**Individual Service Plans** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • On 6/13/25, the Director of Nursing (DON) or designee updated Resident #1's Individualized Service Plan (ISP) to include hospice services and care needs. **How you will identify other residents having the potential to be affected by the same deficient practice.** • The DON or designee conducted a review of resident records on 6/13/25 to identify residents receiving hospice services and verify their ISPs accurately reflect current services. Residents identified with discrepancies in their ISPs had their care plans updated accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The DON or designee will in-service Licensed nurses on the requirement to update ISPs upon admission to hospice services and other significant changes in condition or services. The in-service will be completed by 07/04/2025. The facility's ISP policy has been revised to include specific triggers for ISP updates, including initiation of hospice services. The Social Services Director or designee will review new physician orders daily to identify changes requiring ISP updates. **How the facility plans to monitor its performance to make sure that solutions are sustained** • The DON or designee will audit 10% of resident ISPs weekly for 4 weeks, and monthly for 2 months to ensure ISPs are updated appropriately with changes in condition or services. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review audit findings	07/04/2025

	and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained.	
A4785	**Medication Storage-Separate, Not In Use** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • On 6/13/25, the Director of Nursing (DON) or designee removed all expired medications, medications with discard dates that had passed, medications without proper labeling, and medications not in their original containers from the 100-hall medication cart and pharmacy room. These medications were placed in a designated secure area for proper disposal according to facility policy and state regulations. **How you will identify other residents having the potential to be affected by the same deficient practice.** • On 6/13/25, the DON or designee conducted a facility-wide audit of medication storage areas, including medication carts and the pharmacy room, to identify and remove expired medications, medications with passed discard dates, improperly labeled medications, and medications not in their original containers. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The DON or designee established a designated secure storage area for expired medications and medications pending destruction, separate from current medications. On 07/4/2025, the DON or designee will in-service Licensed nurses and Level One Medication Aides on: 1. Proper medication storage requirements 2. Checking medication expiration dates during medication administration 3. Procedures for handling expired medications 4. Requirements for medication labeling 5. Protocol for accepting medications from residents/families upon admission 6. Weekly medication storage area audits • The facility's "Medication Labeling and Storage" policy was updated on 06/13/2025 to include specific procedures for: 1. Designated storage area for expired medications 2. Weekly medication storage audits 3. Documentation requirements for medication destruction 4. Procedure for accepting medications upon admission	7/01/25

	How the facility plans to monitor its performance to make sure that solutions are sustained. • The Unit Manager or designee will conduct weekly medication storage audits of medication carts and pharmacy room for three months, then monthly for three months. Audits will include: 1. Proper storage of current medications 2. Separation of expired medications 3. Proper labeling 4. Original packaging maintenance 5. Documentation of findings • The DON or designee will review audit results weekly. • Results showing less than 100% compliance will require immediate correction and additional staff education. The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months.	
A4797	**<u>Safe & Effective Medication System</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; How you will identify other residents having the potential to be affected by the same deficient practice.** • On 6/12/25, Resident #1's insulin administration technique was immediately reviewed and corrected. The Licensed nurse assessed Resident #1 for any adverse effects related to the improper insulin administration technique, with none noted. The Director of Nursing (DON) or designee reviewed Resident #1's blood glucose readings for the previous 24 hours to ensure readings were within acceptable parameters. **How you will identify other residents having the potential to be affected by the same deficient practice.** • The DON or designee conducted a review of residents receiving insulin via insulin pens to identify residents with the potential to be affected. The DON or designee audited insulin administration techniques for Licensed nurses and Level I Medication Aides (L1MA) who administer insulin to ensure proper technique, including appropriate priming of insulin pens.	07/01/25

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.
	
	• The DON or designee developed and implemented a facility policy specific to insulin pen administration, including manufacturer guidelines for proper priming technique. On 06/12/2025, the DON or designee will in-service Licensed nurses and L1MAs on proper insulin pen administration, including:
	  • Review of manufacturer guidelines for insulin pen use
	  • Proper priming technique and amount
	  • Documentation requirements
	  • Safety measures during administration
	  • Licensed nurses and L1MAs must demonstrate competency in insulin pen administration before being permitted to administer insulin. The DON or designee will maintain documentation of completed competencies.
	
	How the facility plans to monitor its performance to make sure that solutions are sustained.
	
	• The DON or designee will conduct random audits of insulin pen administration techniques three times weekly for four weeks, then weekly for eight weeks. The audits will focus on proper priming technique and compliance with facility policy. The Assistant Director of Nursing or designee will review audit results weekly.
	• The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

A4837	**<u>Resident Condition/Medication Review</u>** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** • On 6/13/25, the Director of Nursing (DON) or designee completed monthly summaries for Resident #1, Resident #2, Resident #3, and Resident #4. The monthly summaries included a review of each resident's general condition, needs, medication consumption, daily medication administration records, medication regimen review, monthly weights, outside service referrals, and incident records.	07/01/25

	How you will identify other residents having the potential to be affected by the same deficient practice • On 6/13/25, the Director of Nursing (DON) or designee completed monthly summaries for Resident #1, Resident #2, Resident #3, and Resident #4. The monthly summaries included a review of each resident's general condition, needs, medication consumption, daily medication administration records, medication regimen review, monthly weights, outside service referrals, and incident records. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** • The DON or designee developed and implemented a new policy and procedure for completing monthly resident summaries on 6/13/25. The Licensed nurses, L1MA were in-serviced by the DON or designee on 6/13/2025 regarding: • Requirements for monthly summary completion • Documentation of resident general condition and needs • Review of medication consumption • Recording of monthly weights • Documentation of outside service referrals • Recording of resident incidents and accidents • The DON or designee created a monthly summary form to consolidate required information in one location. Licensed nurses will complete monthly summaries by the last day of each month for their assigned residents. **How the facility plans to monitor its performance to make sure that solutions are sustained.** • The DON or designee will audit 10% of resident charts weekly for three months, then monthly for three months to ensure monthly summaries are completed according to requirements. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the results and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained.	

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.