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F 550 SS=C	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela R Moore	Administrator	4-21-25

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

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exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to promote resident independence and dignity while dining when staff served the noon meal on disposable dishware. The facility census was 86.

Review of the facility policy titled, "Resident Rights, Dignity and Visitation Rights," dated 04/01/22, showed:
- It will be the policy of this facility that employees shall treat residents with kindness, respect, and dignity. The facility promotes the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. The facility will ensure that the resident can exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability;
- The facility will make effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity; providing care that is comfortable and consistent with his/her normal life habits, observing resident's choices whenever able;
- The facility will promote care for residents in a manner and in an environment that maintains or enhances dignity and respect in recognition of his/her individuality, preferences, activities, pursuits, goals, and desires.

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Review of the facility policy titled, "Dishes and Infection Control Practices," dated 10/01/23, showed:
- Routine use of disposables for residents in isolation/infection precautions is not recommended unless directed by the Infection Preventionist (IP). Residents requiring isolation precautions may utilize disposable products at the discretion of the facility IP and administration;
- If adequate resources for cleaning utensils and dishes are not available, then disposable products may be used.

Observation on 03/30/25 at 11:45 A.M., showed:
- All residents served lunch from the kitchen on disposable plates, cups, and bowls.

During an interview on 03/30/25 at 11:33 A.M., Day Cook I said the kitchen was shorter staffed on the weekends and served food on paper plates. There was not enough time to cook, clean, and serve with just two staff.

During an interview on 03/30/25 at 11:42 A.M., Resident #24 said meals were often served on paper plates.

During an interview on 03/30/25 at 3:03 P.M., Resident # 71 said staff served food on styrofoam plates and cups a lot instead of using real dinnerware.

During an interview on 03/30/25 at 3:07 P.M., Resident #21 said they always used disposable utensils and plates instead of real dinnerware.

During an interview on 03/31/25 at 10:15 P.M., Day Cook G said he/she thought the paper products were used more for convenience than

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F 550	Continued From page 3 not being able to do dishes. Multiple residents had complained about the food being served on paper plates. During an interview on 04/02/25 at 11:35 A.M., the Dietary Manager (DM) said he/she did not like when staff served food on paper plates. Staff were not supposed to serve food on paper plates but sometimes did one meal a day on the weekends. There were enough dishes where staff did not have to use paper products. During an interview on 04/02/25 at 3:05 P.M., the Administrator said she would expect meals to be served in a way that promotes and maintains dignity and respect for the residents.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		

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with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to create an environment that was respectful of the rights of each resident to make choices about aspects of their lives that were significant by providing a bathing schedule based on staff preference and not resident preference for one resident (Resident #1) and by failing to honor one resident's (Resident #24) preference to be shaved daily out of 18 sampled residents . The facility's census was 86.

Review of the facility's policy titled, "Resident Rights, Dignity and Visitation Rights," dated 04/01/22, showed:
- It will be the policy of this facility that employees shall treat residents with kindness, respect, and dignity. The facility promotes the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems, and cognition limits) in the exercise of these rights. The facility will ensure the resident can exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability;
- Residents are entitled to exercise their rights

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and privileges to the fullest extent possible;
- The facility will make the effort to assist each resident in exercising his/her rights to assure the resident is always treated with respect, kindness, and dignity; providing care that is comfortable and consistent with his/her normal life habits; observing resident's choices whenever able;
- The facility will promote care for residents in a manner and in an environment that maintains or enhances dignity and respect in recognition of his/her individuality, preferences, activities, pursuits, goals, and desires;
- The facility will provide for residents and reception of services with reasonable accommodation of resident needs and preferences except when to do so would endanger the health of safety of the resident or other residents;
- The right to participate in the development and implementation of his/her person-centered plan of care, including but not limited to: the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process; the right to request meetings and the right to request revisions to the person-centered plan of care; the right to participate in establishing the expected goals and outcomes of care; the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care; the right to be informed, in advance, of changes to the plan of care; the right to receive the services and/or items included in the plan of care; the right to see the care plan, including the right to sign after significant changes to the plan of care;
- The facility will encourage and assist residents to dress in their own clothes appropriate to the individual choices of the resident;

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1. Review of Resident #1's medical record showed:
- Admission date of 09/16/16;
- Diagnoses of major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in actives), pain in the left lower leg, non-pressure chronic ulcer of the left lower leg with the fat layer exposed (a sore that takes more than two weeks to heal), hypothyroidism (underactive thyroid disease), generalized anxiety disorder (mental health condition characterized by persistent and excessive worry and anxiety about a wide range of everyday events), and cellulitis (a common bacterial infection of the skin and underlying tissues).

Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated , 02/12/25, showed:
- Cognitively intact;
- Activities and preferences not completed;
- Dependent on staff for assistance with personal hygiene and required substantial/maximal assistance with bathing and showering.

Review of the resident's Skin Monitoring: Comprehensive Certified Nurse Assistant (CNA) Shower Review Sheets, dated February and March 2025, showed:
- Resident refused shower/bath on 02/07/25, 02/11/25, 02/18/25, 03/04/25, 03/07/25, 03/11/25, 03/14/25, 03/19/25, 03/25/25, and 03/28/25;
- Resident received a shower/bath on 02/25/25 and 03/21/25;
- No documentation staff offered a shower/bath after the resident refused at a specific time/date.

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During an interview on 04/02/25 at 12:55 P.M., Resident #1 said staff asked him/her to shower at times when he/she was in pain or during activities. Activities were one of the few times he/she had to socialize with other residents. The staff would only ask the resident one time to shower/bathe and would document refused if the resident didn't want to right then. The staff didn't come back later at a more convenient time for the resident.

2. Review of Resident #24's medical record showed:
- Admission date of 07/13/18;
- Diagnoses of unspecified injury at unspecified level of cervical spinal cord (injury to the neck); quadriplegia (paralysis); spinal muscular atrophy unspecified (deteriorating muscles); and contracture of the right shoulder, the right elbow and the right wrist (shortening and hardening of the muscles, tendons or other tissue).

Review of the resident's quarterly MDS, dated 02/17/25, showed:
- Cognitively intact;
- Activities and preferences not completed;
- Dependent on staff for assistance with personal hygiene, bathing, and showering.

Observation on 03/30/25 at 11:32 A.M., 03/31/25 at 1:16 P.M., and 04/02/25 at 12:55 P.M., of the resident showed:
- Whiskers/stubble on resident's chin.

During an interview on 03/31/25 at 1:30 P.M. Resident #24's two roommates said they had to shave the resident because the staff won't shave him/her.

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F 561	Continued From page 8 During an interview on 04/02/25 at 1:21 P.M., Resident #24 said the staff would not shave him/her. Only times he/she was shaved was when his/her roommates did it. He/She preferred to keep a clean shaven chin daily and did not like it when he/she was not able to do so. During an interview on 04/02/25 at 1:30 P.M., the Administrator said she would expect residents to be able to have the right to make their own decisions regarding if they want to be shaved and when they were showered.	F 561		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.	F 569		

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F 569	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a final accounting of a resident's fund balance within 30 days to the individual or probate jurisdiction administering the resident's estate for one expired resident (Resident #87) out of one expired resident. The facility census was 86. The facility did not provide a policy regarding resident funds balance. Review of Resident #87's medical record showed: - The resident expired on 03/02/25. Record of the facility maintained Trust Trial Balance, dated 04/02/25, showed: - Resident #87 with an account balance of $2,694. During an interview on 04/02/25 at 9:03 A.M., the Social Services Designee (SSD) said normally if someone passed away, their money would go towards any funeral home bills. If the resident had a financial power of attorney (POA), then they would get them a check for the balance and if not, they would send the money to the state. The facility tried to do this process within a week of a death. During an interview on 04/02/25 at 9:24 A.M., the Administrator said she would expect remaining resident funds to be sent to the appropriate party within 30 days.	F 569		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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F 584	Continued From page 10 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to monitor and keep one resident's (Resident #54) equipment in good, working order. The facility also failed to provide a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 86.

The facility did not provide a policy regarding a safe, clean, comfortable, and homelike environment.

The facility did not provide a policy regarding maintenance of residents' equipment.

1. Observation on 03/30/25 at 10:56 A.M., of Room C9 showed:
- A window unit below the window with drywall placed around the top and both sides that did not completely in case the window unit. There were open areas to the top and right side of the unit with light from the outside that showed around the top of the unit. There was insulation pushed in an open area directly above the window unit to cover a gap from the window unit to the drywall nailed in place around the window unit. The top opening was approximately 32 inches (in) by 1 in and the right-side opening was approximately 20 in by 0.5 in.

2. Observation of the dining room on 03/30/25 at 11:30 A.M., showed:
- The wall beneath the kitchen windows with red, green, and brown splatters on it;

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- Approximately two feet of baseboard trim missing underneath the dining room kitchen window;
- Approximately 6 inches of baseboard trip missing next to the left exit door;
- Three ceiling tiles with dark brown/black substance close to the left exit door.

3. Observation on 03/30/25 at 12:30 P.M., of Room B10 showed:
- Four holes in the wall above the bed next to the door;
- Paint chipping off the wall over the bed next to the window;
- Black scuff marks along the wall and bathroom door;
- The window unit missing vents inhibiting the resident's ability to control the direction of the air flow;
- The closet door broken and unable to stay closed;
- The bathroom door latch/handle broken and unable to stay closed.

During an interview on 03/30/25 at 12:30 P.M. the resident in Room B10 said he/she was unhappy with his/her room. The bathroom door handle had been broken for a long time and would not close or latch. He/She purchased some velcro tape to put on the door, so it would stay closed. However, since the door did not latch, there was no way to ensure his/her privacy. He/She had to do the same thing to the closet door because it was broken and would not stay closed. The room needed to be repainted due to all the black scuff marks and the paint chipped off the walls. The air conditioner also needed to be fixed or replaced. It bothered him/her that the vents were missing, because without the vents, the direction of the air

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flow couldn't be controlled.

4. Observation on 03/30/25 at 2:07 P.M., of Resident # 54's wheelchair showed:
- Both arms of the wheelchair with cracked and ripped vinyl;
- The right wheelchair arm with pieces of peeling duct tape around the end of the ripped area.

During an interview on 03/30/25 at 2:07 P.M., Resident # 54 pointed to the arms of his/her wheelchair and said the cracked and ripped vinyl bothered him/her and wanted it replaced or fixed.

5. Observation on 03/30/25 at 2:31 P.M., of Room B8 showed:
- A brown area on the ceiling in front of the window next to the privacy current railing approximately 12 inches wide;
- The window unit with missing vents;
- The drywall of the window ledge chipped and crumbling into pieces;
- The bathroom door handle/latch broken.

During an interview on 03/30/25 at 2:31 P.M., the resident in Room B8 said he/she was upset the bathroom door handle was broken and he/she had no way to ensure privacy when using the bathroom. It was embarrassing when someone would accidentally open the door. He/She was not happy with the way the area around the window unit was. The window seal had been messed up for a long time and the air unit had been missing the vents for a long time.

6. Observation on 03/30/25 at 2:36 P.M., of Room B6 showed:
- The right edge of the curtain hung loose from the window;

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F 584	Continued From page 14 - The closet door was missing; - The air unit was missing vents. 7. Observation on 03/30/25 at 3:24 P.M. of Room D8 showed: - Paint peeled off the wall around the air conditioning unit; - The ceiling vent in the bathroom covered in dust. 8. Observation on 03/31/25 at 8:14 A.M., of Room B3 showed: - The closet door was missing; - The window seal and area around the air unit with chipped drywall, marks, and exposed unpainted areas with gray caulking. During an interview on 04/02/25 at 10:30 A.M., the Maintenance Director said that he/she was unaware of the window unit in Room C9 had any openings to the drywall around the window unit. During an interview on 04/02/25 at 10:40 A.M., the Administrator said that she would expect window units to be properly placed and not be able to see daylight from inside a resident's room with gaps around the unit in the drywall. During an interview on 04/02/25 at 1:45 P.M., the Administrator said she would expect the facility to have a homelike environment and things to be repaired as needed. There was a maintenance log book that anyone could write things that need to be repaired. Normally the repair time should be within a few days even if it's something that had parts that need to be ordered for the repairs.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

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F 623	Continued From page 16 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for transfer, for five residents (Residents #11, #12, #38, #46, and #59) out of 18 sampled residents and one resident (Resident #44) outside the sample. The facility's census was 86.

Review of the facility policy titled, "Transfer and Discharge," dated 04/01/22, showed:
- It is the policy of this facility to provide appropriate transfer and discharge services, documentation that will be included in the medical record, and who is responsible for making the documentation. The facility will allow for sufficient preparation and orientation by informing the resident where he/she is going to take steps to minimize anxiety;
- The Notice of Transfer or Discharge should be made by the facility at least 30 days before the

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resident is transferred or discharged except under the following circumstances and the Notice must be made as soon as practicable before transfer or discharge when: the safety of individuals in the facility would be endangered; the health of individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days;
- When a change in condition or required transfer to the hospital or other higher level of care is determined, the facility should obtain appropriate transfer orders from the physician;
- Documentation of the change of condition or required transfer should be reflected in the medical record;
- Appropriate documentation and forms will be sent to the receiving facility/accompany the resident during transport and attempt to have them signed by the resident/resident representative should be made. The forms can include such items as the Bed Hold policy, Transfer Discharge Notification, listing of current medications/treatments, face sheet, and other forms that may be appropriate if activated;
- Notification of the resident's representative should be denoted in the medical record as is appropriate per the resident's capacity and choice, if applicable;
- In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility will send a notice of discharge to the resident and resident representative, and will also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman;

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- If the resident transfers to another facility or the community from the hospital, the facility may assist, with the request of the resident's representative, with provision of care assistance set up;
- Details regarding the transfer from the facility should be documented in the clinical record.

1. Review of Resident #11's medical record showed:
- Admitted on 07/06/20 ;
- The resident transferred to the hospital on 03/01/25, and returned to the facility on 03/02/25;
- The resident transferred to the hospital on 03/02/25, and returned to the facility on 03/07/25;
- No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfers.

2. Review of Resident #12's medical record showed:
- Admitted on 11/21/23;
- The resident transferred to the hospital on 08/31/24, and returned to the facility on 09/23/24;
- The resident transferred to the hospital on 09/26/24, and returned to the facility on 10/05/24;
- The resident transferred to the hospital on 10/10/24, and returned to the facility on 11/07/24;
- The resident transferred to the hospital on 01/07/25, and returned to the facility on 01/09/25;
- No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfers.

3. Review of Resident #38's medical record showed:
- Admitted on 12/23/24;

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- The resident transferred to the hospital on 12/20/24, and returned to the facility on 12/23/24;
- No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfer.

4. Review of Resident #44's medical record showed:
- Admitted on 06/20/24;
- The resident transferred to the hospital on 01/08/25, and returned to the facility on 01/11/25;
- The resident transferred to the hospital on 02/15/25, and returned to the facility on 02/17/25;
- The resident transferred to the hospital on 03/10/25, and returned to the facility on 03/14/25;
- The resident transferred to the hospital on 03/27/25, and returned to the facility on 03/31/25;
- No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfers.

5. Review of Resident #46's medical record showed:
- Admitted on 09/26/24;
- The resident transferred to the hospital on 11/14/24, and returned to the facility on 11/17/24;
- No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfer.

6. Review of Resident #59's medical record showed:
- Admitted on 10/08/24;
- The resident transferred to the hospital on 10/11/24, and returned to the facility on 10/15/24;
- The resident transferred to the hospital on

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F 623	Continued From page 21 10/19/24, and returned to the facility on 10/22/24; - The resident transferred to the hospital on 11/11/24, and returned to the facility on 11/30/24; - The resident transferred to the hospital on 12/23/24, and returned to the facility on 12/26/24; - No documentation the resident and/or the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfers. During an interview on 04/02/25 at 8:30 A.M., the Administrator said the facility had not been notifying the resident's representatives in writing of the resident's transfers to the hospital. During an interview on 04/02/25 at 1:45 P.M., the Administrator said she would expect the transfer forms to be completed per the regulation.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		

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resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide written notification of their bed hold policy to the residents and/or their resident representatives at the time of transfer for four residents (Residents #11, #12, #38, and #46) out of 18 sampled residents and one resident (Resident #44) outside the sample. The facility census was 86.

Review of the facility policy titled, "Bed Hold," dated 04/01/22, showed:
- It will be the policy of this facility to provide residents with bed hold policies upon admission to the facility and at the time of transfer (i.e. when transferring to hospital or going on therapeutic leave) in accordance with federal and state regulations;
- The initial bed hold policy should be provided to the resident/responsible party as soon after admission as possible when completing the admission packet to the facility. Should specify duration of the bed hold policy under the State Plan, if any, during which the resident is permitted to return and resume residence in the nursing facility. Non-Medicaid residents may be requested to pay for all bed hold days;

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- The initial bed hold policy in the admission packet should be considered an example of how the bed hold policy works in the event it is required by the resident's conditions;
- The bed hold policy applies to all residents residing in the facility;
- The second bed hold policy should be provided at the time of the transfer and if applicable, given with in advance to the transfer;
- In emergency transfer situations, notice at the time of transfer refers to the provision of the resident's copy of the bed hold policy will be provided along with the other transfer paperwork to the hospital;
- Bed hold for days of absence in excess of the state's bed hold limit are considered non--covered services and the resident could use his/her own funds to pay for the bed hold if they desire;
- Residents that are non-Medicaid in payer source may be requested to pay for all days of bed hold;
- Residents are eligible for re-admission following hospitalization or therapeutic leave. per the facility's admission agreement. Private pay, Medicare or other residents not meeting the requirement of Medicaid bed hold: the facility will only reserve a bed for an absent resident if requested in writing by the resident or responsible party and applicable charges paid. In the event that a bed is not reserved, and the resident desires to re-occupy a room in the facility, the resident may be admitted to the next available bed.

1. Review of Resident #11's medical record showed:
- Admitted on 07/06/20;
- The resident transferred to the hospital on

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03/01/25, and returned to the facility on 03/02/25;
- The resident transferred to the hospital on 03/02/25, and returned to the facility on 03/07/25;
- No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers.

2. Review of Resident #12's medical record showed:
- Admitted on 11/21/23;
- The resident transferred to the hospital on 08/31/24, and returned to the facility on 09/23/24;
- The resident transferred to the hospital on 09/26/24, and returned to the facility on 10/05/24;
- The resident transferred to the hospital on 10/10/24, and returned to the facility on 11/07/24;
- The resident transferred to the hospital on 01/07/25, and returned to the facility on 01/09/25;
- No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers.

3. Review of Resident #38's medical record showed:
- Admitted on 12/23/24;
- The resident transferred to the hospital on 12/20/24, and returned to the facility on 12/23/24;
- No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer.

4. Review of Resident #44's medical record showed:
- Admitted on 06/20/24;
- The resident transferred to the hospital on 01/08/25, and returned to the facility on 01/11/25;

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F 625	Continued From page 25 - The resident transferred to the hospital on 02/15/25, and returned to the facility on 02/17/25; - The resident transferred to the hospital on 03/10/25, and returned to the facility on 03/14/25; - The resident transferred to the hospital on 03/27/25, and returned to the facility on 03/31/25; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers. 5. Review of Resident #46's medical record showed: - Admitted on 09/26/24; - The resident transferred to the hospital on 11/14/24, and returned to the facility on 11/17/24; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. During an interview on 04/02/25 at 1:45 P.M., the Administrator said she would expect bed hold forms to be completed per the regulation.	F 625		
F 679 SS=C	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	F 679		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide an on-going program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This practice affected five residents (Residents #13, #21, #22, #24, and #31) out of 18 sampled residents and could potentially affect all residents. The facility census was 86.

Review of the facility policy titled, "Activities," dated 04/01/22, showed:
- It will be the policy of this facility to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an on-going program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community;
- The facility shall provide an on-going person-centered activities program that incorporates the resident's interests, hobbies, and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence;
- The facility shall create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning);
- The facility shall provide meaningful activities that reflect a person's interests and lifestyle, are enjoyable to the person, help the person to feel

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useful, and provide a sense of belonging;
- The program will be based on the resident's comprehensive assessment and person--centered care plan, and meet the resident's interests and preferences, and support his/her physical, mental, and psychosocial well-being;
- Activities can occur at any time, are not limited to formal activities being provided by recreation staff, and can include activities provided by other facility staff, volunteers, visitors, residents, and family members;
- Programs should reflect a resident-centered perspective including programming that takes into consideration physical function, behavioral changes, cognitive function and historical recreation preferences: activity preferences; one-to-one programs, independent activities/in-room activities, etc., group programming, community based, person-centered, gender, cultural, religious/spiritual, individual preferences, and continuation of life roles (former occupation, personal preferences, hobbies, etc.);
- The facility will develop a monthly schedule of activities which will be accessible to residents or the facility will provide for in room/self-directed activities as determined by the activity assessment;
- The facility will honor the resident preference to be independently capable of pursuing their own activities without intervention from the facility. This information will be noted in the assessment and identified in the person-centered care plan;
-The facility will support the resident's preferences to remain involved in the community including interactions such as: assisting the resident to maintain his/her ability to independently shop, attend the community theater, local concerts, library. and participate in

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community groups.

Review of the March 2025 Activities Calendar showed:
- Two activities per day;
- The morning showed coffee with either music, communion, coloring, or currents events;
- The afternoon showed games such as bingo, charades, bowling, Deal or No Deal, and Family Feud or an activity of an ice cream social, Rice Krispie treats, and resident council meeting;
- On Mondays and Wednesdays, there was time listed as 1:1.

1. Review of Resident #13's significant change Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 09/14/24, showed:
- Very important to participate in activities he/she likes.

During an interview on 03/30/25 at 2:39 P.M., Resident #13 said the facility removed the Activities Room. The facility used to have an Activities Room, but it was taken away and the staff expect everything to be held in the dining room. They had a coffee hour in the morning, but they were no longer provide the different creamers. He/She had to purchase his/her own creamer and donated it to the other residents who liked to use it. They didn't normally do anything during the coffee hour like the music or current event listed. It was just coffee in the dining area if residents wanted it. He/She said it wasn't an activity. The calendar listed games in the afternoon, but that was it and nothing else was available for them to do and nothing that interestd him/her. The activities person did not do 1:1 activities with him/her and did nothing for the

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residents.

2. Review of Resident #21's annual MDS, dated 07/01/24, showed:
- The preferences for routine and activities section not completed.

During an interview on 03/30/25 at 3:07 P.M., Resident #21 said the facility did not do activities and if they did, he/she did not know what they were. He/She wished they would do activities so it would give him/her something to do, because watching TV got old. He/She did not know who the activities person was and had never had anyone do any 1:1 activities with him/her.

3. Review of Resident #22's annual MDS, dated 09/22/24, showed:
- Very important to participate in activities he/she likes.

During an interview on 03/30/25 at 12:04 P.M., Resident #22 said activities were non-existent. The facility provided a calendar, but half the time, they didn't do anything that was listed on it. The residents used to have an Activities Room but it was taken away. The residents were told any activities would have to be in the dining room and then that was when the staff quit doing them.

4. Review of Resident #24's significant change MDS, dated 06/13/24, showed:
- The preferences for routine and activities section not completed.

During an interview on 03/30/25 at 1:16 P.M., Resident #24 said the facility did not have activities he/she could do. He/She spent most days watching TV in his/her room because there

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F 679	Continued From page 30 was nothing else to do. During an interview on 03/31/25 at 1:16 P.M., Resident #24 said the Activity Director had never done any sort of 1:1 time that he/she could recall. 5. Review of Resident #31's admission MDS, dated 07/15/24, showed: - Very important to participate in activities he/she likes. During an interview on 03/30/25 11:31 A.M., Resident # 31 said they provided no activities that interested him/her. Half the time what they had listed on the calendar, they didn't even do. The closest thing to an activity he/she had to do was taking a smoke break. During an interview on 03/30/25 at 1:28 P.M. the Activities Director said for residents that needed accommodations, he/she used things like music, movies, or audio books, and tried to do 1:1 time with them to hang out and talk with them for their activities. During an interview on 04/02/25 at 1:54 P.M., the Administrator said she would expect activities to be provided that met the physical, mental, and psychosocial well-being of the residents.	F 679		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in	F 699		

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order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to identify, assess, and provide supportive interventions for one resident (Resident #78) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of three sampled residents. The facility's census was 86.

Review of the facility's policy titled, "Mental and Psychosocial Adjustment Services," dated 04/01/22, showed:
- It is the policy of the facility to ensure (based on the comprehensive assessment of a resident) that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or PTSD, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;
- Residents who experience mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD require specialized care and services to meet their individual needs. The facility will ensure that an interdisciplinary team, which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of

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improvement, or decline in resident's functioning should be documented in the resident's record and steps taken to determine the underlying cause of the negative outcome.

1. Review of Resident #78's medical record showed:
- Admitted on 08/04/24;
- Diagnoses of PTSD, hemiplegia (paralysis of one side of the body) and hemiparesis following a cerebral infarction (stroke), bipolar disorder (a mental disorder that causes unusual shifts in mood), and mood disorder (any mental disorder with a disturbance of mood);
- Trauma Informed Care Assessment, dated 02/18/25, did not address the resident's PTSD triggers.

Review of the resident's Physician Order Sheet (POS), dated April 2025, showed:
- An order for mirtazapine (an antidepressant medication) 7.5 milligrams (mg) daily for mood disorder, dated 08/04/24;
- An order for sertraline (an antidepressant medication) 50 mg daily for mood disorder, dated 08/04/24.

Review of the resident's Preadmission Screening and Resident Review (PASRR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 08/23/24, showed:
- Resident with major depressive disorder (long-term loss of pleasure or interest in life), bipolar disorder, panic disorder, PTSD, and mood disorder;
- No behaviors documented.

Review of the resident's Care Plan, dated

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F 699	Continued From page 33 08/14/24, showed: - Did not identify PTSD as a problem; - Did not address personalized triggers or interventions associated to the resident or triggers. During an interview on 04/02/25 at 2:15 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) Coordinator said a diagnosis of PTSD should be addressed on the care plan with triggers listed. During an interview on 04/02/25 at 3:15 P.M., the Administrator and DON said that they would expect PTSD and triggers to be addressed on the care plan.	F 699		
F 727 SS=E	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 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 use the services of a Registered Nurse	F 727		

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F 727	Continued From page 34 (RN) for at least eight consecutive hours a day, seven days a week. This deficiency had the potential to affect all residents. The facility census was 86. The facility did not provide a RN coverage policy. Review of the facility's Facility Assessment Tool, dated 4/10/24, showed: - The facility required five licensed nurses providing direct care for day shift, which included at least one RN for the day shift. Review of the Nursing Schedules and the Daily Nursing Staffing Sheets for 01/01/25 - 03/31/25, showed: - No RN coverage for eight consecutive hours on 01/06/25, 01/23/25, 01/24/25, 01/27/25, 01/30/25, 01/31/25, 02/03/25, 02/06/25, and 02/07/25; - No RN coverage for eight consecutive worked for nine days out of 90 days. During an interview on 04/02/25 at 3:05 P.M., the Administrator said she would expect the facility to have an RN working eight consecutive hours daily seven days a week.	F 727		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730		

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Based on interview and record review, the facility failed to provide the nurse aides (NAs) an annual individual performance review or evaluation and failed to provide regular in-service education based on these reviews for two certified nursing assistants (CNAs) (CNA A and CNA B). The facility census was 86.

Review of the Facility Assessment Tool, dated 04/10/24, showed:
- A facility must develop, implement, and maintain an effective training program for all new and existing staff;
- In-service training must address areas of weakness as determined in NA's performance reviews;
- In-service training may address the special needs of residents as determined by the facility staff.

1. Review of CNA A's employee file showed:
- A hire date of 09/15/08;
- No documentation of an annual performance review or evaluation;
- No documentation of annual in-service training based on the annual performance review or evaluation for the time frame from 09/15/23 through 09/15/24.

2. Review of CNA B's employee file showed:
- A hire date of 06/10/21;
- No documentation of an annual performance review or evaluation;
- No documentation of annual in-service training based on the annual performance review or evaluation for the time frame from 06/10/23 through 06/10/24.

During an interview on 04/02/25 at 3:05 P.M., the

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F 730	Continued From page 36 Administrator and Director of Nursing (DON) said they would expect CNAs receiving in-services to have at least 12 hours of training annually and for annual performance reviews to be done yearly. The DON and Assistant Director of Nursing (ADON) would be responsible for the annual performance reviews. There had been a lot of staff changes recently and the performance reviews were not done.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		

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§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for two residents (Residents #21 and #36) out of five sampled residents. The facility's census was 86.

Review of the facility policy titled, "Pharmacist Recommendations," dated 04/01/22, showed:
- It will be the policy of this facility to provide pharmacist services to meet the needs of the residents through monthly regimen review (MRR) and properly addressing recommendations per federal and state guidelines;
- The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This review must include a review of the resident's medical chart. An electronic

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medication regimen review will be performed within 72 hours of admission for newly admitted residents, or as soon as reasonably possible;
- The pharmacist must report any irregularities to the attending physician or Licensed Independent Practitioner (LIP) and the facility's Medical Director and Director of Nursing (DON), and these reports must be acted upon as soon as reasonably able, but prior to the following month's MRR; Irregularities include, but are not limited to, any drug that meets the criteria set forth for unnecessary drugs. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician/LIP and the facility's Medical Director and DON and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. The attending physician/LIP must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician/LIP should document his/her rationale in the resident's medical record;
- Each resident's drug regimen must be free from unnecessary drugs;
- The facility, physician/LIP and/or pharmacist shall ensure that residents who have not used psychotropic (medications that affect the brain chemistry, mood, perception, and behavior) drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Residents do not receive psychotropic drugs pursuant to an as

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needed (PRN) order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he/she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

1. Review of Resident #21's medical record showed:
- Admission date of 07/06/22;
- Diagnoses of anxiety (intense, excessive, and persistent worry and fear about everyday situations), major depressive disorder (a mental illness that causes a persistent low mood and loss of interest in activities), psychotic disorder with hallucinations due to known physiological condition (condition where a person experiences hallucinations and other psychotic symptoms like delusions or disorganized thinking), and schizophrenia (a disorder that affects a person's ability to think feel and behave clearly);
- An order for Depakote (an anti-seizure medication also used as a mood stabilizer) delayed release 125 milligram (mg) by mouth two times a day related to schizophrenia, dated 02/26/24;
- An order for Depakote delayed release 250 mg by mouth two times a day related to schizophrenia, dated 02/26/24;
- The physician did not attempt GDRs for the Depakote 125 mg and the 250 mg doses;
- The physician did not document any contraindications of medication adjustments for the Depakote 125 mg or 250 mg doses.

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F 758	Continued From page 40 2. Review of Resident #36's medical record showed: - Admission date of 06/29/23; - Diagnoses of Alzheimer's Disease (progressive mental deterioration), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), anxiety disorder, major depressive disorder, auditory hallucinations, and visual hallucinations; - An order for olanzapine (an antipsychotic (medication used to treat psychosis) 2.5 mg twice a day for delusions, dated 01/01/24; - The physician did not attempt GDRs for the olanzapine 2.5 mg dose - The physician did not document any contraindications of medication adjustments for the olanzapine 2.5 mg. During an interview on 04/02/25 at 9:33 A.M., the Assistant Director of Nursing (ADON) said they did not do GDRs. During an interview on 04/02/25 at 1:30 P.M., the Administrator said she would expect GDRs to be completed per the regulation.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment	F 801		

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F 801	Continued From page 41 required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and	F 801		

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nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to have a clinically qualified nutritional professional designated as the Food and Nutritional Service Manager for one of one food service kitchens, which prepared food for all residents. This deficient practice potentially affected all of the residents who were served food

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prepared by the facility. The facility's census was 86.

Review of the facility policy titled, "Qualified Dietary Staff," dated 10/01/23, showed:
-The dietary/ food services department is staffed by dietary/ food and nutrition services personnel to meet the needs of the residents and the skilled Dietitian will help oversee the dietary/ food and nutrition services in the facility;
-The Dietitian or nutrition professional may be full time or part time consultant or an employee, depending on the current requirements of the facility;
-The qualifications of the Dietitian will include a bachelor's degree from a regionally accredited college with successful completion of a nationally accredited program in nutrition or dietetics, completion of at least 900 hours of dietetics practice supervised by a registered dietitian or nutritional professional, or certification as a dietitian or nutritional professional by the state services are being performed;
-If a dietitian is not employed full time, then a director of food service management will be designated and will be a certified dietary manager, certified food service manager, be nationally certified in food service management and safety, or have an associate's degree or higher in food service management and meet any state requirements and receive frequently scheduled consultations from a qualified dietitian or nutritional professional.

Review of the Dietary Manager (DM) showed he/ she received a certificate of training for completing the food handler essentials course, dated 12/13/24, from StateFoodSafety. Review of the facility's current employee list, undated,

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F 801	Continued From page 44 showed a hire date of 09/30/24 for the Dietary Manager (DM). During an interview on 03/30/25 at 11:30 A.M., the DM said he/she started the role of DM in November of 2024. The previous facility company had worked it out that they would pay for him/her to become certified but then have not done anything yet and do not know if they will now that the facility had a new company in charge. If the facility would help him/her get certified, then he/she would have no problem taking the classes as he/she was more than willing and wanting to become certified. During an interview on 03/31/25 at 5:00 P.M., the Registered Dietician (RD) said she signed a contract to start yesterday 03/30/25 as the RD. She had worked here in the past and does not think they have had a RD for months. She talked to the DM and said he/she is not certified yet but hopeful that the facility would be helping that problem soon. During an interview on 04/02/25 at 3:05 P.M., the Administrator would expect the DM to be certified and qualified. The facility had not had an RD since august 2024.	F 801		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		

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§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.
This REQUIREMENT is not met as evidenced by:
Based on interview and observation, the facility failed to ensure bedtime snacks had been offered to all residents at bedtime. This had the potential to affect all residents in the facility. The facility census was 86.

Review of the facility policy titled, "Nutrition and Hydration Assistance," dated 04/01/22, showed:
- Additional sources of nourishment should/may include provision of snacks;
- Staff will make provision for appropriate snacks as requested or ordered by the physician.

Review of the facility policy titled, "Provide Diet to Meets Needs of Each Resident," dated 04/01/22, showed:
- The facility would provide the services of a Registered Dietitian Nutritionalist or designee to participate in the interdisciplinary care planning team and assure that the nutritional needs of individuals living in the facility are met.

Review of the meal times, as provided by the facility, showed breakfast was served at 7:30

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F 809	Continued From page 46 A.M., lunch was served at 11:30 A.M., and dinner was served at 4:30 P.M. with a 16 hour gap between each dinner and breakfast. During group interview on 03/31/25 at 1:20 P.M., Residents #1, #17, #33, and #35 said snacks were kept at the nurse's station at night. If you were not able to physically go up and ask for a snack, then you did not get one. Staff did not round on the residents to see if they wanted a snack. Observation on 03/31/25 from 10:15 P.M. through 11:30 P.M., showed: - A snack cart kept by the nurse's station; - The only residents that received snacks were the residents who physically came to the nurse's station to ask for one; - Staff did not round to pass or offer the residents a snack. During an interview on 04/02/25 at 11:30 A.M., the Dietary Manager said snacks were left each night behind the nurse's station for anyone who wanted them, and did not think each resident was supposed to be offered one. He/She did not think staff rounded on each resident to offer them a snack. During an interview on 04/02/25 at 3:05 P.M., the Administrator said she would expect each resident to be offered a snack at night.	F 809		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 47 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. The facility failed to ensure that foods were kept covered while waiting to be served and had policies and procedures in place for food brought in from outside the facility. These practices had the potential to affect all residents who are served food from the kitchen. The facility census was 86. Review of the facility policy titled,"Food Delivery and Storage," dated 10/01/23, showed: - It will be the policy of this facility that foods shall be received and stored in a manner that complies with safe food handling practices; - Dietary/Food Services, or other designated staff, will maintain clean food storage areas at all times; - Dry foods that are stored in bins will be removed from original packaging, labeled and dated. Such foods will be rotated using a first in - first out	F 812		

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system;
- All foods stored in the refrigerator or freezer will be covered, labeled, and dated.

1. Observation on 03/30/25 at 10:30 A.M., of the kitchen showed:
- Pancakes, hashbrowns, and an open metal container of a brown substance in the freezer with no label or date on the contents;
- Opened wrapped margarine, wrapped cut up onion, four metal pans not dated with two of them open and unlabeled, and two trays of red jello uncovered and not dated in the refrigerator;
- Three unlabeled and undated tubs with cereal sat on cart outside the freezer;
- Inside of the oven with brown/black debris and buildup with pieces of aluminum foil on the floor of the oven;
- Stove top with all six burners with black/ brown debris and buildup;
- One #10 can of beans and two #10 cans of sauerkraut commercial cans unlabeled;
- A bag of sugar in a plastic tub with no date or label.

2. Observation on 03/30/25 from 11:30 A.M. - 12:28 P.M., showed:
- Drink cart containing lunch drinks for the residents uncovered in the dining room;
- Three different unknown residents self-poured coffee from the coffee container in the dining room with one of those residents coughing before pouring his/her drink;
- One unknown resident in a wheelchair pushed him/herself to a cart with an orange drink picture on it in the dining room, poured his/her old drink out through the kitchen window with some of the liquid spilling on the trays, picked up the picture with the right hand, poured orange drink into the

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old container, and put the orange picture back on the cart.

3. Observation on 03/31/25 at 10:45 P.M., showed:
- An ice machine behind the nurse's station in a room;
- The outside of the ice machine was covered with brown and white substance;
- An unknown resident walked into the room, grabbed the ice scoop with his/her bare hand, opened the ice machine door, scooped ice into cup in his/her left hand, and placed the scoop back in the container on the refrigerator located next to the ice machine.

4. Observation on 04/01/25 at 5:02 P.M., showed:
- A kitchen cart in the dining room with four out of four trays of uncovered beverages.

5. Observation on 04/02/25 at 10:36 A.M., of the kitchen showed:
- Pancakes, hashbrowns, and an open metal container of a brown substance in the freezer with no label or date on contents;
- Opened wrapped margarine, wrapped cut up onion, four metal pans not dated with two of them open and unlabeled, and two trays of red jello uncovered and not dated in the refrigerator;
- Three unlabeled and undated tubs with cereal sat on a cart outside the freezer;
- Inside of the oven with brown/black debris and buildup with pieces of aluminum foil on the floor of oven;
-Stove top with all six burners with black/ brown debris and buildup;
- One #10 can of beans and two #10 cans of sauerkraut commercial cans unlabeled;

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F 812	Continued From page 50 - A bag of sugar in a plastic tub with no date or label; - One tub labeled powdered milk with an undated bag of salt inside; - One bag of white cream baking chips opened and undated. During an interview on 04/02/25 at 10:50 A.M., the Dietary Manager (DM) said he/she would expect everything in the refrigerator, freezer, and dry storage to be labeled and dated appropriately. He/ She would expect the kitchen equipment to be working correctly and cleaned after use. The stove top and oven could use a better cleaning and drinks should be covered when leaving the kitchen. The coffee was self-serve but did not know of anything for infection control for it but would look into it. During an interview on 04/02/25 at 3:05 P.M., the Administrator said she would expect food products to be labeled and stored appropriately, food and drinks to be covered when exiting the kitchen to go to the resident room for resident use, and for kitchen equipment to be clean and working correctly.	F 812		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain or implement a policy regarding the acceptance, usage, and	F 813		

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storage of foods brought into the facility for residents by food delivery services, family, and/or other visitors, to ensure the food's safe and sanitary handling, storage, and consumption. This deficient practice had the potential to affect all residents who ate food brought in by visitors. The facility census was 86.

Review of the facility form titled, "Resident Responsibilities and Rules, Appendix 4," undated, showed:
- Food may be brought into our facility;
- It must be kept in airtight containers;
- Because of diet restrictions, nursing staff should be made aware of any food brought into the facility;
- Should food need to be monitored, it will be kept in a designated room;
- The policy did not address how facility staff will assist the resident in accessing and consuming the food brought in by visitors in a way that either separates or easily distinguishes from the facility food.

Observation on 03/31/25 at 10:45 P.M., a refrigerator located next to ice machine behind the nurse's station had dated resident snacks provided by the facility and several unmarked and undated food items in multiple types of bags and containers in it not provided by the facility.

During an interview on 03/31/25 at 10:30 P.M., Cook G said snacks were kept behind the nurse's station and residents had access to it. All items in the refrigerator should be labeled with a date and name.

During an interview on 04/02/25 at 2:30 P.M., the Dietary Manager (DM) said he/she did not know if

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	265430	A. BUILDING _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR VIEW NURSING AND REHABILITATION	6400 THE CEDARS COURT CEDAR HILL, MO 63016

(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 813	Continued From page 52 the facility had any policies about outside food brought in for the residents. He/She had not had any food brought into the kitchen that was a resident's property. During an interview on 04/02/25 at 3:05 P.M., the Administrator said she would expect to have a policy regarding the use and storage of foods brought to residents by family members or other visitors to ensure safe and sanitary storage, handling, and consumption.	F 813		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to maintain essential equipment in a safe and operable working condition. This deficient practice had the potential to affect all residents. The facility census was 86. The facility did not provide a policy for equipment maintenance. Review of the following invoices showed: - On 12/16/24, an invoice for a laundry washer was serviced but no details of actions taken; - On 12/30/24, an invoice for a laundry washer was serviced with a valve and hose replaced. Observation on 04/02/25 at 9:40 A.M. of the laundry room, showed: - Three commercial laundry washing machines; - Two of the machines were covered in dust and	F 908		

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F 908	Continued From page 53	F 908		

debris and not in use;
- The third machine was running a load of laundry. On top of the third machine was a plastic cup marked with a black line which indicated the fill line for bleach to pour into each load of laundry.

During an interview on 04/02/25 at 9:40 A.M., Laundry Aide (LA) K said he/she had been a laundry employee for over a year and in that time, only one of the three washing machines had worked. The one washer that did work had broken down several times and each time the residents had to go two days or more without clothes getting washed. The working washer broke down every couple of months, and was probably due any time. LA K said they did at least 50 loads of laundry a day, which took it's toll on the one machine. At this moment, the one working machine did not get any hot water for some reason, and the detergent dispensing equipment was not working as well. LA K said for the time being, they were manually adding detergent and bleach to each load. When the only washer did break down, arrangements were made to take the laundry to a laundry mat. Arranging to get all the laundry to and from the laundry mat was complicated and delayed the process time significantly. LA K said the facility administration/company owners had said there was a quote to get a washer a while back, but he/she did not think it would happen.

During an interview on 04/02/25 at 10:10 A.M., the Maintenance Director (MD) said there was a quote for a commercial laundry washing machine, but did not know where the company was in the process of actually getting one. He/She was aware of the hot water problem, and hoped the

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F 908	Continued From page 54 latest filter replacement would help get the hot water to the laundry.. During an interview on 04/02/25 at 2:00 P.M., the Administrator said the backup plan for when the laundry machine went out would be to go to the laundromat. She would expect the laundry equipment to be in proper working conditions and function appropriately.	F 908		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe and functional environment for the residents by allowing items to be stored on top of the overbed light fixtures for residents in three rooms. Storing items on the overbed light creates a hazard of the items falling on the resident below, and does not utilize the light fixtures as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 86. The facility did not provide a policy regarding storing items on the overbed light fixtures. 1. Observation on 03/03/25 at 2:39 P.M., of Room B 5-1 showed a large picture in a wooden frame on the light above the resident's bed. 2. Observation on 03/31/25 at 11:09 P.M., of Room C 8-2 showed three medium sized stuffed	F 921		

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F 921	Continued From page 55 animals, two medium glass figurines, and two small plastic animals on the light fixture above the bed on the left side of the room. 3. Observation on 04/01/25 at 1:00 P.M., of Room C 10-2 showed two large stuffed animals and three medium sized stuffed animals on the light fixture above the bed on the right side. 4. Observation on 04/01/25 at 4:30 P.M., of Room A 6-1 showed one medium stuffed animal and one boxed figurine resting on the light fixture above the bed. During an interview on 04/02/25 at 1:15 P.M., the Maintenance Director said he/she could purchase shelves for the residents' personal belongings. The light fixtures above the bed should be free of clutter for safety reasons. During an interview on 04/02/25 at 1:45 P.M., the Administrator said she would expect light fixtures to be free from items due to a possible fire hazard.	F 921		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		

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F 947	Continued From page 56 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide (NA) in-service education per year. This affected two Certified Nurse Assistants (CNAs) (CNA A and CNA B) out of two sampled CNAs. The facility's census was 86. The facility did not provide a policy regarding annual NA education. 1. Review of CNA A's employee file showed: - A hire date of 09/15/08; - A total of 2 hours 50 minutes of annual in-service training completed for the time frame of September 2023 through September 2024; - The facility failed to provide at least 12 hours of in-service education for September 2023 through September 2024. 2. Review of CNA B's employee file showed: - A hire date of 06/10/21; - A total of 5 hours 45 minutes of annual in-service training for June 2023 through June 2024; - The facility failed to provide at least 12 hours of in-service education for June 2023 through June 2024.	F 947		

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F 947	Continued From page 57 During an interview on 04/02/25 at 3:05 P.M., the Administrator and Director of Nursing (DON) said they would expect CNAs to receive at least 12 hours of training annually.	F 947		

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	12647	A. BUILDING: _____ B. WING _____	C 04/02/2025

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class III. Refer to F584.	A3038		
A4026	19 CSR 30-85.042(22) In-service Training-Nursing Personnel The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs related to problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency. II/III This regulation is not met as evidenced by: Class III. Refer to F730 and F947.	A4026		
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	A4040		

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A4040	Continued From page 1 evening and night shifts. II This regulation is not met as evidenced by: Class II. Refer to F727.	A4040		
A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident. Irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. II/III This regulation is not met as evidenced by: Class III. Refer to F758.	A4061		
A4101	19 CSR 30-85.042(92) Activity Program The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities, and activities outside the facility as appropriate to his/her needs and interests. II/III This regulation is not met as evidenced by:	A4101		

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A4101	Continued From page 2 Class III. Refer to F679.	A4101		
A5007	19 CSR 30-85.052(7) Bedtime Snacks, Offered/Nourishing Bedtime snacks of nourishing quality shall be offered to all residents unless medically contraindicated. III This regulation is not met as evidenced by: Class III. Refer to F809.	A5007		
A5015	19 CSR 30-85.052(15) Food Service Supervisor All facilities shall employ a food service supervisor who shall have overall supervisory responsibility for dietary services. II This regulation is not met as evidenced by: Class II. Refer to F801.	A5015		
A8008	19 CSR 30-88.010(8) Informed Services/Charges - Alz Disclosure Prior to or at the time of admission and during his or her stay in the facility, each resident and/or his or her next of kin, legally authorized representative or designee shall be fully informed, in writing, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or federal or state programs. Information shall include procedures to be	A8008		

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A8008	Continued From page 3 followed by the facility in cases of medical emergency, including transfer agreements and costs. All residents who receive treatment in an Alzheimer's special care program or unit and their next of kin, legally authorized representatives or designees shall be given a copy of the Alzheimer's Special Care Services Disclosure Form at the time of admission. Residents also shall be informed of services outside the facility which may reasonably be made available to the resident and of any reasonable estimate of any foreseeable costs connected with those services. II/III This regulation is not met as evidenced by: Class III. Refer to F625.	A8008		
A8018	19 CSR 30-88.010(18) Emergency Discharges In emergency discharge situations the facility shall submit to the resident and his or her next of kin, legally authorized representative or designee a written notice of discharge. The written notice of discharge shall be given as soon as practicable and advise the resident of the right to request an expedited hearing. In the event that there is no next of kin, legally authorized representative or designee known to the facility, the facility shall send a copy of the notice to the appropriate regional coordinator of the Missouri State Ombudsman's office. II/III This regulation is not met as evidenced by: Class III. Refer to F623.	A8018		

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A8030	Continued From page 4	A8030		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class III. Refer to F550.	A8030		
A8042	19 CSR 30-88.010(41) Resident Lives Not Regulated/Controlled Residents shall not have their personal lives regulated or controlled beyond reasonable adherence to meal schedules and other written policies which may be necessary for the orderly management of the facility and the personal safety of the residents. II This regulation is not met as evidenced by: Class II. Refer to F561.	A8042		

PLAN OF CORRECTION

Provider/Supplier Name:	Arbor View Nursing and Rehabilitation
Street Address, City, Zip:	6400 The Cedars Ct Cedar Hill Mo 63016
Date of Survey:	3-30-25 through 4-2-2025

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
F 550	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No paper products being used • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents were at risk of this deficient practice, Administrator or designee to educate Dietary staff on resident rights before their next scheduled shift. • **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** Administrator or designee will educate all dietary staff of the resident's rights focusing on dignity and how the paper products are a dignity issue and should not be used for the convenience of staff can only be used during a time there is an equipment failure. Audits of dining room for paper product will be conducted 2 times daily 5 times per week for 4 weeks then 5 times per week for 3 weeks then 5 times monthly for 3 months. Corrections to be made immediately if deficiencies found. Progressive discipline up to including termination for employees found using paper products for their convenience. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its**	5-8-25

	effectiveness. The plan of correction is integrated into the quality assurance system; and Results of audits will be reviewed and any deficient practices addressed immediately, results brought to the monthly qapi meeting for discussion and review.	
F561	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Residents can receive showers and shaves according to the times convenient to residents and are not missing chosen activities for showers • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents are at risk of this deficient practice. DON or designee to educate all nursing staff on residents' rights. Residents interviewed for their requested morning/afternoon/evening/night of showers and shaves, shower days/times to be adjusted accordingly. • **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** All staff educated on resident rights. All residents will be interviewed by adon or designee inquiring about shower schedule and shaving frequency. Requested changes by residents to be made to resident shower/shave schedule. DON or designee to interview 5 Residents daily 3 times per week for 4 weeks then 8 residents per week for 3 weeks then 8 residents monthly for 3 months for accuracy of schedule of requests. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Any deficient results need to be addressed immediately. Staff to be progressively disciplined for failure to acknowledge residents' rights with shower/shave times. Results to be discussed and reviewed at monthly Qapi meeting.	5-8-25

F 569	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** RFMS Accounts for discharged residents have been closed. No other Medicaid residents with RFMS accounts are above asset limit • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents are at risk of this deficient practice. BOM to run trial balance in RFMS monthly to determine which residents with active Medicaid have balances within 200.00 of asset limit. From that list letters will be presented to responsible party to notify of the asset limit and encourage spend down to avoid possible loss of MCD benefit. • **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** BOM and SSD to be educated by the Admin or designee of the closing a resident's account within 5 days of dc or death. If no funeral home expense. TPL to be sent to the state within 30 days of death, $200 letters to be sent to the residents RP when residents account gets within the 200.00 limit to remain eligible for Medicaid. BOM to review and Administrator to audit Resident account trial balances will be reviewed weekly for dc'd residents weekly for 3 months and the process for moving those monies to the correct entities. Administrator to audit weekly trial balance to ensure all dcd residents accounts are closed for 3 months. Administrator will also audit 200.00 letters being sent and progress made for spend down. Progressive discipline will be presented to the BOM for failure to follow plan. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Audits to be reviewed and discussed at the monthly qapi meeting, initial audit length maybe extended if audits found to be deficient.	5-8-25

F 584	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Wall area around heating/air unit repaired in C9 Window area in the kitchen has been cleaned. Cove base and trim have been replaced, ceiling tiles replaced. Resident's rooms C9, B6, D8, B3, B8, B10 have been repaired and non-working items have been replaced. Cracked wc arm pads have been replaced on R54 wheelchair • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents are at risk of this deficient practice. All resident rooms to be audited for needed repairs or replacement of items needed. Education to all staff on clean safe home like environment on providing a safe clean/ clean/comfortable homelike environment, also on the maintenance requisition log book. Maintenance to add review of rooms needing paint, and repairs to their monthly maintenance log. Therapy dept to complete an audit of all resident wheelchairs for cracks on the arm rests. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Administrator or designee to audit 10 rooms per week for 4 weeks then 5 rooms per week for 3 weeks then 5 rooms needing cleanliness, paint, repairs and that all doors are closing correctly, these audits will include other areas (kitchen or dining room ect) and offices in the building. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Results of these audits will be reviewed at the monthly qapi meeting. Any deficient findings will be discussed with possible adjustment made to plan or initial duration of audits extended.	5-8-25
F 623	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	5-8-25

Responsible parties and physicians of residents are informed of dc and admission when a discharge or admission occurs with proper documentation of notification in EMR.

- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**

All residents are at risk of this deficient practice. All licensed staff will be educated by the DON or designee of the dc and admission policy of notifying the RP and physician and properly documenting they were notified. Written documentation to be sent with resident at the time of DC. Don or designee will maintain file folder of blank transfer/dc forms are available for licensed staff, DON or Designee will review the 24 hour report daily for admissions and discharges to verify RP and physician were notified, also that proper documentation was sent with resident at DC and DC was properly documented. Medical Records to upload those completed forms into EMR.

- **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;**

DON or designee to review 24 hour report for dc's, Audit to be completed 5 times per week for 4 weeks then 3 times per week for 3 weeks then 5 per month for 3 month of DC forms within 24- 72 hours for residents who are dc'd.
Copies of completed written transfer forms to be given to DON for review of accuracy then to Medical records for uploading into EMR. Licensed staff to receive progressive discipline up to including termination for failing to follow these steps

- **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;**

Undesirable findings of audits will result in progressive discipline up to and including termination. Results of audits to be brought to the Qapi meeting and discussed to ensure plan/education is working.

F 625	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents/ RP to be informed/provided a bed hold agreement at the time of admission and at the time of discharge and nurse to document info was provided • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents are at risk of this deficient practice. DON or Designee to educate licensed staff about the bed hold agreement and sending the proper document to the hospital with the resident, also documenting that the RP was notified of bed hold and document sent with the resident at dc. SSD will upload docs into EMR • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** DON or designee to educate licensed nursing staff and social services on the transfer and discharge forms. Transfer and Bed hold forms to be added to the admission packet. Bed hold and transfer packets have been created by the DON and are at the nurses station. All licensed staff have been educated on the process of notification, completing the forms and sending one copy and keeping one copy. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** DON or designee to audit 24 hour report 5 times per week to ensure proper documentation was sent and properly documented within the residents EMR. Social service or designee will audit 5 times per week for 4 weeks then 3 times per week for 3 weeks then 5 times monthly for 3 months to ensure copies are complete and uploaded into the EMR for each dc. Unfavorable results of findings to be addressed immediately, progressive discipline up to including termination for Nurses who fail to follow policy. Results are to be brought to Qapi and discussed, review to maintain the policy is being followed.	5-8-25

F 679	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents #13, #21, #22, #24 and #31 have been re-assed for likes and dislikes. Proper 1:1 sessions complete and documented. Activities for community engagement added to the monthly activities calendar. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents could have been affected by this deficient practice. Administrator to educate Activities director on the importance of meeting the interests and the physical, mental and psychosocial well being of each resident. All residents will be reassessed for likes and dislikes, additional activities focused for the male population to including those who have more physical deficits than others. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Activity participation log to be adjusted to include 1:1 interactions. Community outings to be scheduled monthly and added to the activities calendar. Administrator or designee to interview 10 residents weekly for 4 weeks then 10 residents per week for 3 weeks then 10 residents monthly for 3 months for resident activities participation. Administrator or designee to Audit the activities participation logs weekly for 3 months to include 1:1 times, activity and activity provided to ensure participation and/or 1:1s are being maintained. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; and** Results of audits to be brought to the monthly qapi meeting. Undesirable results of Audits to be addressed immediately and plan adjusted including initial time of audits to be extended depending on audits outcome and qapi team input.	5-8-25
F 699	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	5-8-25

	All Care plans have been updated to address PTSD triggers. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with a dx of PTSD were at risk of this deficient practice. An audit was completed of all charts of residents with PTSD to ensure a care plan addressing triggers for PTSD was within the chart. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** DON or designee to educate MDS/Careplan nurse on the importance of addressing personalized triggers or interventions associated to the resident or triggers in residents careplan. DON or designee to educate all staff on the importance of Trauma informed care, what triggers are and how residents and staff can be affected by them. MDS nurse to Audit CP and dx of new admits will be added to the ongoing clinical meeting review within 72 hours of admission with the clinical team to ensure all DX have been addressed in care plan. DON or designee to audit care plans of new admissions within 72 hours of admission for PTSD care plan for 3 months. Progressive discipline up to including termination for failure to put in care plan. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Audit results to be brought to the monthly qapi meeting for review, deficient audits will be discussed with possible extension of audit timeline depending on results.	
F 727	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Daily RN coverage is in place.	5-8-25

	• **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents are at risk of this deficient practice. Placing ads and open interviews for RN's also scheduling practices have been adjusted to ensure coverage. Daily RN currently in place coverage 7 days per week • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Daily DON and ADON review of daily staffing pattern with continued monitoring of the schedule to ensure proper RN coverage. RN ads on Indeed have been placed continued offerings of hiring bonus and competitive wages in place. Admin to audit schedule and daily staffing sheets for 3 months to ensure coverage remains appropriate. Future gaps to be addressed immediately, continued hiring efforts to maintain RN coverage. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Audits to be discussed at the monthly qapi meeting. Any concerns will lead to possible adjustment to plan and initial auditing time line depending on audit results.	
F 730	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Annual performance reviews and 12 hour training have been completed • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents are at risk of this deficient practice. Education and performance review event scheduled for all staff. Each CNA must participate and pass an annual performance review with an acceptable score, any cna with an unfavorable review score will be reeducated to ensure understanding and retested.	5-8-25

	• **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** Performance reviews to be conducted yearly ongoing. DON to approve education material for effectiveness. DON or designee to monitor reviews and sign off on completed review as being acceptable. Periotic reeducation ongoing if CNA found to be proficient in duties. If CNA fails to meet required education and performance review expectations CNA will be removed from schedule until able to complete requirements. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Results of reviews to be brought to the qapi meeting for review to ensure proper protocol continues to be followed and changes made if found deficient.	
F 758	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 21 & 36 have had chart review completed and any unnecessary drugs were dc'd. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents prescribed psychotropic medications are at risk of this deficient practice. GDRs will be sent timely to prescribing physician and orders changed timely by ADON. ADON will audit EMR for new orders for psychotropic meds needing stop dates weekly for 3 months. Pharmacy consultant has reviewed charts and made recommendations, those orders have been adjusted accordingly. • **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** Licensed nursing staff educated by DON or designee of the policy of stop dates for psychotropic medications. DON to educate ADON on pharmacy recommendation process.	5-8-25

	Residents receiving psychotropic medications will have their medications reviewed by pharmacists to ensure gdrs are attempted. GDR,s will be sent timely to prescribing physicians. Weekly follow up by ADON to prescribing physician for decision on pharmacy recommendation. ADON to follow through with any order changes. DON or designee to audit ADONs efforts to ensure efforts are being made to get the pharmacy recommendations returned and addressed timely. DON or designee will audit new PRN orders for psychotropic medications will be reviewed 5 times per week to ensure 14 day stop is attached to the order for 4 weeks then 3 times weekly for 3 weeks then monthly for 3 months. DON or designee to audit weekly of follow up of Pharmacy recommendations being sent and orders addressed timely for 4 weeks then 2 times per month for 3 months. Unfavorable results to be addressed immediately • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Results of audits to be reviewed at the monthly qapi meeting initial audit dates may be extended depending on the outcome of audits	
F 801	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Registered Dietician contract in place. Dietary Manager has received his Certified Manager food handlers certificate • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents are at risk of this deficient practice. Dietary Manager to maintain active certification. Registered Dietician contract signed 3-30-25 to remain in place. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Registered Dietician to remain in place to oversee dietary and nutrition services and make recommendations. Dietary Manager to maintain Certified Manager food handlers certification while employed at Arbor view.	5-8-25

	• **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Administrator to review and maintain current contracts/certifications. Any failure for DM to optain/maintain active certification will result in being removed from the schedule until active status can be made. To be reviewed during qapi to ensure follow through of certs/contracts are maintained	
F 809	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Meal times adjusted to be within 14 hour required time frame. Resident 1, 17. 33 and 35 are being offered snacks in the evening. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents are at risk of this deficient practice. Meal times have been adjusted to 7:30- 12noon and 5:30pm snacks to be offered to residents who are unable to get to the nurses station. Administrator or Designee to educate dietary staff on the importance of meal time delivery times. Nursing staff educated on offering snacks to residents in the evening time including walking the snack cart around for those who are unable to go to the nurses station.. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** SSD or designee to interview 6 residents daily for 4 weeks then 6 residents weekly for 3 weeks then 6 residents monthly for 2 months inquiring about snack availability, if it were offered and brought to them. SSD or designee to audit meal serving start times 2 times per day for 4 weeks then 5 times per week for 3 weeks then 5 times monthly for 2 months • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its**	5-8-25

	effectiveness. The plan of correction is integrated into the quality assurance system; Deficient findings will be addressed immediately and progressive discipline up to including termination for continued failure to serve meals at the set times or if snacks are not being passed. Results of audits to be brought to Qapi for review of compliance, audits may continue beyond initial time frame depending on out come of audits.	
F 812	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Open unlabeled items have been removed from the kitchen, open items are labeled and dated Drinks are covered before leaving the kitchen Coffee dispenser removed from the dining room, Juice pitchers not readily available to residents Cooktop and oven have been cleaned removing debris Ice machine to be cleaned Door behind nurses station to clean utility room to remain locked. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **All residents are at risk of this deficient practice. Administrator or designee to educate dietary staff on proper storage, labeling and dating of items, cleanliness of the kitchen and importance of keeping the stove/ oven free of debris and build up.** Administrator or designee to educate all staff Food Procurement store/prepare/Serve-Sanitary practices and requirements. HSK super or designee to clean Ice maker behind nurses station on a on a weekly cleaning schedule. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur**; Daily cleaning schedule for cooks to include stove top and oven. Housekeeping Supervisor or designee to Audit cleanliness of the stove/oven to be conducted 5 times per week for 4 weeks then 3 times a week for 3 weeks then 5 times monthly for 2 months HSK supervisor to audit Clean utility behind the nurses station for cleanliness of the ice machine weekly times 3 months. DM or designee to Audit refrigerator, freezer, all plastic containers, and dry storage are for open unlabeled items 5 times per week for 4 weeks then 3 times per week for 3 weeks	5-8-25

	then 10 times monthly for 3 months. Unsatisfactory findings will be corrected immediately. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Audits to be brought to the monthly qapi meeting for discussion, initial audit may be extended depending on the outcomes of the audits.	
F 813	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All items in fridge behind nurses station are labeled and dated in air tight containers. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who ate food brought in by visitors • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All staff to be educated by Administrator or designee by cert date or before the start of their next shift on resident personal food brought into facility by family or visitors policy. Housekeeping supervisor or designee to audit refrigerator 5 times per week for 4 weeks then 3 times per week for 3 weeks then 5 times per month for 2 months. Items found unlabeled or not in an air tight container to be removed and thrown away • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Results of audits to be brought to the qapi meeting for discussion, initial time frame may be adjusted depending the outcomes of audits	5-8-25

F 908	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Automatic soap dispenser has been repaired. • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents were at risk of this deficient practice. Laundry staff, Housekeeping director and Maintenance director educated by Administrator or designee on how to notify the maintenance director when there is a problem with equipment via maintenance requisition book. Maintenance director to add equipment inspection to monthly check off and to call for service as needed. • **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** The administrator or designee will audit monthly work logs and check off lists weekly for equiptment check, repairs and completion monthly for 3 months. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** . Results of this audit will be brought to the qapi meeting and reviewed initial audits may continue longer depending on the outcome of the audits	5-8-25
F 921	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All items have been removed from light fixtures in rooms B5-1, C8-2, C10-2, 61, • How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents and staff are at risk of this deficient practice. A room audit has been completed, removing all items from lighting fixtures. All staff are educated by administrator or designee on safe/functional/ sanitary and comfortable environment.	5-8-25

	• **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Hsk and maintenance director or designee to audit all rooms to remove any objects from lighting. Hsk to add removing items from light fixtures to deep clean check list. Hsk director or designee to audit 8 resident rooms weekly for 4 weeks for items on light fixtures then 4 rooms per week for 3 weeks then 4 resident rooms monthly for 3 months. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Audits to be brought to the qapi meeting for review initial time of audits maybe extended depending on the audit outcome.	
F 947	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All CNAs have received 12 CNA training hours • **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** This deficient practice affected 2 cnas. Skills fair conducted. • **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** DON to educate ADON on creating and maintaining a plan to achieve all cna education hours are provided. Nursing admin to provide Skills and educational fair, planned yearly with ongoing educational hours monthly for all cnas to ensure 12 minimum hours are achieved. HR director or designee to audit educational hours are received yearly. Any CNA who does not achieve their 12 hours of Inservice training will be removed from the schedule until achieved. • **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** Audits to be reviewed at the monthly qapi meeting any needed changes to the plan be discussed at this time	5-8-25

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

PLAN OF CORRECTION

Provider/Supplier Name:	Arbor View Nursing and Rehab
Street Address, City, Zip:	6400 The Cedars Ct Cedar Hill Mo 63016
Date of Survey	3-30-25 through 4-2-2025

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
A3038	Refer to F584	5-8-2025
A4026	Refer to F730 & F947	5-8-2025
A4040	Refer to F727	5-8-2025
A4061	Refer to 758	5-8-2025
A4101	Refer to F679	5-8-2025
A5007	Refer to F809	5-8-2025
A5015	Refer to F801	5-8-2025
A8008	Refer to F625	5-8-2025
A8018	Refer to F623	5-8-2025
A8030	Refer to F550	5-8-2025
A8042	Refer to F561	5-8-2025

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.