STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265420	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE RIDGE CARE CENTER	100 WEST THOMAS AVENUE WAVERLY, MO 64096

(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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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	F 623		

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

Michael W Marshall — Administrator — 10-3-24

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

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F 623	Continued From page 1	F 623		

(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.

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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 provide written notification of a hospital transfer/discharge for one sampled resident (Resident #23) out of 13 sampled residents, as well as the Ombudsman (a person who advocates for residents of nursing homes) when the resident was transferred to the hospital. The facility census was 40 residents.

A policy regarding transfer/discharge was requested from the facility and not provided.

1. Review of Resident #23's nurse progress notes, dated 7/7/24, showed:
-The resident was reported to be on the floor.
-Resident complained of pain to his/her right hip.
-Hospice, Assistant Director of Nursing (ADON), and Administrator were notified.
-Facility physician notified and sent orders to send the resident to the emergency room.

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F 623	Continued From page 3	F 623		

Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 8/20/24 showed the resident had moderate cognitive impairment.

Review of the resident's paper chart and electronic health record showed no notification of a transfer/discharge was provided to the resident as well as no notification provided to the Ombudsman.

During an interview on 9/11/24 at 10:00 A.M. the resident said:
-He/She was sent to the hospital due to a fall.
-He/She was unaware if he/she received notification in writing regarding being transferred to the hospital.

During an interview on 9/11/24 at 10:30 A.M., Licensed Practical Nurse (LPN) B said:
-He/She was not employed at the facility when the resident had the fall.
-When residents were transported out of the facility the physician and family were notified in writing.
-The Ombudsman must also be notified.

During an interview on 9/11/24 at 11:54 A.M., the Director of Nursing (DON) said:
-Transfer/discharge notifications were given to residents when they were sent to the hospital.
-A transfer/discharge notification should have been issued to the resident.
-The Ombudsman should have been notified of transfer to hospital.
-Family and residents should be notified in writing with reason for transfer to the hospital.

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F 625	Continued From page 4	F 625		
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 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 the facility's Bed Hold policy (a policy that specified how residents can secure their bed in the facility if they have to go to the hospital) for one sampled resident (Resident #23) out of 13 sampled	F 625		

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residents when the resident was transferred to the hospital. The facility census was 40 residents.

A policy regarding bed hold was requested from the facility and not provided.

1. Review of Resident #23's nurse progress notes, dated 7/7/24, showed:
-The resident was reported to be on the floor.
-Resident complained of pain to his/her right hip.
-Facility physician notified and sent orders to send the resident to the emergency room.

Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 8/20/24 showed the resident had moderate cognitive impairment.

Review of the resident's paper chart and electronic health record showed no bed hold policy was issued to the resident.

During an interview on 9/11/24 at 10:00 A.M. the resident said:
-He/She was sent to the hospital due to a fall.
-He/She was unaware if he/she received notification in writing regarding holding his/her bed.

During an interview on 9/11/24 at 10:30 A.M., Licensed Practical Nurse (LPN) B said:
-He/She was not employed at the facility when the resident had the fall.
-Bed hold policies must be provided in writing.

During an interview on 9/11/24 at 11:54 A.M., the Director of Nursing (DON) said:

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F 625	Continued From page 6 -Bed hold policies were given when residents were sent to the hospital. -A bed hold policy should have been issued to the resident.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		

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regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on interview, and record review, the facility failed to complete an annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) for one sampled resident (Resident #32) out of 13 sampled residents. The facility census was 40 residents.

Review of the facility's undated policy titled "MDS Completion and Submission Timeframes" showed:

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-The assessment coordinator or designee was responsible for ensuring resident assessments were submitted in accordance with current federal and state guidelines.
-The timeframes for completion and submission of assessments were based on the current requirements published in the Resident Assessment Instrument Manual (RAI).

Review of the RAI manual, Version 1.18.11, dated October 2023 showed after the admission assessment, the next comprehensive assessment would be scheduled within 366 days.

1. Review of Resident #32's assessments showed the following:
-Admission MDS was completed on 1/27/23.
-No annual MDS was completed (an annual MDS was due 1/28/24).

During an interview on 9/11/24 at 9:21 A.M., the MDS Coordinator said:
-He/She was the MDS Coordinator since the end of February 2024 (was not at the facility when the annual should have been completed).
-The previous program they used for MDS completion had a calendar that showed when each MDS was due.
-The previous program did not send notices of past due assessments.
-He/She did not have a notification in the old program that the resident's MDS was late.
-The previous program was available until 8/1/24.
-They switched to a new program on 8/19/24.
-The new program gave a list of residents and when their MDS was due.
-The new system showed the resident's next MDS was due in June 2024.

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F 636	Continued From page 9 During an interview on 9/11/24 at 11:49 A.M., the Director of Nursing (DON) said the MDS should be done timely and completed following the RAI manual.	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) no less frequently than once every three months for one sampled resident (Resident #32) out of 13 sampled residents. The facility census was 40 residents. Review of the facility's undated policy titled "MDS Completion and Submission Timeframes" showed: -The assessment coordinator or designee was responsible for ensuring resident assessments were submitted in accordance with current federal and state guidelines. -The timeframes for completion and submission of assessments were based on the current requirements published in the Resident Assessment Instrument Manual (RAI). Review of the RAI manual, Version 1.18.11, dated October 2023 showed after the admission assessment, quarterly assessments should be	F 638		

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scheduled within 92 days after the previous assessment and the next comprehensive assessment would be scheduled within 366 days after any comprehensive assessment including admission, significant change or annual assessment.

1. Review of Resident #32's assessments showed the following:
-Admission MDS was completed on 1/27/23.
-First quarterly MDS was completed on 4/24/23.
-Second quarterly MDS was completed on 7/22/23.
-Third quarterly MDS due 10/22/23 was not completed timely.
-Third quarterly MDS was completed on 11/2/23 (one month late).
-Annual MDS due 1/28/24 was not completed.
-Another quarterly MDS was completed on 4/19/24.
-No assessments completed since 4/19/24.

Review of the facility's assessment transmission report dated 5/3/24 showed:
-5/3/24 was the date of the last transmission.
-The resident's assessment was late.
-No other transmissions for the resident were received.

During an interview on 9/11/24 at 9:21 A.M., the MDS Coordinator said:
-He/She was the MDS Coordinator since the end of February 2024.
-The previous program they used for MDS completion had a calendar that showed when each MDS was due.
-The previous program did not send notices of past due assessments.
-He/She did not have a notification in the old

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F 638	Continued From page 11 program that the resident's MDS was late. -The previous program was available until 8/1/24. -They switched to a new program on 8/19/24. -The new program gave a list of residents and when their MDS was due. -The new system showed the resident's MDS was due in June 2024. During an interview on 9/11/24 at 11:49 A.M., the Director of Nursing said the MDS should be done timely and completed following the RAI manual.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess one sampled resident, (Resident #37), for oral/dental status of broken natural teeth and mouth pain or discomfort, out of 13 sampled residents. The facility census was 40 residents. Review of the undated facility policy Resident Assessments showed: -Comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) was to include both the completion of the MDS as well as the completion of the Care Area Assessments (CAA, a problem-oriented framework for arranging MDS information and additional clinically relevant information about an individual 's health problems or functional status) process and care planning.	F 641		

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-The resident assessment coordinator was responsible for ensuring that the interdisciplinary team conducts timely and appropriate assessments.
-Assessments were to be completed by staff members who had the skills and qualifications to assess relevant care areas and who were knowledgeable about the resident 's strengths and areas of decline.
-Information in the MDS would consistently reflect information in the progress notes, plans of care, and resident observations and interview.
-The results of the assessments would be used to develop, review and revise the resident's comprehensive care plan.

1. Review of Resident #37's undated Face Sheet showed he/she was initially admitted on 6/21/24 and the most recent admission to the facility on 7/1/24 with the following diagnoses:
-Dysphagia, unspecified, a swallowing disorder that is characterized by difficulty swallowing.
-Gastrostomy status, the presence of an artificial opening in the stomach.

Review of the resident's Admission Nursing Evaluation dated 6/21/24 and 7/1/24 showed:
-Dental:
--Resident has his/her own teeth.
--Broken teeth.

Review of the resident's admission MDS Section L Oral/Dental Status dated 7/22/24 showed:
-No documentation of any dental concerns.
--NOTE: The MDS was not marked to indicate the resident had broken missing teeth and was not marked to indicate mouth or facial pain or discomfort.

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F 641	Continued From page 13 Review of the resident's Admission Nursing Evaluation dated 6/21/24 and 7/1/24 showed: -Dental: --Resident has his/her own teeth. --Broken teeth. During an interview on 9/11/24 at 8:40 A.M. the resident said: -He/She reported concern regarding his/her teeth and pain daily. -His/Her teeth hurt. Observation on 09/11/24 at 8:56 A.M. of the resident's mouth showed multiple missing and broken teeth. During an interview on 9/11/24 at 9:20 A.M. the MDS nurse said: -He/She reviewed the resident's chart to retrieve data for the completion of the MDS. -He/She expected the MDS would be accurate and reflect the current condition of the resident. -He/She said the MDS would reflect nursing assessments. -He/She was not aware of the resident's broken teeth. During an interview on 9/11/24 at 11:47 A.M. the Director of Nursing (DON) said: -He/She would expect the MDS nurse to capture the documentation from the clinical chart. -He/She would expect the MDS nurse to conduct his/her own assessments. -He/She was not aware the resident had broken teeth. -He/She would expect the MDS to be accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

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

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to personalize a communication care plan for two sampled residents (Resident #4 and #37) out of 13 sampled residents. The facility census was 40 residents.

Review of the undated facility policy Resident Assessments showed:
-Information in the Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) would consistently reflect information in the progress notes, plans of care, and resident observations and interview.
-The results of the assessments would be used to develop, review and revise the resident's comprehensive care plan.

Review of the facility's policy titled "Care Plans, Comprehensive Person-Centered" dated as revised March 2022 showed each resident's comprehensive care plan should be person-centered and describe the services that were to be provided.

1. Review of Resident #4's admission MDS showed the following staff assessment of the resident:
-Spanish was the resident's preferred language.

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-He/She did not want or need an interpreter for health care.
-He/She was usually understood by others and usually understood others.
-He/She was moderately cognitively impaired.
-He/She was independent with all cares except he/she required supervision for bathing.

Review of the resident's communication care plan dated 8/20/24 showed:
-The resident's primary language was Spanish.
-The desired outcome was that the resident would maintain current level of communication function by "(specify how, with what assistance, such as making sounds, using appropriate gestures, responding to yes/no questions appropriately, using communication board, writing messages)" through the next review date.
-Interventions included monitoring effectiveness of communication strategies and assistive devices "(SPECIFY)."

Observation on 9/9/24 showed:
-At 6:36 A.M., the resident communicated in Spanish.
-At 9:10 A.M.,
--The resident was watching something on his/her tablet in Spanish.
--The resident answered some questions using a translator application on a phone for English/Spanish.

During an interview on 9/9/24 7:18 A.M., Certified Nursing Assistant (CNA) B and CNA C said:
-The resident used hand gestures, pointed to things, could answer yes/no questions, could say things like "thank you."
-Nursing Assistant (NA) A spoke a little bit of Spanish and could communicate with the

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resident.

During an interview on 9/10/24 at 1:39 P.M., the Social Services Director said:
-He/She relied on the resident's family members to translate.
-The resident's family members were very involved.

During an interview on 9/11/24 at 8:15 A.M., NA A said:
-He/She speaks quite a bit of Spanish and could looks up things if needed.
-Therapy made cards that were English/Spanish for staff to use with the resident regarding basic needs.
-The resident used hand gestures and staff could usually understand what the resident was saying.

During an interview on 9/11/24 at 8:30 A.M., Certified Medication Technician (CMT) A said:
-The resident understood him/her when he/she asked him/her things like if he/she was feeling ok, if he/she had any pain and he/she pointed to things.
-The resident usually understood most things he/she tried to communicate to him/her.

During an interview on 9/11/24 at 9:22 A.M., the MDS Coordinator said:
-He/She was the MDS Coordinator since the end of February 2024.
-He/She was responsible for developing the resident's communication care plan.
-The resident could give short answers.
-The resident could communicate things that were not complex.
-The resident answered yes/no questions and short phrases.

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-Sometimes the resident pointed to things he/she wanted.
-The resident also used a tablet.
-He/She was working on the resident's care plan.
-The care plan should have had the details about his/her communication in the care plan and should have had current intervention details.

During an interview on 9/11/24 at 11:49 A.M., the Director of Nursing (DON) said the care plan should have had specific interventions.

2. Review of Resident #37's undated Face Sheet showed he/she was initially admitted on 6/21/24 and the most recent admission to the facility on 7/1/24 with the following diagnoses:
-Dysphagia, unspecified, a swallowing disorder that is characterized by difficulty swallowing.
-Gastrostomy status, the presence of an artificial opening in the stomach.

Review of the resident's Admission Nursing Evaluation dated 6/21/24 and 7/1/24 showed:
-Dental:
--Resident has his/her own teeth.
--Broken teeth.

Review of the resident's admission MDS Section L Oral/Dental Status dated 7/22/24 showed:
-No documentation of any dental concerns.
--NOTE: The MDS was not marked to indicate the resident had broken missing teeth and was not marked to indicate mouth or facial pain or discomfort.

Review of the resident's Care Plan dated 7/24/24 did not show a Dental care plan.

Observation on 09/11/24 at 8:56 A. M. of the

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F 656	Continued From page 19 resident's mouth showed multiple missing and broken teeth. During an interview on 9/11/24 at 8:40 A.M. the resident said: -He/She reported concern regarding his/her teeth and pain daily. -His/Her teeth hurt. During an interview on 9/10/24 at 2:07 P.M. LPN B said he/she was not aware of the resident's broken teeth. During an interview on 09/10/24 at 1:22 P.M. the Social Services Designee (SSD) said he/she was not aware the resident had broken teeth. During an interview on 9/11/24 at 8:45 A.M. CNA B said he/she was not aware resident had broken teeth. During an interview on 9/11/24 at 8:45 A.M. CNA C said he/she was not aware resident had broken teeth. During an interview on 9/11/24 at 9:20 A.M. the MDS nurse said: -He/She was not aware of the resident having broken teeth. -He/She completed the care plan. During an interview on 9/11/24 at 11:47 A.M. the Director of Nursing (DON) said: -He/She was not aware the resident had broken teeth. -He/She would expect the care plan to reflect dental concerns.	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident	F 679		

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F 679	Continued From page 20 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities to meet the interests as well as the physical, mental, and psychosocial well-being for three sampled residents (Residents #19, #23, and #36) out of 13 sampled residents. This deficient practice had the potential to affect all residents. The facility census was 40 residents. Review of the facility's Activities Policy, undated, showed: -The activities department worked with the nursing department to coordinate resident care and needs with scheduled activities. -Activity staff were aware of the resident's safety concerns and transfer needs. -The Activities Director was responsible for filling out the activities section of the Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning). -The activities director assisted with the activity care plan and attending care plan meetings.	F 679		

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-Activities were meaningful and individualized to meet the needs of all residents.

1. Review of Resident #19's Annual MDS assessment, dated 10/18/23, showed it was somewhat important to the resident to be able to go outside and get fresh air.

Review of the resident's care plan, dated 3/8/24, showed:
-The resident was invited to activities.
-The resident was informed of planned activities.
-The resident enjoyed playing cards.
-The resident enjoyed working with models.

Review of the resident's Quarterly MDS, dated 7/16/24, showed the resident was cognitively intact.

Review of the resident's Activity Participation Log for June 2024 showed the resident participated in "coffee club" on 6/11/24, 6/12/24 and 6/13/24.

Review of the resident's Activity Participation Log for July 2024 showed:
-The resident participated in "coffee club" on July 1, 2, 3, 4, 5, 11, 12, 14, 19, and 25.
-The resident participated in bingo on July 5, 12, and 19.

Review of the resident's Activity Participation Log for August 2024 showed:
-The resident participated in "coffee club" on August 2, 9, 13, 14, 15, 16, 18, 23, and 30.
-The resident participated in bingo on August 2, 9, 16, 23, and 30.

Review of the resident's Activity Participation Log for September 2024 showed the resident

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participated in "coffee club" on 9/3/24.

During an interview on 9/9/24 at 9:30 A.M. the resident said:
-There were things to do during the week but not on the weekend.
-The Activity Director told the resident that he/she did not know what to plan for the residents on the unit as they were not crafty.

2. Review of Resident #23's quarterly MDS, dated 8/20/24, showed the resident was moderately cognitively impaired.

Review of the resident's Activity Participation Log for July 2024 showed:
-The resident participated in "coffee club" on July 1, 4, 5, 6, 9, 12, 18, 19, 20 and 27.
-The resident participated in bingo on July 5, 12, 19 and 27.

Review of the resident's Activity Participation Log for August 2024 showed:
-The resident participated in "coffee club" on August 1, 2, 5, 8, 10, 16, 23, 24, 25, and 27.
-The resident participated in bingo on August 16 and 17.

There were no activity participation logs for September 2024.

Review of the resident's care plan, dated 7/1/24 showed the Activities Director was to provide a monthly calendar of scheduled activities.

During an interview on 9/9/24 at 9:54 A.M. the resident said:
-He/She had nothing to do, especially on the weekends.

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-He/She would go to activities but there isn't always someone to do them with the residents.
-He/She used to go to the dining area and do activities with the other residents at the facility but since some of the residents from his/her unit had behavior issues they were no longer allowed to do activities with the others.

3. Review of Resident #36's admission MDS assessment, dated 6/27/24, showed:
-This showed the resident was cognitively intact.
-It was very important to the resident to listen to music that he/she liked.
-It was very important to do his/her favorite activities.
-It was very important to go outside to get fresh air.

Review of the residents care plan, dated 7/1/24, showed:
-The resident enjoyed social activities.
-The Activity Director was to provide a monthly calendar of scheduled activities.

The resident's activity participation logs for July, August and September 2024 were requested and not provided.

During an interview on 9/9/24 at 9:15 A.M., the resident said:
-There was not much to do at the facility.
-There was nothing on the calendar in the hall.
-He/She wanted something to do on Saturday and Sundays.
-The residents on his/her unit used to do activities with the other residents but were no longer allowed to because some residents had bad behaviors and now no one can go up there.
-Since that happened there has not been much to

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do back on the unit.

Review of the August 2024 Activities calendar, displayed on the wall in the resident's room on 9/9/24 at 10:41 A.M., showed:
-No activities were scheduled on the weekends.
-There was no calendar for September noted on the unit.

4. Observations conducted multiple times from 9/9/24 to 9/11/24 between 9:00 A.M. to 3:30 P.M. showed no activities being conducted with the residents on the unit.

During an interview on 9/9/24 at 1:16 P.M., Certified Nursing Assistant (CNA) D said:
-The Activity Director provided activities for the residents on the unit.
-There were no activities on Saturday.
-If the Activities Director was not at the facility, then the CNAs were supposed to provide an activity for the residents on the unit, but they do not have time.
-The Activities Director was out of the building due to illness so no activities were conducted since he/she has been out.

During an interview on 9/10/24 at 2:00 P.M. CNA A said he/she had only seen activities on the unit 2-3 times a week.

During an interview on 9/11/24 at 8:13 A.M., Certified Medication Technician (CMT) A said:
-There were not many activities to do on the unit.
-The residents complained there was nothing to do on the weekends.
-The nurse sometimes came in on Sundays and popped popcorn and put on a movie.
-The Activities Director was out sick the last few

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days.
-When the Activities Director was out of the facility then nursing staff tried to do something with the residents but not always.
-The Activities Director put out a monthly calendar.

During an interview on 9/11/24 at 8:44 A.M., CNA A said:
-There were no activities for the residents on the unit during the week.
-He/She did not receive any notification he/she was supposed to do any activity with the residents.
-There was an activity calendar posted on the hall for August, but it was blank.

During an interview on 9/11/24 at 8:53 A.M., Licensed Practical Nurse (LPN) A said:
-Activities should be done daily.
-The activities director was out sick for the last few days.
-He/She was unaware if someone else was supposed to be doing activities with the residents.
-The residents on the unit used to do activities with the rest of the residents but due to behavior issues they were only to be doing activities on their unit.

A phone interview was attempted on 9/11/24 at 10:20 A.M. with the Activities Director. There was no answer.

During an interview on 0/11/24 at 12:00 P.M., the Director of Nursing (DON) said:
-Activities were scheduled and completed on the unit.
-The residents on the unit were offered activities two to three times a day.

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F 679	Continued From page 26 -The activities calendar should be current and posted on the hall. -The Activities Director was sent home on Monday due to illness. -If residents attended activities, it should be documented on the participation log. -He/She was not aware of activities not being conducted on the unit on the weekends. -He/She was unaware of who did the activities when the Activities Director was not at the facility. -The Administrator was able to do them if needed.	F 679		
F 680 SS=D	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the activities program was	F 680		

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directed by a qualified professional. The facility census was 40 residents.

A policy for Activities Director (AD) was requested from the facility and was not provided.

1. Review of facility's undated Activity Director job description education and experience requirements showed:
-Must possess, as a minimum, two (2) years of college.
-Must be a qualified therapeutic recreation specialist or an activities professional who is licensed by this state and is eligible for certification as a recreation specialist or as an activities professional; or
-Must have as a minimum of two (2) years' experience in a social or recreation program within the last five (5) years, and on (1) of which was full time in a patient activities program in a health care setting; or
-Must be a qualified occupational therapist or occupational therapy assistant; or
-Must have completed a training course approved by this state.

Review of the current Activity Director's resume showed:
-He/She was a Certified Medication Technician (CMT).
-He/She was a Certified Nurse Assistant (CNA).
-He/She did not have a college degree.
-He/She did not have two (2) years of college experience.
-He/She had a General Education Development (GED).
-He/She completed one (1) year of college.
-He/She had no experience in a patient activities/social recreation program.

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F 680	Continued From page 28 -He/She did not complete a training course approved by the state. During an interview on 9/11/24 at 9:12 A.M., the Administrator said: -The Activity Director has been at the facility three months. -He/She does not have required qualifications for the position. -He/She needs to become qualified. An attempted to interview the Activity Director 9/11/24 at 10:15 A.M., a voicemail was left. The AD never returned the phone call to conduct a phone interview.	F 680		
F 699 SS=E	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 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 view, the facility failed to provide trauma informed care (understanding a resident's life experiences to provide effective care) for one sampled resident (Resident #30) with a diagnosis of Post Traumatic Stress Disorder (PTSD-a mental health condition caused by an extremely stressful or terrifying event), out of 13 sampled residents. The facility census was 40 residents.	F 699		

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Review of the facility's Trauma Informed Care Policy, dated March 2019, showed:
-The purpose of the policy was to guide staff in appropriate and compassionate care specific to individuals who had experienced trauma.
-All staff were provided in-service training about trauma, its impact on health, and PTSD.
-Nursing staff were trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization.
-All staff were guided in evidence-based organizational and interpersonal strategies that supported trauma informed care.
-Trauma informed care was person centered.
-Caregivers were taught strategies to help eliminate, mitigate, or sensitively address a resident's triggers.
-The facility used trauma-informed principles in strategic planning.
-Include trauma informed care as part of Quality Assurance Improvement Plan (QAPI).
-Implement universal screenings for residents with trauma.

1. Review of Resident #30's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/10/24, showed:
-The resident was moderately cognitively impaired.
-The resident was diagnosed with anxiety disorder (a condition that causes excessive worry and feelings of fear, dread, and uneasiness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and PTSD.

Review of the resident's care plan (an individualized plan that summarizes a person's

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health conditions and current treatments for their care), dated 6/11/24, showed:
-The resident had mental distress evidenced by the inability to concentrate related to PTSD.
-Approaches included:
--Keep an open and accepting attitude with the resident al all times.
--Notify the physician if resident was having PTSD events, which may need an psych referral.
--Administer medications per order.
--Offer counseling if resident was agreeable.

Observation on 9/9/24 at 11:58 A.M. showed the resident walking from his/her room to the dining area. The resident ate at a table with no other residents. Resident sat quietly and ate his/her lunch and returned to his/her room.

Observation on 9/10/24 at 10:42 A.M. showed the resident in his/her room in bed with his/her eyes closed.

During an interview on 9/11/24 at 8:13 A.M., Certified Nursing Assistant (CNA) A said:
-He/She worked on the unit on a regular basis and knew the residents pretty well.
-He/She was familiar with the resident.
-He/She was not a hundred percent sure of what his/her needs or diagnoses were.
-He/She could find the information on the care plan.
-The resident did need some guidance for personal care and lots of redirection.
-The resident seemed to feel sorry for him/herself and was sad.
-The resident repeated said he/she though he/she was going to die at the facility.
-The resident had PTSD.
-Some of the resident's behaviors included

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pacing, and watching other resident's televisions from the hallway.
-The resident was not verbally or physically aggressive.
-The resident did not have outbursts.
-The resident just seemed to be confused a lot of the time.
-The resident was a smoker and sometimes the resident said he/she was claustrophobic while smoking outside with the other residents.
-He/She was not sure what to do for the residents claustrophobia she he/she told the resident to go out to the picnic table where he can be alone.
-Sometimes it made the resident feel better.
-The resident didn't focus on one thing at a time and was restless sometimes.
-He/She just talked to him/her or tried to redirect him/her to something else.

Observation on 9/11/24 at 8:46 A.M. showed the resident in bed watching television.

During an interview on 9/11/24 at 8:24 A.M., Licensed Practical Nurse (LPN) A said:
-He/She usually worked on the unit.
-He/She was familiar with the resident.
-He/She looked up the resident's on the electronic health record (EHR) and saw his/her diagnoses included major depressive disorder, anxiety, and PTSD.
-He/She was unaware of any triggers the resident had.
-He/She had not seen any behaviors related to PTSD.
-He/She was unsure why the resident had that diagnosis.
-If the resident had specific triggers and approaches, he/she found it in the residents progress notes or care plan.

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-He/She believed the PTSD was possibly alcohol related.
-He/She had not received any recent training or in-service related to PTSD.

During an interview on 9/11/24 at 8:28 A.M., LPN B said:
-He/She did not work on the unit with the resident.
-If a resident was diagnosed with PTSD he/she expected to see it addressed on the resident's care plan and should include triggers and strategies to help the resident.
-The diagnosis should also be on resident's orders.
-He/She had not received any recent training regarding PTSD.
-He/She was unaware of any negative behaviors from the residents on that unit.

During an interview on 9/11/24 at 9:21 A.M., the MDS coordinator said:
-He/She had been in this position since February of this year.
-He/She expected the resident's MDS was accurate and reflected current conditions at the time it was completed.
-He/She was unaware of the resident's history or what the main cause of the PTSD was for the resident.
-He/She was unaware if the care plan addressed the resident's PTSD diagnosis.
-He/She expected to see triggers on the care plan as well as any history related to PTSD.

During a follow up interview on 9/11/24 at 9:56 A.M., the MDS coordinator said:
-The resident's PTSD was caused from being in the war.
-He/She did not specify which war or how it was

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F 699	Continued From page 33 related specifically to the resident. During an interview on 9/11/24 at 11:49 A.M., the Director of Nursing (DON) said: -If a resident had a diagnosis of PTSD, he/she expected to see the history of the diagnosis on the care plan. -He/She expected to see triggers and approaches for the resident on their care plan. -He/She was unaware of how often trauma informed care training was offered or provided to the staff. -He/She suggested to talk to the administrator or the Regional Nurse Consultant. During an interview on 9/11/24 at 2:50 P.M., the administrator said: -He/She was unable to locate the last training sign-in sheets for trauma informed care. During an interview on 9/11/24 at 2:50 P.M., the Regional Nurse Consultant said: -He/She was developing trauma informed care in-services that he/she has started to implement. -He/She was unaware of when the last training was.	F 699		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		

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resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure staffing was posted correctly at the beginning of each shift including the total number and actual hours worked per shift which could have the potential to affect all residents in the facility. The facility census was 40 residents.

Review of the Facility undated Posting Nursing Staffing Information showed:

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-Current federal regulations mandate that the facility posts a form daily at the beginning of each shift in a prominent place readily accessible to residents and visitors in a clear and readable format with the following information:
--Facility Name
--Current Date
--Total Number and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift, separated by these categories: Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA).
--Resident census
-The above data must be available to the public upon written or oral request at a cost not to exceed the community standard.
-The posting data must be maintained by the facility for a minimum of 18 months.

1. Review of the posted daily staffing sheets from 9/5/24 through 9/11/24 showed no total actual hours worked for each discipline worked on these dates.

Observation on 9/9/24 of the posted daily staffing sheet near the front nurse's station did not show the actual hours worked per shift for RNs, LPNs, Certified Medication Technician (CMTs), CNAs, and Nursing Assistant (NAs).

Observation on 9/9/24 of the locked Behavioral Unit showed no posted staffing sheet.

Observation on 9/10/24 of the posted daily staffing sheet near the front nurse's station did not show the actual hours worked per shift for RNs, LPNs, CMTs, CNAs, and NAs.

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F 732	Continued From page 36 Observation on 9/10/24 of the locked Behavioral Unit showed no posted staffing sheet. Observation on 9/11/24 of the posted daily staffing sheet near the front nurse's station did not show the actual hours worked per shift for RNs, LPNs, CMTs, CNAs, and NAs. Observation on 9/11/24 of the locked Behavioral Unit showed no posted staffing sheet. During an interview on 9/11/23 at 10:40 A.M., CNA A said: -The daily staffing sheet is not kept on the locked Behavioral Unit. -It is just posted near the main nursing station. During an interview on 9/11/23 at 10:45 A.M., LPN B said the daily staffing sheet is only posted in the front near the nurse's station. During an interview on 9/11/23 at 11:47 A.M., the Director of Nursing (DON) said: -The actual number of hours worked per discipline should be on the daily staffing sheet. -The form the facility uses for daily staffing does not show a total for the actual hours worked per discipline. -The daily staffing sheet is only posted in the front near the nurse's station. -The daily staffing sheet should also be posted in the locked Behavioral Unit.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		

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them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure accurate documentation of narcotic pain medication on the Medication Administration Record (MAR) and the narcotic count log for four sampled residents (Resident # 8, Resident # 23, Resident #19, and Resident #36) out of 13 sampled residents and failed to complete and/or sign shift change narcotic counts each shift. The facility census was 40 residents.

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Review of the facility policy titled Pharmacy and Medication Administration, not dated, showed:
-Narcotics must be counted at the beginning and end of each shift and signed on the narcotic log by the oncoming and off going nurse or medication technician.
-Monitoring the log weekly can help identify any missed counts or lax in counting by staff.
-Medication Administration Records (MARs should be completed with each med pass and audited regularly for missing initials or holes in the MAR.
-Documentation should be provided on the MAR for PRN (medications given on an as needed basis) meds, pain meds, and behavior meds.
-The facility must ensure that it is free from medication error rates of five percent (5%) or greater and residents are free of any significant medication errors.

Review of the facility policy titled Pain, not dated, showed:
-The MAR should document the frequency of pain, medication use, and its effectiveness.

1. Review of Resident #8's face sheet, with an admission date of 4/21/21, showed he/she had:
-Pain in other specified joint.
-Unspecified abdominal pain.
-Pain in right shoulder.
-Chronic pain syndrome.

Review of the resident's Physician Order Sheet (POS), dated 7/2024, showed:
-Oxycodone (a narcotic pain reliever) 20 milligram (mg) 1 tablet every 6 hours while awake dated 6/24/24 and discontinued on 7/3/24.
-Oxycodone 20 mg 1 tablet by mouth every 6

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hours PRN for pain dated 7/3/24.

Review of the resident's MAR, dated 7/2024, showed:
-Oxycodone 20 mg 1 tablet every 6 hours while awake dated 6/24/24 and discontinued on 7/3/24.
-A physician order for Oxycodone 20 mg 1 tablet by mouth every six (6) hours PRN for chronic pain dated 7/3/24.
-Oxycodone 20 mg was documented as administered 102 times between 7/1/24 - 7/31/24.
-NOTE: Only 51 Oxycodone 20 mg tablets were documented as being available for administration for the resident between 7/1/24-7/31/24. The facility was not able to provide documentation for the additional 51 tablets staff documented as administered between 7/6/24-7/23/24.

Review of the resident's Oxycodone (opioid) 20 mg tablet narcotic log for 7/2024, showed:
-51 Oxycodone 20 mg tablets were signed out between the dates of 7/1/24-7/31/24.
-No documentation of Oxycodone 20 mg tablets between 7/6/24 - 7/23/24. (Note- the resident's MAR showed documentation Oxycodone 20 mg was administered during this timeframe).
-The resident's narcotic count went from 6 available tablets on 7/5/24 to 52 available tablets on 7/24/24 with no documentation regarding the 46 tablet discrepancy.
-On 7/3/24 at 6:00 A.M., two Oxycodone 20 mg tablets were signed out at the same time, by different staff members.
-On 7/28/24 at 7:30 P.M., two Oxycodone 20 mg tablets were signed out at the same time, by the same staff member.
-Note: The physician order is for one Oxycodone 20 mg tablet.

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Review of the resident's POS, dated 8/2024, showed an order for Oxycodone 20 mg 1 tablet by mouth every 6 hours PRN for chronic pain dated 7/3/24.

Review of the resident's MAR, dated 8/2024, showed:
-A physician order for Oxycodone 20 mg 1 tablet by mouth every 6 hours PRN for chronic pain dated 7/3/24.
-56 Oxycodone 20 mg tablets were documented as administered to the resident between 8/1/24-8/19/24.
-Documentation of the resident's MAR for 8/20/24-8/31/24 was requested and not provided at the time of exit.

Review of the resident's Oxycodone 20 mg tablet narcotic log for 8/2024, showed:
-70 Oxycodone 20 mg tablets were signed out between the dates of 8/1/24-8/19/24.
-Note: 56 Oxycodone 20 mg were documented as administered by the staff on the resident's MAR. 14 tablets were unaccounted for.
-44 Oxycodone 20 mg tablets were signed out between the dates of 8/20/24-8/31/24. The resident's MAR for those dates were requested and not provided at the time of exit.
2. Review of Resident #23's POS showed Hydrocodone (a narcotic pain reliever) 5/325 mg one or two tablets every six hours as needed for pain dated 7/13/24.

Review of the resident's Hydrocodone narcotic log showed between 8/1/24 - 8/31/24:
-One tablet Hydrocodone 5/325 mg was removed from the narcotic count 10 times.
-Two tablets Hydrocodone 5/325 mg was removed from the narcotic count three times (for

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a total of six tablets).

Review of the resident's 8/2024 MAR showed:
-Hydrocodone 5/325 mg one tablet every six hours as needed was documented as administered four times.
-Hydrocodone 5/325 mg two tablets every six hours as needed showed no documentation of administration.
-NOTE: A total of 12 tablets of Hydrocodone 5/325 mg are unaccounted for.

3. Review of Resident #19's July 2024 POS showed a physician order for Norco 10/325 mg one tablet orally two times a day for pain, dated 1/17/24.

Review of the resident's Narcotic log for July 2024 showed 47 Norco tablets were signed out for administration.

Review of the resident's July 2024 Medication Administration Record showed:
-Norco 10/325 mg one tablet orally two times a day for pain, dated 1/17/24.
-53 Norco tablets were signed out as administered. No documentation where the additional six tablets were obtained.

4. Review of Resident #36's Face Sheet showed he/she was admitted to the facility on 6/17/24 with a diagnosis of an open wound to his/her left lower leg(after motor vehicle accident).

Review of the resident's June 2024 POS showed a physician order for Oxycodone 5 mg every six hours as needed for pain dated 6/17/24.

Review of the resident's Narcotic log for June

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2024 showed 17 Oxycodone tablets were signed out for administration.

Review of the resident's June 2024 MAR showed:
-Oxycodone 5 mg every six hours as needed for pain dated 6/17/24.
-14 Oxycodone tablets were documented as administered. NOTE: Three tablets were unaccounted for.

Review of the resident's Narcotic log for July 2024 showed 41 Oxycodone tablets were signed out for administration.

Review of the resident's July 2024 MAR showed:
-Oxycodone 5 mg every six hours as needed for pain dated 6/17/24.
-30 Oxycodone tablets were documented as administered. NOTE: 11 tablets were unaccounted for.

Review of the resident's August 2024 POS showed a physical order for Oxycodone hydrochloride oral tablet 5 mg one tablet by mouth every six hours as needed for pain, dated 8/14/24.

Review of the resident's Narcotic log for August 2024 showed 16 Oxycodone tablets were signed out for administration.

Review of the resident's August 2024 Medication Administration Record showed:
-Oxycodone 5 mg every six hours as needed for pain dated 8/14/24.
-14 Oxycodone tablets were documented as administered. NOTE: Two tablets were unaccounted for.

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5. During an interview on 9/11/24 at 10:30 A.M. Licensed Practical Nurse (LPN) B said staff removing the narcotics from the narcotic logs were responsible to ensure the narcotic was also on the MAR documented as administered.

During an interview on 9/11/24 at 12:00 P.M. the DON said:
-Medications that were signed off on the Narcotic Count Sheet should have match the amount that was signed off on the MAR.
-He/She was ultimately responsible for ensuring the narcotic count was correct and that the count matched what was signed off on the MAR.

During an interview on 9/11/24 at 12:56 P.M., LPN A said:
-Staff should document PRN pain medication on the front and back of the MAR when administered.
-Staff should document PRN pain medication on the narcotic log when administered.
-The MAR and the narcotic log should match.
-Two PRN Oxycodone should not have been administered at the same time for resident #8.
-The narcotic logs and MAR's had medication errors.

During an interview on 9/11/24 at 1:00 P.M., the Regional Nurse Consultant said:
-Narcotic sign out logs and MAR's should match.
-There had been no previous audits of the narcotic logs and MAR's prior to him/her coming to the facility.
-Narcotics logs and MAR's should have been audited to ensure accuracy.
-Narcotic logs and MAR's should have been audited at least once per month.
-The narcotic logs and MAR's had medication

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errors.

6. Review of the Controlled Drug Count Sheet on the Men's unit from June 1, 2024 through September 10, 2024 showed:
-Staff were directed to count all controlled drugs accessible to the medication nurse at each shift change.
-NOTE: the facility shift change was two times daily.
-Each shift were to sign the count sheet by the incoming nurse and the outgoing nurse. In addition, staff were to check "yes" or "no" if the count was "okay" (meaning no discrepancies).
-Between 6/1/24 - 6/30/24 showed no documentation by either the incoming nurse and/or the outgoing nurse 28 out of 120 opportunities. No documentation the count was ok 15 out of 60 shifts.
-Between 7/1/24 - 7/31/24 showed no documentation by either the incoming nurse and/or the outgoing nurse 86 out of 124 opportunities, including no documentation by either shift between 7/5/24 night shift through 7/23/24 night shift. No documentation the count was ok 43 out of 62 shifts.
-Between 8/1/24 - 8/31/24 showed no documentation by either the incoming nurse and/or the outgoing nurse 47 out of 124 opportunities. No documentation the count was ok 24 out of 62 shifts.

During an observation of medication pass and interview at 9/9/24. at 8:43 A.M. with LPN B said:
-Observation of the narcotic count did not show the nurse counted the liquid Morphine that was stored in the refrigerator.
-He/She said that don't usually count it because it was a full bottle still unopened.

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During an interview on 9/11/24 at 8:20 A.M. Certified Medication Technician (CMT) A said:
-Staff was expected to count the narcotics with the off going nurse and both the nurses would sign at the same time that they counted.
-Counting the narcotics should have been done at the beginning and end of each shift or whenever the keys to the medication cart were passed on to the next shift.
-There have been times when there were not two signatures on the narcotic count.
-If someone did not sign and count the narcotics he/she would have notified the DON.

During an interview on 9/11/24 at 9:02 A.M. LPN A/Charge Nurse (CN) said:
-As soon as you receive report you and the off going nurse should have counted the narcotics at the same time and signed at the same time.
-There should not have been any blanks on the narcotic count.
-If there were blanks the DON should have been notified.
-There have been many blanks on the narcotic sheet, maybe people forgot to sign it.
-He/She had not notified the DON about the blanks on the narcotic sheets.
-The DON or Assistant Director of Nursing (ADON) were ultimately responsible for ensuring the narcotic count was correct.

During an interview on 9/11/24 at 10:30 A.M. LPN B said:
-The narcotics should have been counted with the oncoming and off going nurses together at the same time.
-The count should have been correct.
-If the count was not correct he/she would not

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F 755	Continued From page 46 have taken the keys from the previous shift. -If the count was not correct he/she would have notified the DON or ADON. -There was some blanks on the Narcotic Count Sheet and that should never have happened. -He/She had not notified the DON as it had not happened on his/her shift. -The number of narcotic cards and the liquid medication in the medication refrigerator were counted first. -Then you count how much medication was on each card. -The amount should be correct. -They had received education recently from the DON on ensuring the narcotic count was correct. During an interview on 9/11/24 at 12:00 P.M. the DON said: -Nursing staff was expected to count the narcotics at the beginning and at the end of their shift with a second nurse. -If there were any blank spots the staff should have notified him/her or the ADON. -All of the medications including the Narcotics in the medication refrigerator should have been counted even if it was full as someone could have taken the whole bottle and just left the box. -He/She was ultimately responsible for ensuring the narcotic count was correct.	F 755		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility-	F 790		

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§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident;

§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;

§483.55(a)(4) Must if necessary or if requested, assist the resident;
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services location; and

§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure routine and emergency dental services to meet the needs of residents were offered to one sampled resident, (Resident #37), out of 13 sampled residents.

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The facility census was 40 residents.

Review of the undated facility policy Availability of Services, Dental showed:
-Dental services were available to all residents requiring routine and emergency dental care.
-Social services was responsible for making necessary dental appointments.

1. Review of Resident #37's undated Face Sheet showed he/she was initially admitted on 6/21/24 and the most recent admission to the facility on 7/1/24 with a diagnosis of Dysphagia, unspecified, a swallowing disorder that is characterized by difficulty swallowing.

Review of the resident's undated Order Summary Report showed an order for a dental consult and treat.

Review of the resident's Admission Nursing Evaluation dated 6/21/24 and 7/1/24 showed:
-Dental:
--Resident has his/her own teeth.
--Broken teeth.

Observation on 09/11/24 at 8:56 A.M. of the resident's mouth showed he/she had multiple missing and broken teeth.

During an interview on 9/11/24 at 8:40 A.M. the resident said:
-He/She was unsure the last time he/she saw a dentist.
-He/She reported concern regarding his/her teeth and pain daily.
-He/She provided his/her own oral care.
-His/Her teeth hurt.

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During an interview on 9/10/24 at 2:07 P.M. Licensed Practical Nurse (LPN) B said:
-He/She was not aware of the resident's broken teeth.
-Social Service Director (SSD) would be notified for dental referrals.

During an interview on 09/10/24 at 1:22 P.M. the SSD said:
-The facility had a provider for dental care.
-He/She was not aware when dental services had last been provided.
-He/She would ask on admission if the resident wanted dental and would obtain the signed consent form.
-There was no documentation a dental consent form was provided to the resident upon admission to the facility.
-He/She would fax consents to the dental provider.
-He/She would receive a list from the dental provider with the residents' names for the next visit.
-The dentist was last at the facility on 7/25/24. The resident was not seen by the dentist during that visit. He/She did not know when the next scheduled dental visit to the facility will be.
-He/She was not aware the resident had broken teeth.

During an interview on 9/11/24 at 8:45 A.M. Certified Nurses Aide (CNA) B said:
-The resident performed his/her own oral care.
-The resident had not reported the need for dental care
-He/She provided oral care supplies to the resident.
-He/She was not aware resident had broken teeth.

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F 790	Continued From page 50 -He/She would tell the charge nurse if a resident had complaints of teeth missing or pain. During an interview on 9/11/24 at 8:45 A.M. CNA C said: -The resident performed his/her own oral care. -The resident had not reported the need for dental care -He/She was not aware resident had broken teeth. -He/She would tell the charge nurse if a resident had complaints of teeth concerns or pain. During an interview on 9/11/24 at 9:20 A.M. the MDS nurse said: -He/She would look through the resident's chart to obtain data for the MDS. -He/She was not aware of the resident's broken teeth. During an interview on 9/11/24 at 11:47 A.M. the Director of Nursing (DON) said: -The SSD would obtain consent from resident on admission or as requested. -The SSD would fax consent to dental provider for scheduling. -He/She was not aware the resident had broken teeth.	F 790		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 51 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of Legionella (A genus of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease), and failed to provide documented assessments for such an outbreak with accepted response protocols, in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines. This deficient practice had the

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potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility failed to ensure all residents received a two-step tuberculosis (TB - a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) skin test upon admission to the facility for five sampled residents (Residents #15, #32, #36, #37, and #342) and failed to ensure the staff were following Enhanced Barrier Precautions (EBP-a strategy to reduce the spread of Multidrug-Resistant Organisms in Nursing Homes) protocol when providing wound care for two sampled residents with wounds (Residents #23 and #36) and failed to ensure staff knew which residents to use EBP on when providing cares for three sampled residents (Residents #23, #36 and #37) out of 13 sampled residents. The facility census was 40 residents with a licensed capacity for 60 residents at the time of the survey.

1. Observation on 9/9/24 between 10:04 A.M. and 11:07 A.M. during the initial facility Life Safety Code (LSC) kitchen inspection with the Dietary Manager (DM) showed there was a three-sink area, an ice machine, a low-heat chemical dish-washing machine, and a hand-washing sink.

Observation on 9/10/24 between 12:10 P.M. and 3:09 P.M. during the facility LSC walk-through inspection with the Administrator showed the following:
-The building was equipped with a full fire sprinkler system and had its incoming water supplied by the local water company.
-There was a piped fire sprinkler riser room (A dedicated space for fire protection equipment)

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which served the whole facility's system.
-There were at least 26 resident rooms with private or shared bathrooms and sinks.
-There were two Shower Rooms and two tankless water heaters.
-There was a Janitor's Closet with a mop hopper and a Breakroom and a Medication Room with sinks.
-There were two gender specific public restrooms and a Beauty Shop with a sink.

Review of the facility's maintenance folder entitled "Legionella Water Management Plan," last reviewed 1/10/23 and provided by the Administrator, showed the following:
-The first 31 pages of the binder had a watermark (the process of superimposing a logo or piece of text atop a document or image file) that read "Draft Version" behind the text in a diagonal manner.
-The water flow diagram on page 12 did not indicate areas of risk with the potential risk level for each.
-On page 15, with the heading "Control Measures: Cold Water Systems," the Upper and Lower Control Limits were marked as N/A (not applicable, not available, not assessed, or no answer) and that the water management plan expired on 01/01/0001.
-On page 16, with the heading "Control Measures: Hot Water Systems" it stated to check the water heaters monthly though there was no documentation for it, and that the water management plan expired on 01/01/0001.
-The page with the heading "Water Management Plan Program Team Meeting Minutes" did not list the facility name where indicated and was left entirely blank.
-There was a printed copy of an email from a

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state surveyor dated 1/28/19 with a link to the CDC's Legionella website page and a list of what assessments and toolkits were required to be completed and added to their program.
-There was a copy of the 36-page (pg.) CDC toolkit including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens, though the assessment included was left blank.
-There was an undated 2-pg. "Quarterly/Semi Annual/Annual Maintenance Schedule of Duties" which had a column of a year's twelve months broken down on the left hand side with an explanation of what actions should be done next to each month, but the right hand column of places for the dates completed was left blank.
-The undated 1-pg. "[Facility Name] Weekly Maintenance Schedule of Duties" had 44 blanks to be filled in that were not.
-The 15-pg. CDC "environmental Assessment Form" had numerous blanks to fill in and questions to be answered, but none were.
-There were no facility-specific testing protocols and acceptable ranges for control measures with a method of monitoring them at this facility, with interventions or action plans for when control limits were not met.
-There was no documentation of any "site log book" being maintained with any cleanings, sanitizings, descalings, and inspections mentioned.

During an interview on 9/11/24 at 11:11 A.M. the Administrator said the following:
-Their Director of Maintenance (DOM) would be responsible for implementing the Legionella program when they hired one.
-They were currently interviewing applicants for

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that position.
-He/She had been made aware of some of the basic requirements of the program through Quality Improvement Program for Missouri (QIPMO).
2. Review of the facility's Screening Residents for Tuberculosis policy dated August 2019 showed:
-No guidance for the facility to complete a two-step TB skin test for all residents with the first step to be administered prior to or upon admission to the facility.

Review of Resident #32's Face Sheet showed he/she was admitted to the facility on 1/18/23.

Review of the resident's medical records showed:
-No documentation of the resident's admission two step TB skin test.
-An Annual Statement for Tuberculin Reactors signs and symptoms screening form dated 7/23/24.

Review of Resident #37's Face Sheet showed he/she was admitted to the facility on 7/1/24.

Review of the resident's medical records showed:
-No documentation of the resident's admission two step TB skin test.
-An Annual Statement for Tuberculin Reactors signs and symptoms screening form dated 7/23/24.

Review of Resident #36's Face Sheet showed he/she was admitted to the facility on 6/17/24.

Review of the resident's medical records showed:
-No documentation of the resident's admission two step TB skin test.
-An Annual Statement for Tuberculin Reactors

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signs and symptoms screening form dated 7/23/24.

Review of Resident #15's Face Sheet showed he/she was admitted to the facility on 4/8/24.

Review of the resident's medical records showed:
-No documentation of the resident's admission two step TB skin test.
-An Annual Statement for Tuberculin Reactors signs and symptoms screening form dated 7/23/24.

Review of Resident #342's Face Sheet showed he/she was admitted to the facility on 8/27/24.

Review of the resident's medical records showed:
-The first step TB skin test was administered on 8/27/24.
-No date documented when the test was read. The results were negative with zero millimeters of induration.

During an interview on 9/10/24 at 12:21 P.M., the Assistant Director of Nursing (ADON) said:
-The nurse admitting the resident was responsible to ensure the first step TB skin test was administered.
-The test should be read in 48-72 hours.
-About two weeks later the second step should be administered by the nurse on duty.

During an interview on 9/11/24 at 12:24 P.M., the Director of Nursing (DON) said:
-Residents should have a two step TB test upon admission.
-The first step test was done by the admitting nurse then the nurse in charge would do the second step a couple weeks later.

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-The test should have a date it was read.
3. Review of the facility's policy, "Enhanced Barrier Precautions," dated 2024 showed:
-It was the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.
-EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.
-All staff receive training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions.
-The facility would have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff were aware of which residents required the use of EBP prior to providing high-contact care activities.
-Enhanced barrier precaution would have been initiated for residents with any of the following:
-Wounds (chronic wounds such as pressure ulcers, unhealed surgical wounds), and indwelling medical devices (feeding tubes).
-Make gowns and gloves immediately available near or outside of the resident's room.
-Personal Protective Equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) for enhanced barrier precautions was only necessary when performing high-contact care activities.
-The Infection Preventionist would have incorporated periodic monitoring and assessment of adherence to determine the need for additional training and education.
-Place a yellow sticker or magnet on the name plate of the resident's door to identify the need of

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EBP.

Review of #36's face sheet showed he/she was admitted to the facility on 6/17/24 with a diagnosis of open wound, left lower leg.

Review of the Admission Assessment Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 6/27/24 showed:
-He/She was cognitively intact.
-He/She had a surgical wound.

Review of the resident's Care Plan dated 7/1/24 showed:
-He/She had a wound on left shin related to a motor vehicle accident (MVA).
-Did not show EBP were to be utilized when providing cares, including wound care, for the resident.

Review of Nurses' Notes from 8/1/24 to 9/10/24 showed no documentation of EBP.

Review of the September 2024 Physician's Order Sheet (POS) showed the following orders:
-Extended (Enhanced) Barrier Precautions for wound, dated 8/12/24.

During an observation and interview on 9/9/24 at 9:12 A.M. the resident said:
-He/She had a wound on his/her left shin from a MVA.
-He/She had a wound 8 centimeters (cm) long by 3 cm wide that was oozing off-white colored pus.
-The nurse changes the dressing daily.
-The nurse wore gloves and a mask but did not think he/she wore a gown while changing the dressing.

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-There was nothing outside the resident's door which showed he/she was on EBP.
-There was no isolation cart in the resident's room.

Observation on 9/9/24 at 3:34 P.M. showed:
-There was no sign on the resident's door which indicated EBP was to have been used in the room.
-There was no isolation cart in the room.

Observation of wound care on 9/10/24 at 10:35 A.M. with Licensed Practical Nurse (LPN) A showed:
-He/She provided wound care for the resident without wearing a gown.
-There was no sign on the resident's door which indicated EBP was to have been used in the room.
-There was no isolation cart in the room.

During an interview on 9/10/24 at 10:43 A.M. LPN A said:
-He/She did not know when to use EBP.
-The resident came with the wound.
-They did not have a Wound Care Nurse each nurse does their own wound cares.
-The DON had provided EBP education for the staff.
-EBP meant keeping wounds dry.
-All you needed to wear was gloves if the wound was not airborne.
-He/She did not know if the resident should have had EBP.
-If the resident should have had EBP then there should have had a sign on the door "a yellow dot".
-There was no sign on the resident's door.
-The Infection Preventionist would have been responsible for ensuring there was a sign on the

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resident's door which would have shown staff EBP were needed.

During an interview on 9/10/24 at 10:53 A.M. Certified Nursing Assistant (CNA) D said:
-If a resident had an open wound staff should have wore full PPE while providing cares for the resident.
-There was no sign on the resident's door which indicated EBP was to have been used in the room.
-There was an isolation cart under the sink in the resident's room.
-The DON provided an inservice every month but could not remember if they had education on EBP.
-He/She was not sure what EBP was for or how to know which residents were on EBP.
-He/She was a" germaphobe" and always wore a gown, mask and gloves while giving providing cares for the resident such as changing them or providing a shower.
-The Wound Care Nurse would have been in charge of ensuring the staff knew which residents were on EBP.
-There should have been a sign on the door denoting the resident was on EBP.
-The resident did not have a sign on his/her door for EBP.

Review of Resident #23's face sheet showed he/she was admitted to the facility on 7/13/24 with the following diagnoses:
-Edema (fluid retention within the bodies tissue).
-Diabetes.

Review of the resident's Care Plan dated 8/1/24 showed:
-Did not show anything about EBP.

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-He/She had the potential for skin breakdown related to diabetes diagnosis.
-He/She had a wound on his/her right heel.

Review of the resident's Quarterly MDS, dated 8/20/24 showed:
-He/She was moderately cognitively impaired.
-He/She had Diabetes.
-He/She had a stage 3 pressure ulcer (a full-thickness skin loss that extends into deeper tissue and fat).
-He/She had an application of ointment/medication to his/her feet.
-He/She had dressings to his/her feet.

Review of September 2024 POS showed the following orders:
-Extended (Enhanced) Barrier Precaution for wound, dated 8/12/24.

Observation on 9/9/24 at 3:34 P.M. showed:
-There was no sign on the resident's door which indicated EBP was to have been used in the room.
-There was no isolation cart in the room.
-Resident #23 and Resident #36 were roommates.

Observation on 9/10/24 at 10:35 A.M. showed:
-There was no sign on the resident's door which indicated EBP was to have been used in the room.
-There was no isolation cart in the room.

Observation of wound care and interview on 9/10/24 at 2:59 P.M. LPN A showed:
-He/She provided wound care for the resident daily.
-The resident had a Stage 3 pressure ulcer on

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his/her right heel which measured 3 cm by 2 cm.
-He/She had not been using EBP on the resident and maybe should have.

During an interview on 9/10/24 at 3:20 P.M. the resident said:
-The nurse does wound care every day.
-He/She was not able to say if the staff wore full PPE while doing cares with him/her.

During an interview on 9/10/24 at 3:30 LPN B/Charge Nurse (CN) said:
-He/She had never heard of EBP.
-He/She had heard of isolation but did not know what the difference was.
-They (the staff) have completed education on the computer system.
-For regular isolation staff should wear gown, gloves, and a mask.
-If a resident was on isolation there should have been a little sign in the shape of a gown by the resident's name on the outside of the resident's room.
-Isolation residents would have had an isolation cart by their door.
-This resident did not have either.
-The Assistant Director of Nursing (ADON) was the facilities Infection Preventionist and was currently on vacation.

Review of Resident # 37's face sheet showed he/she was admitted to the facility on 7/1/24 with the following diagnosis:
-Gastronomy status (a surgical creation of a permanent opening into the stomach through the skin for the introduction of nourishment and fluids through a tube).

Review of the resident's Admission MDS dated

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7/1/24 showed:
-He/Shewas moderately cognitively impaired.
-He/She had a feeding tube.

Review of the resident's Care Plan dated 7/24/24 showed:
-He/She had an enteral feeding tube.
-Staff was to change the dressing around the stoma (insertion site) per physician's order.

Review of the September 2024 POS showed the following order:
-EBP due to feeding tube, dated 8/12/24.

Observation of tube feeding and interview on 9/11/24 at 10:49 A.M. with LPN B/CN showed:
-There was no sign on the resident's door which indicated EBP was to have been used in the room
-He/She said he/she had not known about EBP before the surveyor asked about it yesterday and had not worn EBP when working with the resident's feeding tube before today.
-He/She said there should have been a sign on the resident's door indicating EBP was to have been used as the resident had a feeding tube.

During an interview on 9/11/24 at 11:15 A.M. the resident said:
-He/She declined to be interviewed as he/she was too ill.

4. During an interview on 9/9/24 at 1:20 P.M. CNA A said:
-If a resident had a wound or any type of tubing you should wear a mask, gloves, and a gown (EBP).
-There should have been a sign on the door indicating EBP should be worn.
-He/She was not sure what the sign would have

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F 880	Continued From page 65 looked like. -There should have been an isolation cart outside the resident's room. -The (DON) or CN was responsible for ensuring staff knew which residents had EBP and ensuring staff also knew. -The facility had two meetings last month about EBP provided by the DON. -Staff did not know before today that they should have started wearing PPE for a resident on EBP. During an interview on 9/11/24 at 12:00 P.M. the DON said: -If a resident had a wound or any tubing such as a feeding tube or a foley (tube inserted into the bladder to drain urine) they should have been placed on EBP. -If a resident was on EBP there should have been a yellow gown on their name plate on the door. -There should have been an isolation cart outside their door. -Staff had received education by his/her self and the Administrator on EBP this last month. -He/She would have expected staff to wear a gown, gloves, and a mask when entering a resident's room that was on EBP.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		

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	265420	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE RIDGE CARE CENTER	100 WEST THOMAS AVENUE WAVERLY, MO 64096

(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 883	Continued From page 66	F 883		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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F 883	Continued From page 67	F 883		

immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure a resident's vaccination status and/or provide education regarding the pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus) vaccines upon admission to the facility for five sampled residents (Residents #15, #32, #36, #37, and #342) out of 12 sampled residents. The facility census was 40 residents.

Review of the facility's Pneumococcal Vaccine policy dated March 2022 showed:
-All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.
-Prior to or upon admission, residents are assessed for eligibility to receive pneumococcal vaccine series.
-Before receiving the vaccine, residents or their representatives are offered education regarding the benefits, risks, and potential side effects of the vaccine.

1. Review of Resident #32's Face Sheet showed he/she was admitted to the facility on 1/18/23.

Review of the resident's medical records showed:
-No documentation of the resident's pneumonia vaccination status.
-No documentation the resident was offered a pneumonia vaccination upon admission to the facility.

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F 883	Continued From page 68	F 883		

-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

2. Review of Resident #37's Face Sheet showed he/she was admitted to the facility on 7/1/24.

Review of the resident's medical records showed:
-No documentation of the resident's pneumonia vaccination status.
-No documentation the resident was offered a pneumonia vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

3. Review of Resident #36's Face Sheet showed he/she was admitted to the facility on 6/17/24.

Review of the resident's medical records showed:
-No documentation of the resident's pneumonia vaccination status.
-No documentation the resident was offered a pneumonia vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

4. Review of Resident #15's Face Sheet showed he/she was admitted to the facility on 4/8/24.

Review of the resident's medical records showed:
-No documentation of the resident's pneumonia vaccination status.

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F 883	Continued From page 69	F 883		

-No documentation the resident was offered a pneumonia vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

5. Review of Resident #342's Face Sheet showed he/she was admitted to the facility on 8/27/24.

Review of the resident's medical records showed:
-No documentation of the resident's pneumonia vaccination status.
-No documentation the resident was offered a pneumonia vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

6. During an interview on 9/10/24 at 12:21 P.M., the Assistant Director of Nursing (ADON) said:
-He/She was not sure who was responsible to ensure resident pneumonia education was provided upon admission to the facility.
-Vaccination status should be documented in the resident's medical record.

During an interview on 9/11/24 at 12:24 P.M., the Director of Nursing (DON) said:
-Pneumonia education and/or vaccination records should be obtained and entered in the resident's medical record upon admission.
-He/She was not sure if the residents were given education regarding pneumonia vaccines upon admission to the facility.

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F 887	Continued From page 70	F 887		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)	F 887		

§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:
(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the

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benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure provision and documentation of education regarding the benefits, risks and potential side effects associated with the COVID-19 (a new disease caused by a novel (new) coronavirus) vaccine for residents upon admission to the facility for five sampled residents (Residents #15, #32, #36, #37, and #342) out of 12 sampled residents and for five out of five sampled staff (Employees A, B, C, D, and E). The facility census was 40 residents.

Review of the Coronavirus Disease (COVID-19) Vaccination of Resident's policy dated May 2023 showed:
-Each resident is offered the COVID-19 vaccine unless the vaccine is medically contraindicated or the resident is fully vaccinated.

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F 887	Continued From page 72	F 887		

-The resident (or resident's representative) has the opportunity to accept or reject a COVID-19 vaccine.
-COVID-19 vaccine education, documentation, and reporting are overseen by the Infection Preventionist.
-Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. The information is provided in a format or language that is understood by the resident and/or representative.

Review of the Employee Infection and Vaccination Status policy dated August 2013 showed:
-Employees will be offered vaccinations per state or local agency policies/regulations.
-Employees will be provided with educational materials to make informed decisions for non-mandated vaccinations. If declined, a declination form will be completed and placed in the employee's health record.

1. Review of Resident #32's Face Sheet showed he/she was admitted to the facility on 1/18/23.

Review of the resident's medical records showed:
-No documentation of the resident's COVID vaccination status.
-No documentation the resident was offered a COVID vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

Review of Resident #37's Face Sheet showed he/she was admitted to the facility on 7/1/24.

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F 887	Continued From page 73	F 887		

Review of the resident's medical records showed:
-No documentation of the resident's COVID vaccination status.
-No documentation the resident was offered a COVID vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

Review of Resident #36's Face Sheet showed he/she was admitted to the facility on 6/17/24.

Review of the resident's medical records showed:
-No documentation of the resident's COVID vaccination status.
-No documentation the resident was offered a COVID vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

Review of Resident #15's Face Sheet showed he/she was admitted to the facility on 4/8/24.

Review of the resident's medical records showed:
-No documentation of the resident's COVID vaccination status.
-No documentation the resident was offered a COVID vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

Review of Resident #342's Face Sheet showed he/she was admitted to the facility on 8/27/24.

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F 887	Continued From page 74	F 887		

Review of the resident's medical records showed:
-No documentation of the resident's COVID vaccination status.
-No documentation the resident was offered a COVID vaccination upon admission to the facility.
-No documentation the resident was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon admission to the facility.

Review of Employee A's employment record showed:
-His/Her date of hire was 8/22/24.
-No documentation of the employee's COVID vaccination status.
-No documentation the employee was offered a COVID vaccination upon hire.
-No documentation the employee was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon hire.

Review of Employee B's employment record showed:
-His/Her date of hire was 5/18/24.
-No documentation of the employee's COVID vaccination status.
-No documentation the employee was offered a COVID vaccination upon hire.
-No documentation the employee was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon hire.

Review of Employee C's employment record showed:
His/Her date of hire was 12/14/23.
-No documentation of the employee's COVID

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F 887	Continued From page 75	F 887		

vaccination status.
-No documentation the employee was offered a COVID vaccination upon hire.
-No documentation the employee was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon hire.

Review of Employee D's employment record showed:
-His/Her date of hire was 3/8/24.
-No documentation of the employee's COVID vaccination status.
-No documentation the employee was offered a COVID vaccination upon hire.
-No documentation the employee was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon hire.

Review of Employee E's employment record showed:
-His/Her date of hire was 4/30/24.
-No documentation of the employee's COVID vaccination status.
-No documentation the employee was offered a COVID vaccination upon hire.
-No documentation the employee was provided education regarding the risks and benefits and potential side effects associated with the vaccine upon hire.

During an interview on 9/10/24 at 12:21 P.M., the Assistant Director of Nursing (ADON) said:
-He/She did not provide the education for COVID vaccines for the staff or residents.
-He/She thought the Director of Nursing (DON) did that.

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F 887	Continued From page 76 During an interview on 9/10/24 at 1:37 P.M., the Regional Nurse said: -He/She would not have COVID vaccination information for staff or residents. -He/She did not think the facility needed to get vaccination status or provide education to staff or residents regarding the COVID vaccination since the Public Health Emergency was over. During an interview on 9/11/24 at 12:24 P.M., the Director of Nursing (DON) said: -Staff should have vaccination records so they can be entered in their employee medical file. -Residents should have vaccination records so they can be entered in their medical record. -He/She was not sure if residents were given education regarding COVID vaccines, but he/she was sure if the staff were provided with the education. -He/She did not think it was still required.	F 887		

Missouri Department of Health and Senior Services

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A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: 1. Refer to F887.	A4031		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Refer to F755.	A4055		
A4071	19 CSR 30-85.042(62) Controlled Substance Reconcile/Record The facility must establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The system must enable the facility to determine that drug records are in order and that an account of all controlled drugs is	A4071		

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A4071	Continued From page 1 maintained and reconciled. II/III This regulation is not met as evidenced by: Class II* *"The higher classification merited due to the extent of the violation." 1. Refer to F755.	A4071		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Refer to F699. 2. Refer to F790. 3. Refer to F625.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as	A4086		

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A4086	Continued From page 2 amended. I/II This regulation is not met as evidenced by: Class II 1. Refer to F880. 2. Refer to F883. 3. Refer to F887.	A4086		
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: Class III 1. Refer to F679. 2. Refer to F680.	A4101		

PLAN OF CORRECTION

Provider Name:	Apple Ridge Care Center
Street Address, City, Zip:	100 West Thomas Avenue Waverly, MO. 64096
Date of Survey:	09/11/2024
Provider number:	1134157191

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Apple Ridge Care Center agrees with the allegations and citations listed on the statement of deficiencies. Apple Ridge Care Center maintains that the alleged deficient practices do not, individually and collectively, jeopardize the health and safety of the residents nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Apple Ridge Care Center written credible allegation of compliance. By submitting this plan of correction, Apple Ridge Care Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Apple Ridge Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding	
F623	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 13 had no negative outcome or adverse effects due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** SSD will be educated by administrator and/or disignee on the need to notify Ombudsman monthly of all transfers/discharges and to provide resident with copies of notices.	**10/18/2024**

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator to review transfer/discharge practice within facility during daily meeting 5x/week x 4 weeks then weekly x 3, then monthly x 2. Education to be provided when deficient practice or education needs are noted. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F625	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #23 had no adverse or negative outcomes related to this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DON and/or ADON will in-service all nursing staff regarding the need to provide and fully complete regulatory notice to residents and/or family members prior to transfer or discharge from facility, this will be completed by compliance date. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections**	**10/18/24**

	achieved are 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 ADON will review daily in morning meeting 3-5 times weekly times 3 weeks, then weekly x 3 and monthly x 3 and ongoing to validate compliance. DON and/or ADON to report compliance to the QAA committee to review monthly x 3 months then, QAA committee to review monthly x 3 months, then quarterly x 3, then augment review process as necessary to maintain compliance.	
F636	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #32 had no negative outcomes or adverse effects from this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The regional MDS coordinator will in-service facility MDS coordinator regarding regulatory time frames to complete all MDS. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** Regional Nurse and/or Regional MDS will monitor timely completions of MDS twice weekly x 4 weeks, then weekly x 4 weeks, reeducation will be provided at the time of need identified. Audit results will be presented to QAA committee monthly x 3 months, then QAA committee to review monthly x 3	**10/18/24**

	months, then quarterly x 3 months, then augment review process as necessary to maintain compliance.	
F638	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #32 had no negative outcomes or adverse effects from this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The regional MDS coordinator and/or regional nurse manager will in-service facility MDS coordinator regarding regulatory time frames to complete all MDS by the date of compliance. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** Regional nurse and/or Regional MDS will monitor timely completions of MDS twice weekly x 4 weeks, then weekly x 4 weeks, reeducation will be provided at the time of need identified. QAA committee to review monthly x 3 months, then quarterly x 3 months then augment review process as necessary to maintain compliance.	**10/18/24**
F641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	**10/18/2024**

	Resident #37 had no negative outcomes or adverse effects from this alleged deficient practice and MDS will be corrected by the compliance date. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The regional MDS coordinator and/or regional nurse manager will in-service facility MDS coordinator regarding regulatory guidelines for accuracy of all assessments by the compliance date. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** Regional Nurse and/or Regional MDS will monitor accuracy of all completed MDS twice weekly x 4 weeks, then weekly x 4 weeks, reeducation will be provided at the time of need identified and report findings to the QAA committee monthly, then QAA committee to review monthly x 3 months, then quarterly x 3 months then augment review process as necessary to maintain compliance.	
F656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 4 will be assessed, and care planned for communication in Spanish and possible need for translation on occasion. Resident # 37 will be assessed, and care planned for dental care needs and possible adverse effects by the compliance date. **How will you identify other residents having the potential to be affected by the same deficient practice?**	**10/18/24**

	All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** Regional nurse and/or DON to monitor each new admission for the completion of PHQ-9 and the need for trauma informed care once weekly times 4 weeks, then biweekly x 4 weeks then monthly, reporting findings to the QAA committee then, QAA committee to review monthly times 3 months, then quarterly times three months then augment review process as necessary to maintain compliance.	
F679	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 18, 23, and 36 will be provided with activities based on resident preference, care planned and documented, this will be completed by the compliance date. These residents did not experience any negative outcomes from the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Activity director will be in-serviced by Administrator and/or designee to plan and offer activities that meet the interest of and support the physical, mental and psychosocial well-being of each resident, male and female, daily to include group and one	**10/18/24**

	to one activity and the need for individual preferences then place calendar in common area and each resident room. The Activity director will complete individual activity assessments for all residents and place in medical record by the compliance date. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** The Administrator and/or designee will validate activities based on resident needs, documentation of activity participation and attendance 2-3 x weekly x 3 weeks, weekly x3 weeks and monthly ongoing to validate compliance. The activity director will report to QAA committee on new activities and groups for the facility monthly, then QAA committee to review monthly times 3 months, then quarterly times three months then augment review process as necessary to maintain compliance.	
F680	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents experienced negative outcomes from this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Activity Director will be enrolled in Activity Directors course from Missouri Healthcare Association by the compliance date. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for**	**10/18/24**

	its effectiveness. The plan of correction is integrated into the quality assurance system. The administrator and/or designee will review and approve monthly calendars, and attendance logs monthly x 4 months and report findings to the QAA committee monthly then, QAA committee to review monthly x 3 months, then quarterly x 3 months and then augment the review process as necessary to maintain compliance.	
F699	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 4 will be assessed, and care planned for trauma informed care by the compliance date. Resident # 37 will be assessed, and care planned for trauma informed care by the compliance date. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** SSD to be reeducated related to performing trauma assessments and care planning upon admission and formulating an individual plan of care by the compliance date. Facility staff to be in-serviced on trauma informed care by the compliance date. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** Regional nurse and/or DON to monitor each new admission for the completion of PHQ-9 and the need for trauma informed care once weekly x 4 weeks, then biweekly x 4 weeks then monthly, reporting findings to the QAA committee, then QAA committee to review monthly x 3 months, then quarterly x 3 months then	**10/18/24**

	augment the review process as necessary to maintain compliance.	
F732	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents experienced any adverse effects of this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All registered, and licensed staff will be in-serviced, on the need to display accurate posted daily hours per discipline on each unit of the facility daily, by the DON or designee. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** The DON and/or designee will validate current and accurate daily hours are posted 3 x weekly x 3 weeks, then weekly x 4 weeks then report findings to the QAA committee monthly, then the QAA committee to review monthly x 3 months, then quarterly x 3 months and then augment the review process as necessary to maintain compliance.	**10/18/24**
F755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #8, 23, 19, and 36 experienced no negative outcome from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice?**	**10/18/24**

	All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DON, ADON and/or designee will in-service all licensed, registered and certified nursing staff who have access to administer narcotics on signing out, documentation of Prn doses and counting narcotics at the beginning and end of their shifts.** DON, ADON and/or designees to monitor narcotic administration 3 x weekly x 4 weeks then weekly x 3 weeks then monthly and report findings and education provided to QAA committee monthly then, QAA committee to then review monthly x 3 months, then quarterly x 3 months and then augment the review process as necessary to maintain compliance.	
F790	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 37 has dental appointment scheduled and will receive dental evaluation by the date of compliance. **How you will identify other residents having the potential to be affected by the same deficient practice.** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Inservice will be provided to nursing staff and SSD by Administrator and/or DON of the process in place to notify SSD of dental needs upon admission and per request of residents, then SSD to make the appointment for resident for a dental evaluation and treatment if necessary. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.**	**10/18/24**

	The administrator and/or designee will meet with SSD weekly x 4 weeks to review resident referral care needs and completion of tasks then biweekly x 2 weeks then monthly. Reeducation will be provided as identified. Then SSD will report to QAA committee monthly and the QAA committee to review monthly x 3 months, then quarterly x 3 months then augment review process as necessary to maintain compliance.	
F880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents experienced and negative outcomes of this alleged deficient practice How you will identify other residents having the potential to be affected by the same deficient practice.** . All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The facility will have a legionella water program in place with maintenance checks for standing water. All nursing staff that perform wound care will be educated regarding the need to utilize gowns with wound care and all residents have been assessed for tuberculosis by the compliance date. **How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** The administrator and/or designee will provide in-service to maintenance personnel regarding maintaining scheduled checks in facility for the water system and review weekly x 3 weeks then report findings QAA committee monthly then, QAA committee to review monthly x 3 months, then quarterly x 3 months then augment review process as necessary to maintain compliance.	**10/18/24**
F883	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 15, 32, 36, 37 and 342 will have updated vaccination status of flu, PNA by the date of compliance.	**10/18/24**

	How will you identify other residents having the potential to be affected by the same deficient practice? All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The SSD will be in-serviced by DON and/or ADON and/or designee by the date of compliance to collect all information and immunization documents upon admission. **How the facility plans to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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.** SSD will audit each new admission for all required immunization documents 2x weekly for 3 weeks, then weekly x 3 weeks, report findings to QAA committee monthly then, QAA committee to review monthly x 3 months, then quarterly x 3 months then augment review process as necessary to maintain compliance.	
F887	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 15, 32, 36, 37 and 342 will have updated vaccination status of TB and COVID by the date of compliance. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents were at risk of being affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The SSD will be in-serviced by DON and/or ADON and/or designee by the date of compliance to collect all information and immunization documents upon admission.	**10/18/24**

	How will the facility plan to monitor its performance to make sure that solutions are sustained? The facility must develop a plan for ensuring that corrections achieved are 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. The DON and/or ADON and/or designee will monitor newly admitted residents for TBST administration 3-5 times a week x 3 weeks, then weekly x 3 weeks, reporting findings to QAA committee then, QAA committee review monthly times 3 months, then quarterly times three months then augment review process as necessary to maintain compliance	
A4031	Refer to F887	**10/18/24**
A4055	Refer to F755	**10/18/24**
A4071	Refer to F755	**10/18/24**
A4075	Refer to F699, F790, F625	**10/18/24**
A4086	Refer to F887, F880, F883	**10/18/24**
A4101	Refer to F679, F680.	**10/18/24**

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.