STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265249	A. BUILDING _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIES MANOR	174 BALLPARK ROAD VIENNA, MO 65582

(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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to review and revise care plan for one resident (Resident #3) out of one sampled resident with interventions for cellulitis and for one resident (Resident #47) out of one sampled resident with medication noncompliance. The facility census was 62.	F 657		

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

Admin 6/7/24

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 657	Continued From page 1 1. Review of the facility's policies showed staff did not provide a policy for care plans. 2. Review of the facility's Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, 3.0 and Care Planning Policy, undated, showed: -The Comprehensive Care Plan will also be individualized to each resident; -Comprehensive Care Plan will be updated when a change of condition is warranted; -Included in the Comprehensive Care Plan will be the resident's right to refuse treatment, any specialized services the facility will provide, the resident's goals for admission, desired outcomes, and discharge plans; -The Comprehensive Care Plan will be revised on an ongoing basis to reflect changes in the resident and/or changes in the care the resident is receiving including interventions, measurable objectives, goals, and care instructions; -The Comprehensive Care Plan shall be adhered to in caring for the resident and outline the resident's care needs; -All staff will have access to the comprehensive care plan and know that is it located in the resident's chart under the care plan tab. 3. Review of Resident #3's quarterly MDS, dated 03/03/24, showed staff assessed the resident as: -Severe cognitive impairment; -Diagnoses of peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes, and dementia -Dependent for activities of daily living (ADL)s and putting on/taking off footwear;	F 657		

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F 657	Continued From page 2 -Application of dressings to feet. Review of the resident's care plan, dated 12/18/23, showed the care plan did not contain direction or interventions for the use of a compressive boot. Review of the resident's Physician Order Sheet (POS), dated 05/2024, showed an order to check legs daily, apply compression boot to lower left extremity and bilateral, change every three days for cellulitis. Observation on 05/20/24 at 12:30 P.M. showed the resident in his/her wheelchair in the dining room with compression boot to lower left extremity. Observation on 05/21/24 at 8:30 A.M., showed the resident in his/her wheelchair in the hallway by the nurses station with compression boot to lower left extremity . Observation on 05/22/24 at 3:20 P.M., showed the resident in his/her wheelchair in their room with compression boot to lower left extremity. Observation on 05/23/24 at 12:15 P.M., showed the resident in his/her wheelchair in the dining room with compression boot to lower left extremity. 4. Review of Resident #47's quarterly MDS, dated 03/20/24, showed staff assessed the resident as: -Cognitively intact; -Does not reject care; -Non-traumatic brain injury.	F 657		

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F 657	Continued From page 3	F 657		

Review of the resident's nurses note, dated 12/14/23 at 1:23 P.M., showed staff documented a nurse witnessed the resident attempted to conceal his/her pills when staff administered his/her medication to the resident.

Review of the resident's nurses note, dated 03/13/24 at 1:48 P.M., showed staff documented to monitor the resident closely with medications as he/she has been found to conseal and store medications.

Review of the resident's care plan, date 03/08/24, showed the care plan did not contain direction for staff in regard to the resident's noncompliant behavior to conceal and store his/her medications in his/her room.

During an interview on 05/23/24 at 9:30 A.M., LPN E said the resident has had this behavior before, hiding pills instead of taking them, he/she believes they are poison. The doctor is aware, but he/she is not aware of any specific intervention in place other then watching the resident take their medications.

During an interview on 05/23/24 at 10:15 A.M. LPN H said resident specific information is what is expected to be on the residents care plan. LPN H said when staff administer medication they are expected to watch residents take them before they walk away.

During an interview on 05/23/24 at 10:19 A.M. MDS Coordinator Registered Nurse said he/she is responsible for MDS and Care plans. The MDS Coordinator said any treatments or interventions should be on the care plan. If they are not on the care plan, it is because he/she was not made

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F 657	Continued From page 4 aware of it. During an interview on 05/23/24 at 4:58 P.M., the Director of Nursing (DON) said behaviors such as a medication refusals or hoarding pills should be care planned with interventions. The DON said any resident specific treatments and interventions are expected to be on a care plan. During an interview on 05/23/24 at 4:59 P.M. the Administrator said staff are expected to watch medications being given to each resident. The Administrator said she would expect medication issues or concerns, treatment and interventions to be on a residents care plan.	F 657		
F 658 SS=F	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to follow professional standards when staff prepared 40 medication cups with medications prior to the timed medication pass and performed resident blood sugar tests with expired test strips for four residents (Resident #14, #58, #61, and #62) out of four sampled residents. The facility census was 62. 1. Review of the facility's policy titled, "Medication Administration Guidelines", dated 03/2015, showed facility staff are directed as follows:	F 658		

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F 658	Continued From page 5 -The complete act of administration entails removing an individual dose from a previously dispensed, properly labels container, verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information; -Medications may not be prepared in advance and must be administered within one hour of preparation; -The same person preparing the doses for administration must administer the medications. 2. Observation on 05/20/24 at 9:08 A.M., showed the east side medication cart contained the following: -One medication cup labeled with a first name contained one pill; -One medication cup labeled with a first name contained half of a pill; -One medication cup labeled with a first name contained two pills; -Two medication cups labeled with a illegible name contained one pill; -Two medication cup labeled with a first name contained two pill; -One medication cup labeled with a first name contained 11 loose pills; -One medication cup labeled with a first name contained seven loose pills; -One medication cup labeled with a first name contained six loose pills; -One medication cup labeled with a first name contained 12 loose pills. During interview on 05/20/24 at 9:10 A.M., Certified Medication Technition (CMT) C said he/she only pre-pops medications for his/herself.	F 658		

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F 658	Continued From page 6 He/She said that at least six of the pre-popped medications are narcotics. He/She said he/she pre-popped the narcotics this morning at 6:45 A.M. because the facility does not have enough cards for both medication carts. He/She said that is why he/she pre-pops the narcotics early. 3. Observation on 05/20/24 at 11:51 A.M., showed the east side medication cart drawer contained seven medication cups with various pills inside labeled with only first names. At this time, CMT C said he/she will give the medications in a bit. He/She said, "actually I will go give them now." Observation showed CMT C went and delivered the pre-popped medications to the residents. 4. Observation on 05/22/24 at 8:55 A.M., east side medication cart contained the following: -One medication cup labeled with a first name contained four various pills; -One medication cup labeled with a first name contained eight various pills; -One medication cup labeled with a first name contained six various pills. During interview on 05/22/24 at 9:00 A.M., CMT C said he/she normally does not pre-pop medications. CMT C said risk of pre-popping medications and leaving them in the medication cart could be if cart was left unlocked another resident could get inside cart and take medications. He/She said if something was to happen and he/she had to leave, he/she would make sure the medications were administered before leaving. Is the CMT aware of the faciity policy of pre-popping medication?	F 658		

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F 658	Continued From page 7 5. Observation on 05/22/24 at 11:06 A.M., showed the memory care unit medication cart top drawer contained 27 medication cups labeled with first names only contained various medications inside each medication cup, stacked inside each other in three different rows. During interview on 05/22/24 at 11:10 A.M., Licensed Practical Nurse (LPN) D said one row of pre-popped medications were for the noon medication pass, one row was for 2 P.M. medication pass, and the other row were for the supper medication pass. He/She said the pharmacist said it is okay to pre-pop pills as long as he/she is the one giving the medications. The LPN said he/she would not be able to identify pills without looking at medication cards. During interview on 05/22/24 at 3:20 P.M., LPN D said he/she was not aware of what the policy said about pre-popping medications. LPN D said he/she spoke with the Director of Nursing (DON) and the DON said it is okay to pre-pop medications if he/she is the one administering them. During interview on 05/23/24 at 4:41 P.M., the Director of Nursing (DON) said per the medication technician instructors, they now allow pre-popping of medications. He/She said it is not acceptable to pre-pop medications more then one hour before giving medications. He/She said there are specific times medication are given during the day. He/She said he/she was not aware the facility policy stated pre-popping medication was not allowed. During interview on 05/23/24 at 4:45 P.M., the administrator said the only time pre-popping	F 658		

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F 658	Continued From page 8	F 658		

medication is allowed is if the person administering them can identify all the pills in the cup. He/She was not aware the policy said medication can not be pre-popped.

6. Review of the facility's policies showed staff did not provide a glucose strip policy.

7. Observation on 05/20/24 at 11:26 A.M., showed LPN E used a blood sugar test strip with an expiration date of 12/29/23 to obtain Resident #58's blood sugar.

Observation on 05/20/24 at 11:41 A.M., showed LPN E used a blood sugar test strip with an expiration date of 12/29/23 to obtain Resident #14's blood sugar.

Observation on 05/20/24 at 11:59 A.M., showed LPN E used a blood sugar test strip with an expiration date of 12/29/23 to obtain Resident #61's blood sugar.

Observation on 05/20/24 at 12:04 A.M., showed LPN E used a blood sugar test strip with an expiration date of 12/29/23 to obtain Resident #62's blood sugar.

During an interview on 05/20/24 at 12:06 P.M., LPN E said he/she did not know if the blood sugar test strips needed to be labeled with an open date, but he/she said it would probably be a good idea to have. He/She said he/she did not realize the test strips were expired when he/she used them for the residents. He/She said since they were expired, they were probably not very accurate. He/She said the nurse or CMT who is administering insulin is in charge of checking the

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F 658	Continued From page 9 insulin cart and the insulins as they are given. During an interview on 05/23/24 at 4:46 P.M., the DON said the nurse or CMT who is responsible for medication pass is also responsible for checking to ensure blood sugar test strips are not expired and should be check on every shift. He/She said it is his/her expectation staff would re-test the residents blood sugar if they discovered the test strips were expired to ensure its accuracy. During an interview on 05/23/24 at 4:48 P.M., the administrator said it is his/her expectation nurses or CMT's who are checking blood sugars are also looking at expiration dates of the glucose strips. He/She said using expired test strips runs the risk of not getting accurate readings. He/She said if a staff member realizes the testing strips are expired, they should discard the old ones and re-check the blood sugars with new testing strips.	F 658		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		

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F 761	Continued From page 10 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to store and label medications in a safe and effective manner when staff failed to date the opened multi-dose medication bottles, insulin vials, and medications were left unattended on top of one medication cart. The facility census was 62. 1. Review of the facility's Storage of Medication policy, undated, shows facility staff were directed as follows: -All medications for residents must be stored at or near the nurse's station in a locked medicine room or one or more locked mobile medication carts; -All mobile medication carts must be under visual control of the staff at all times when not stored safely and securely; -No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing pharmacy or destroyed in accordance with established guidelines; -Drugs must be stored in an orderly manner in cabinets, drawers, or carts.	F 761		

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F 761	Continued From page 11 2. Observation on 05/20/24 at 9:08 A.M., showed the east side medication cart contained: -One opened bottle of magnesium oxide, undated; -One opened bottle of vitamin D, undated; -One opened bottle of vitamin B-1, undated; -One opened bottle of one-a-day multi vitamin, undated; -One opened bottle of saline nasal spray, undated; -One opened bottle of latanoprost oph (used to treat glaucoma) 0.005%, undated; -One opened bottle of fluticasone (treats allergy symptoms) nasal spray, undated. During an interview on 05/22/24 at 3:30 P.M., Certified Medication Tech (CMT) C said when opening bottles of medications, he/she should always put the open date on the bottle. He/She said if there is no open date then he/she is not sure how long is has been opened and the medication may not be effective anymore. He/She said it is the person opening the bottles responsibility to put the open date on bottle when it is opened. During an interview on 05/23/24 at 2:29 P.M., Licensed Practical Nurse (LPN) E said multidose medication bottles should always be labeled with an opened date. He/She said if there is no opened date then he/she would not know how long the bottle has been open and the medication may not be effective if it has been open to long. He/She said the medication should be disposed of if no open date and open a new bottle. He/She said it is the nurse or CMT's responsibility to label with open date when opening the bottle.	F 761		

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F 761	Continued From page 12 During an interview on 05/23/24 at 4:41 P.M., the Director of Nursing (DON) said multidose medication bottles need to be labeled with an opened date when bottle is opened. He/She said if there is no open date on medication then the medication may be old and not effective. He/She said it is the CMT's and Nurse's responsibility to insure multi dose medication have open dates on them each shift. During an interview on 05/23/24 at 4:45 P.M., the administrator said all multidose medications should be dated when opened otherwise the medication may be expired and not effective anymore. He/She said the staff opening the bottle should label with open date. 3. Review of the facility's Insulin and Injectable Diabetic Medication Chart, undated, showed staff is to follow the insulin expiration dates after opening: -Humolog (treat diabetes) Kwik Pen 28 days; -Humulin R (treat diabetes) 3 milliliter (ml) vial 31 days; -Lantus (treat diabetes) SoloStar pen 28 days; -Levemir (treat diabetes) Flex touch pen 42 days; -Novolog (treat diabetes) Flex pen 28 days. 4. Observation on 05/20/24 at 9:12 A.M., showed the insulin cart contained: -Three opened Levemir Flex touch pens, undated; -Two opened Lantus SoloStar pens, undated; -One opened Humalog Kwik pen, undated; -One opened 3 ml vial of Humlin R labeled with	F 761		

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F 761	Continued From page 13 an open date of 4/16/24; -One opened Novolog flex pen labeled with an open date of opened 3/27/24. Observation on 05/21/24 at 8:52 A.M., showed the insulin cart contained one opened Novolog flex pen with an open date of 4/19/24. During an interview on 05/20/24 at 9:24 A.M., LPN E said insulin should be labeled when opened. He/She said the expiration date of insulins vary. He/She said there is a cheat sheet they use to keep track of insulin expiration dates once opened. He/She said it is the responsibility of the DON and their MDS coordinator to check medication carts and medication storage rooms. He/She said he/she believes they check the carts and storage rooms weekly. During an interview on 05/21/24 at 8:54 A.M., LPN E said insulin just got switched to one cart. He/She said opened dates and expiration dates should be checked at change of shift. He/She said he/she missed the expired and not dated medications the previous day during his/her checks. He/She said he/she must have missed that insulin pen the day before and today. During an interview on 05/23/24 at 4:46 P.M., the DON said the nurse or CMT who is responsible for the medication pass is also responsible for checking to ensure medications are labeled with opened dates. He/She said the expectation is it is done per shift. He/She said insulin pens are good for a limited time from the date of open. He/She said there is a list in each medication book and pharmacy also provided an insulin chart that gives the specific expiration dates from time of open.	F 761		

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F 761	Continued From page 14 During an interview on 05/23/24 at 4:48 P.M., the administrator said it is his/her expectation that insulin pens are dated upon opening. He/She said the nurses or CMT's who are giving the insulins on the cart are responsible for maintaining the cart and making sure they are labeled. He/She said not labeling insulin pens runs the risk of giving an insulin that won't be effective. 5. Observation on 05/20/24 at 8:56 A.M. showed the west side medication cart, left unattended with a medication on top which contained: -One bottle of Senna-Plus 50 mg; -One bottle of Tylenol 325 mg; -One Fluticasone Propionate nasal spray; -One tube of Betamethasone Valerate cream (treat a variety of skin conditions). During an interview on 05/20/24 at 9:01 A.M., CMT C said he/she was not sure why medications were on left unattended on top of the medication cart. He/She said the cart was last used by the night shift and the medications were night time medications. He/She said medications should not be left unattended on top of medication carts. During an interview on 05/23/24 at 3:43 P.M., LPN H said it is his/her expectation medications not be left unattended on top of medication carts. He/She said it is very important medications are locked up and not accessible to residents. He/She said if he/she walks away he/she would lock it in his/her medication cart. he/she said if he/she found medications unattended on top of medication carts he/she would put it away and he/she would not leave it out.	F 761		

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F 761	Continued From page 15 During an interview on 05/23/24 at 4:46 P.M., the DON said it is his/her expectation medications be in the medication storage room or a locked medication cart. He/She said he/she expects staff who find medications left out and unattended, to store the medications locked and away. He/She said he/she was unaware medications were left out and unattended on top of medication carts. During an interview on 05/23/24 at 4:48 P.M., the administrator said it is his/her expectation medications be kept in a locked medication cart or medication room. He/She said there is a risk a resident or visitor could get into the medications. He/She was not aware there were medications left out and unattended on top of medication carts.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by	F 801		

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F 801	Continued From page 16 a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or	F 801		

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F 801	Continued From page 17 D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 62. 1. Review of the facility's Dining Services Supervision policy, dated May 2015, showed "Overall supervisory responsibility of the Dining Services Department shall be assigned to a full-time qualified Dining Services Manager. This Dining Services Manager, if not qualified, functions with frequent regularly scheduled	F 801		

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F 801	Continued From page 18	F 801		

consultation from a person so qualified." Review showed the policy did not contain information related to the education and experience requirements for the dining services manager.

Review of the facility's Dining Services Manager policy, dated May 2015, showed the policy listed the minimum qualifications for the Dining Services Manager as:

-High school diploma or GED equivalent;
-Two years of experience in a supervisory capacity of a hospital, skilled nursing care facility or other medical facility;
-Certified Dietary Manager if required by state regulations.

Review of the dietary manager's (DM) personnel records, showed a hire date of 03/26/24. Review showed the records did not contain documentation of at least two years prior dietary manager experience in a nursing facility and certification or other education required for the director of nutritional services position.

During an interview on 05/20/24 at 9:05 A.M., the DM said he/she became the DM in March 2024 and had previously worked at the facility as the dietary manager from 2012 to 2014. The DM said prior to 2012 he/she was a certified nursing assistant and he/she did not have a degree, certification or education related to food service management. The DM said the administrator told him/her the facility would enroll him/her in a certification class after his/her 90-day probationary period and he/she did not know he/she needed to meet the qualifications upon hire. The DM said the facility has a part-time consultant registered dietician who comes to the

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F 801	Continued From page 19 facility once a month and they did not have any certified or clinically qualified nutrition staff employed full-time. During an interview on 05/21/24 at 3:05 PM, the administrator said he/she hired the DM in March 2024. The administrator said the DM had previously been the dietary manager, but the DM did not have a degree, certification or the required education required to be the director of nutritional services. The administrator said the facility policy is to wait until 90 days after hire to enroll the DM into a certification course and he/she did not know that the DM needed to meet the requirements upon hire. The administrator said the facility has a part-time registered dietician consultant and they did not have any certified or clinically qualified nutrition staff employed full-time.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 20 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff to wear facial hair restraints to protect food and food contact surfaces from potential contamination. The facility staff failed to allow sanitized dishes to air dry prior to stacking in storage and use to prevent the growth of food-borne pathogens. These failures have the potential to affect all residents. The facility census was 62. 1. Review of the facility's Dietary Personnel Guidelines policy, dated May 2015, showed the policy directed hairnets or bouffant disposable caps should be worn at all times and should cover the entire head of hair. Review showed the policy did not contain information related to facial hair restraints. Review of a sign posted on the back of the door to the mechanical dishwashing station, undated, showed "Food employees shall wear hair restraints such as hats, hair coverings or nets and beard restraints that cover hair exceeding ¼ of 1 inch and are designed to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles. Food employees shall also wear clothing that covers excessive body hair following the above stipulations." Observation on 05/20/24 at 10:01 A.M., showed Cook A had facial hair. Observation showed the cook prepared potatoes and ham and beans for	F 812		

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F 812	Continued From page 21 service to residents at the lunch meal without use of a facial hair restraint. Observations on 05/20/24 from 10:50 A.M. to 11:06 A.M., showed Cook A continued to prepare food items, including ham and beans, potatoes and rice, for service to residents at the lunch meal without the use of a facial hair restraint. During an interview on 05/20/24 at 11:14 A.M. Cook A said he/she had worked at the facility for about three years and had always been told that if his/her facial hair was a quarter inch long or less, he/she did not need to wear a facial hair restraint. During an interview on 05/20/24 at 11:15 A.M., the dietary manager (DM) said the hair restraints sign was posted on the door in the kitchen when he/she became the manager in March 2024. The DM said he/she had questioned the cook about wearing a facial hair restraint and the cook said that he/she was told that if it was a quarter inch long or less then he/she did not need to wear one. The DM said based on the sign posted and the information from the cook, he/she did think the staff with facial hair needed to wear facial hair restraints. During an interview on 05/21/24 at 2:58 P.M., the administrator said staff should put on hair restraints, including facial hair restraints, when they enter the kitchen. The administrator said he/she did not know about the sign posted in the kitchen that directed for staff to only wear facial hair restraints if their facial hair was a quarter inch long or less. The administrator said the information on the sign was not correct and he/she did not know the DM did not know dietary staff with facial hair of any length should wear a	F 812		

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F 812	Continued From page 22 facial hair restraint. 2. Review of the facility's Dishwashing policy, dated April 2011, showed the policy directed staff to allow cleansed dishes to thoroughly dry before storage. Observation on 05/20/24 at 9:31 A.M., showed four metal food preparation/service pans stacked together wet on the shelf by three compartment sink and eight plastic food storage containers stacked together wet on the shelf beneath the preparation counter. During an interview on 05/20/24 at 9:38 A.M., the DM said staff should allow dishes to air dry before they are put away and staff had been trained on this requirement. Observation on 05/20/24 at 9:58 A.M., showed 28 plastic food service trays stacked together wet in the upright position on the counter by the plate heater. Observation on 05/20/24, during the lunch meal service which began at 11:20 A.M., showed staff used the wet stacked trays to serve food to the residents. Observation on 05/20/24 at 1:13 P.M., showed dietary aide (DA) B removed sanitized trays from the mechanical dishwasher, stacked them together while wet and put them in storage. During an interview on 05/20/24 at 1:14 P.M., the DA said he/she did not know the dishes needed to be dry before he/she put them away. During an interview on 05/21/24 at 3:01 P.M., the	F 812		

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F 812	Continued From page 23 administrator said staff should allow dishes to air dry before they are put away and staff should be trained on this requirement. The administrator said the dietary manager is responsible to monitor dish storage and he/she believed that the DM had trained the staff to allow dishes to air dry.	F 812		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to ensure call lights were within reach for three residents (Resident #18, #44, and #51) out of 16 sampled residents. The facility census was 62. 1. Review of facility's Call Light, Use of policy, undated, showed the following: -Respond promptly to resident's call for assistance; -When providing care to residents, be sure to position the call light conveniently for the resident's use. -Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. -Check the call light system at regular intervals.	F 919		

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F 919	Continued From page 24 2. Review of Resident #18's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated 02/27/24, showed staff assessed the resident as: -Moderate cognitive impairment; -Diagnoses: Dementia, and Traumatic brain injury (TBI); -Dependent assistance needed for toilet transfers, tub/shower transfers, and personal hygiene. Review of the resident's care plan, last reviewed on 02/23/24, showed staff are directed to keep call light in reach. Observation on 05/21/24 at 1:12 P.M., showed the resident in his/her in his/her broda chair (a type of wheelchair that gives patients the ability to tilt and recline) with the call light on the bed, not within reach. Observation on 05/21/24 2:45 P.M., showed an unidentified staff member pushed the resident to his/her room. The staff member left the resident in the broda chair in front of the TV, with the call light on the bed behind the resident, not within reach. 3. Review of Resident #44's Annual MDS, dated 03/02/24, showed staff assessed the resident as: -Cognition not assessed; -Diagnoses of dementia and TBI; -Total dependent for activities of daily living (ADL)s and transfers. Review of the resident's care plan, last reviewed	F 919		

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F 919	Continued From page 25 on 03/08/24, showed the facility are directed to keep call light within reach. Observation on 05/21/24 1:23 P.M. and 2:48 P.M., showed the resident in his/her room in his/her broda chair in front of the TV with the call light on the bed behind the resident, not within reach. Observation on 05/22/24 3:02 P.M., showed the resident in his/her room in his/her broda chair in front of the TV with the call light on the bed behind the resident, not within reach. Observation on 05/23/24 9:57 A,M, showed the resident in his/her room in his/her broda chair in front of the TV with the call light on the bed behind the resident, not within reach. 4. Review of Resident #51's quarterly MDS, dated 05/08/24, showed staff assessed the resident as: -Severe cognitive impairment; -Total dependent for activities of daily living (ADL)s and transfers. Review of the resident's care plan, last reviewed on 05/03/24, showed the facility are directed to keep call light within reach. Observation on 05/21/24 at 1:32 P.M., showed the resident in his/her bed with the call light draped over the bedside table next to the recliner not within reach. Observation on 05/22/24 at 9:00 A.M., showed the resident in his/her bed with the call light on the arm of the recliner not within reach.	F 919		

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F 919	Continued From page 26 5. During an interview on 05/23/24 at 3:15 P.M., Certified Nurse Aide (CNA) F and CNA G said resident call lights are to be in reach of residents at all times, and should be placed back into the residents reach after care is provided. CNA G said they make rounds to check for call light placement. During an interview on 05/23/24 at 4:37 P.M., Licensed Practical Nurse (LPN) H said call lights should be in reach of residents, sometimes they are pinned to the resident, or might be on their bed or chair. LPN H said even residents who are confused should still have their call lights within reach. During an interview on 05/23/24 at 4:58 P.M., the Director of Nursing said call lights should be within the resident's reach. During an interview on 05/23/24 at 4:59 P.M., the administrator said call lights should be within reach for all residents and staff should check when doing rounds that they are in place.	F 919		

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	10491	A. BUILDING: _____ B. WING _____	C 05/23/2024

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MARIES MANOR	174 BALLPARK ROAD VIENNA, MO 65582

(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 OEFICIENCY)	(X5) COMPLETE DATE
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III Refer to F761	A4064		
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 Refer to F658	A4075		
A5014	19 CSR 30-85.052(14) Personnel Sufficient, Trained There shall be sufficient personnel properly trained in their duties to assure adequate preparation and serving of food. II This regulation is not met as evidenced by: Class II Please refer to F801	A5014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10491	A. BUILDING: _____ B. WING _____	C 05/23/2024

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MARIES MANOR	174 BALLPARK ROAD VIENNA, MO 65582

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A7003	Continued From page 1	A7003		
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints The outer clothing of all employees shall be clean and employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. III This regulation is not met as evidenced by: Class III Please refer to F812	A7003		
A7086	19 CSR 30-87.030(84) Equip/Utensils Air Dried, Self-Drain Utensils After mechanical or manual sanitization, all equipment and utensils shall be air dried. All utensils shall be stored in a self-draining position. III This regulation is not met as evidenced by: Class III Please refer to F812	A7086		

PLAN OF CORRECTION

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	This plan of correction is being submitted as required under State and Federal law. The submission under this plan of correction does not constitute admission on the part of Maries Manor, as to the accuracy of the surveyor's findings or the conclusion drawn from there. The Facility's submission of this plan of correction does not constitute any admission on the part of the Facility that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
	The Facility submits the plan of correction with the intention that it be inadmissible by any third party and any civil or criminal action against the Facility or any employee, agent, officer, director, or shareholder of the Facility.	
	Any changes to Facility policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis.	
	Please accept this plan as the Facility's Credible Letter of Allegation that all deficiencies have been corrected by the last day noted in this plan of correction.	

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.

Sara Hyatt Hahn 7/8/24

PLAN OF CORRECTION

Provider/Supplier Name:	Maries Manor
Street Address, City, Zip:	174 Ballpark Road, Vienna, 65582
Date of Survey:	5/23/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265249

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F657	The facility does and will continue to review and revise care plans timely and appropriately.	7/07/2024
1.	**Corrective action will be accomplished for the resident(s) found to be affected by the alleged deficient practice by:**	
	1) Resident #3 will have Minimum Data Set Coordinator (MDSC) update the careplan addressing his/her cellulitis no later than July 7th, 2024.	
	2) Resident #47 will have MDSC update the careplan addressing his/her medication noncompliance no later than July 7th, 2024.	
2.	**The facility recognizes all residents with skin issues and/or are medication noncompliant may potentially be affected by this alleged deficient practice.**	
3.	**The corrective action will be accomplished by:**	
	1) The MDSC will audit current residents to identify those who have skin issues and/or exhibit medication noncompliance no later than June 30th, 2024. MDSC will audit the care plan of those identified residents to ensure the careplan is correct in relation to those areas and will make corrections as needed no later than July 8th, 2024. These careplans will be updated quarterly and as needed.	
	2) All residents admitted on or after July 7th, 2024, will have MDSC compose their careplans to address skin issues and medication noncompliance with first due careplan; then quarterly and as needed.	
	3) Inservice education for MDSC will be conducted by Director of Nursing (DON)/Designee beginning June 10th, 2024, on the following: 1) 1) All residents admitted on or after July 8th, 2024, and current residents will have MDSC compose their careplans to address skin issues and medication noncompliance with first due careplan; then quarterly and as needed.	
4.	**The measures put in place and the systemic changes made**	

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F657	**to ensure the alleged deficient practice does not recur were:**	7/07/2024
	1) The above documented inservice education will be reviewed annually and with the orientation process of newly hired MDSCs.	
	2) MDSC/Designee will monitor for the following weekly beginning July 7th, 2024, x 60 days or as determined by monthly QAPI committee meeting if substantial compliance is achieved prior: 1) All residents admitted on or after July 7th, 2024, and current residents will have MDSC compose their careplans to address skin issues and medication noncompliance with first due careplan; then quarterly and as needed.	
	3) Administrator/Designee will monitor for the following quarterly beginning July 8th, 2024: 1) All residents admitted on or after July 7th, 2024, and current residents will have MDSC compose their careplans to address skin issues and medication noncompliance with first due careplan; then quarterly and as needed.	
5.	**The facility plans to monitor its performance to ensure that solutions are sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All negative findings of the Quality Assurance checks as related to compliance to the following will be documented and submitted to the monthly Facility Quality Improvement Committee for review and additional interventions will be made as needed: 1) All residents admitted on or after July 7th, 2024, and current residents will have MDSC compose their careplans to address skin issues and medication noncompliance with first due careplan; then quarterly and as needed.	

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F658	The facility does and will continue to follow professional standards related to medication administration and blood sugar tests.	7/07/2024
1.	**Corrective action will be accomplished for the resident(s) found to be affected by the alleged deficient practice by:**	
	1) Certified Medication Technicians (CMTs) and medication nurses will perform medication administration according to facility protocol and will not prepare medications in advance.	
	2) Residents #58, #14, #61, and #62 will have insulin certified CMTS and/or nurses perform blood sugar testing with non-expired glucometer strips.	
2.	**The facility recognizes all residents that require medication administration and/or blood sugar testing may potentially be affected by this alleged deficient practice.**	
3.	**The corrective action will be accomplished by:**	
	1) All expired glucometer strips were disposed of on May 23rd, 2024.	
	2) All current and future admitted residents will have CMTs and medication nurses perform medication administration according to facility protocol and will not prepare medications in advance.	
	3) All current and future admitted residents whom require blood sugar testing will have insulin certified CMTs and/or nurses perform blood sugar testing with non-expired glucometer strips.	
	4) Inservice education for insulin certified CMTS and nurses will be conducted by Director of Nursing (DON) beginning June 10th, 2024, on the following: 1) All current and future admitted residents will have CMTs and medication nurses perform medication administration according to facility protocol and will not prepare medications in advance. 2) All current and future admitted residents whom require blood sugar	

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F658	testing will have insulin certified CMTs and/or nurses perform blood sugar testing with non-expired glucometer strips.	7/07/2024
4.	**The measures put in place and the systemic changes made to ensure the alleged deficient practice does not recur were:**	
	1) The above documented inservice education will be reviewed annually and with the orientation process of newly hired CMTs and nurses.	
	2) CMTs/nurses will monitor for the following every shift beginning July 7th, 2024, x 60 days or as determined by monthly QAPI committee meeting if substantial compliance is achieved prior: 1) All current and future admitted residents will have CMTs and medication nurses perform medication administration according to facility protocol and will not prepare medications in advance. 2) All current and future admitted residents whom require blood sugar testing will have insulin certified CMTs and/or nurses perform blood sugar testing with non-expired glucometer strips.	
	3) DON/Designee will monitor for the following weekly beginning July 7th, 2024, x 60 days or as determined by monthly QAPI committee meeting if substantial compliance is achieved prior: 1) All current and future admitted residents will have CMTs and medication nurses perform medication administration according to facility protocol and will not prepare medications in advance. 2) All current and future admitted residents whom require blood sugar testing will have insulin certified CMTs and/or nurses perform blood sugar testing with non-expired glucometer strips.	
	4) Administrator/Designee will monitor for the following quarterly beginning July 8th, 2024: 1) All current and future admitted residents will have CMTs and medication nurses perform medication administration according to facility protocol and will not prepare	

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F658	medications in advance. 2) All current and future admitted residents whom require blood sugar testing will have insulin certified CMTs and/or nurses perform blood sugar testing with non-expired glucometer strips.	7/07/2024
5.	**The facility plans to monitor its performance to ensure that solutions are sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All negative findings of the Quality Assurance checks as related to compliance to the following will be documented and submitted to the monthly Facility Quality Improvement Committee for review and additional interventions will be made as needed: 1) All current and future admitted residents will have CMTs and medication nurses perform medication administration according to facility protocol and will not prepare medications in advance. 2) All current and future admitted residents whom require blood sugar testing will have insulin certified CMTs and/or nurses perform blood sugar testing with non-expired glucometer strips.	

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F761	The facility does and will continue to store and label medications in a safe and effective manner.	7/07/2024
1.	**Corrective action will be accomplished for the resident(s) found to be affected by the alleged deficient practice by:**	
	1) The opened/undated bottles of magnesium oxide, Vitamin D1, Vitamin B1, one a day multivitamin, and saline nasal spray from the east side medication cart were destroyed on May 23rd, 2024.	
	2) The opened/undated bottles of Latanoprost solution and Fluticasone nasal spray from the east side medication cart were dated for the delivery date of the medication (as they could not have been opened sooner) on June 17th, 2024.	
	3) The opened/undated pens of Levemir, pens of Lantus, and pen of Humalog from the insulin cart were dated for the delivery date of the medication (as they could not have been opened sooner) on June 17th, 2024.	
	4) The vial of Humulin R with an open date of 4/16/24 was destroyed May 23rd, 2024, the pen of Novolog with an open date of 3/27/24 was destroyed May 23rd, 2024, and the Novolog pen with an open date of 3/27/24 was destroyed June 17th, 2024.	
	5) The following medications left on the top of the west side medication cart were placed in appropriate/designated carts May 20th, 2024: bottle of Senna-Plus 50 mg, bottle of Tylenol 325 mg, bottle of Fluticasone Propionate nasal spray, and tube of Betamethasone Valerate cream.	
2.	**The facility recognizes all residents who receive medications may potentially be affected by this alleged deficient practice.**	
3.	**The corrective action will be accomplished by:**	
	1) Director of Nursing (DON) will audit all medication and insulin carts no later than June 26th, 2024, to identify bottles of multidose medications, pens, and/or vials that	

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F761	are opened and not dated. Identified over the counter (OTC) bottles will be destroyed and prescription vials and pens and other medications will be dated for delivery dates (as they could not have been opened sooner).	7/07/2024
	2) All current and future admitted residents will have CMTs and nurses date multi-dose medication bottles and insulin vials/pens when opened and ensure medications are stored in locked medications rooms or locked carts.	
	3) Inservice education for CMTs and nurse will be conducted by DON beginning June 10th, 2024, on the following: 1) All current and future admitted residents will have CMTs and nurses date multi-dose medication bottles and insulin vials/pens when opened and ensure medications are stored in locked medications rooms or locked carts.	
4.	**The measures put in place and the systemic changes made to ensure the alleged deficient practice does not recur were:**	
	1) The above documented inservice education will be reviewed annually and with the orientation process of newly hired CMTs and nurses.	
	2) CMTs and nurses will monitor for the following every shift beginning July 7th, 2024, x 60 days or as determined by monthly QAPI committee meeting if substantial compliance is achieved prior: 1) All current and future admitted residents will have CMTs and nurses date multi-dose medication bottles and insulin vials/pens when opened and ensure medications are stored in locked medications rooms or locked carts.	
	3) DON will monitor for the following weekly beginning July 7th, 2024, x 60 days or as determined by monthly QAPI committee meeting if substantial compliance is achieved prior: 1) All current and future admitted residents will have CMTs and nurses date multi-dose medication bottles and insulin vials/pens when opened and ensure	

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F761	medications are stored in locked medications rooms or locked carts.	7/07/2024
	4) Administrator/Designee will monitor for the following quarterly beginning July 8th, 2024: 1) All current and future admitted residents will have CMTs and nurses date multi-dose medication bottles and insulin vials/pens when opened and ensure medications are stored in locked medications rooms or locked carts.	
5.	**The facility plans to monitor its performance to ensure that solutions are sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All negative findings of the Quality Assurance checks as related to compliance to the following will be documented and submitted to the monthly Facility Quality Improvement Committee for review and additional interventions will be made as needed: 1) All current and future admitted residents will have CMTs and nurses date multi-dose medication bottles and insulin vials/pens when opened and ensure medications are stored in locked medications rooms or locked carts	

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F801	Qualified Dietary Staff:	7/07/2024
	The facility will employ sufficient staff with the appropriate competencies and skillsets to carry out the functions of the Food and Nutrition Services, taking into consideration resident assessments, individualized plans of care and the number, acuity, and diagnosis of the facility resident population in accordance with the facility assessment required. This includes: 1) A qualified Registered Dietitian on a consultant basis. 2) A designated Director of Food and Nutrition Services whom: a. is a Certified Dietary Manager b. is a Certified Food Service Manager c. has a similar National Certification for Food Service Management d. has an Associates or higher level of education in Food Service or Hospitality Management	
	1. The Dietary Manager has completed the course of study and passed the certification exam as of July 7th, 2024. 2. The Dietary Manager will continue to have regular consultation from the Registered Dietitian Consultant.	
	The Administrator will ensure the certification for the Dietary Manager remains up to date.	
	The Dietary Manager's completion of certification will be reported to the QAA Committee and 90 days thereafter.	

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F812	Food Procurement, Storage, Preparation, Service and Sanitation:	7/07/2024
	Facility will ensure: 1) Food is procured from sources approved by or considered satisfactory by Federal, State, or Local authorities; • May include food items obtained directly from local producers, subject to state and local laws or regulations. • Does not prohibit or prevent facility from using produce grown in facility gardens. • Does not preclude residents from consuming foods not procured by the facility. 2) Food is stored, prepared, distributed and served in accordance with professional standards for food service safety.	
	All residents were potentially affected by the alleged deficient practice.	
	The facility will ensure: 1) All staff entering the kitchen have all hair, inclusive of facial hair, properly restrained. Inaccurate signate will be removed from the rear door. 2) All dishes will be washed, rinsed, sanitized, and allowed to air dry before stacking and storage.	
	All dietary staff will be educated by the Administrator/Dietary Manager on or before July 7th, 2024, on the following areas: 1) Hair restraints 2) Washing and storage of dishes	
	The Administrator, Dietary Service Manager, or designee will monitor the above practice areas 3-4 times weekly for compliant practice for 90 days.	

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F812	The Registered Dietitian will monitor for during regular scheduled visits.	7/07/2024
	All results will be reported to QAA Committee and monitored for 90 days thereafter.	

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F919	The facility does and will continue to ensure call lights are in reach of residents.	7/07/2024
1.	**Corrective action will be accomplished for the resident(s) found to be affected by the alleged deficient practice by:**	
	1) Resident #18 will have nursing staff ensure call light is within reach.	
	2) Resident #44 care plan indicates the following: Do not keep my call light within reach as I have shorted out the system in my room previously due to chewing items within reach and this may present a danger to myself or others. Check on my safety and need for care at frequent intervals (every 2 hours and as needed).	
	3) Resident #51 no longer resides at the facility.	
2.	**The facility recognizes all residents whom have the directive in care plan to place call light within reach may potentially be affected by this alleged deficient practice.**	
3.	**The corrective action will be accomplished by:**	
	1) All current and future admitted residents whom have the directive in care plan to place call light within reach will have nursing staff to do so.	
	2) Inservice education for nursing staff will be conducted by DON beginning June 10th, 2024, on the following: 1) All current and future admitted residents whom have the directive in care plan to place call light within reach will have nursing staff to do so.	
4.	**The measures put in place and the systemic changes made to ensure the alleged deficient practice does not recur were:**	
	1) The above documented inservice education will be reviewed annually and with the orientation process of newly hired nursing staff.	
	2) Charge nurses will monitor for the following every shift beginning July 7th, 2024, x 60 days or as determined by monthly QAPI committee meeting if substantial compliance is achieved prior: 1) All current and future admitted residents whom have the directive in care plan	

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F919	to place call light within reach will have nursing staff to do so.	7/07/2024
	3) DON/Designee will monitor for the following weekly beginning July 7th, 2024: 1) All current and future admitted residents whom have the directive in care plan to place call light within reach will have nursing staff to do so.	
	4) Administrator/Designee will monitor for the following quarterly beginning July 8th, 2024: 1) All current and future admitted residents whom have the directive in care plan to place call light within reach will have nursing staff to do so.	
5.	**The facility plans to monitor its performance to ensure that solutions are sustained. This plan will be implemented and the corrective action will be evaluated for its effectiveness. The plan of correction will be integrated into the Quality Assurance System.**	
	All negative findings of the Quality Assurance checks as related to compliance to the following will be documented and submitted to the monthly Facility Quality Improvement Committee for review and additional interventions will be made as needed: 1) All current and future admitted residents whom have the directive in care plan to place call light within reach will have nursing staff to do	

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A4064	Refer to F761	7/07/2024
A4075	Refer to F658	7/07/2024
A5014	Refer to F801	7/07/2024
A7003	Refer to F812	7/07/2024
A7086	Refer to F812	7/07/2024

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