STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265574	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE CITY MANOR CARE CENTER	1010 HIGHWAY 24 & 36 EAST MONROE CITY, MO 63456

(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 732 SS=B	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 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	F 732		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B. Vanbandingham | TITLE: LNHA | (X6) DATE: 12-7-23

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 732	Continued From page 1 by: Based on observation, interview, and record review, the facility failed to post the total hours nursing staff (registered nurse (RN), certified nurse assistant (CNA), certified medication technician (CMT), and licensed practical nurse (LPN)) worked for each shift. The facility census was 54. Review of the facility's undated policy, Posting Direct Care Daily Staffing Numbers, dated 2001 and last revised 2006, showed the following: -Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents; -Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and Licensed Vocational Nurse (LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format; -Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living (ADLs), performing gastrointestinal feeds, giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physicians of changes of condition; -Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information ·recorded on the form shall include: a. The name of the facility; b. The date for which the information is posted; c. The resident census at the beginning of the	F 732		

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F 732	Continued From page 2 shift for which the information is posted; d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift; g. The actual time worked during that shift for each category and type of nursing staff; h. Total number of licensed and non-licensed nursing staff working for the posted shift; -When computing hours of direct care staff working split shifts, count only the total number of hours the individual is actually scheduled to work for the shift information being posted. (Example: You are posting data for the Day Shift. A CNA reports to work and is scheduled to work four (4) hours on the Day Shift and four (4) hours on the Evening Shift. In computing the number of hours worked for that shift, count only the four (4) hours scheduled for the Day Shift. The remaining four (4) hours would then be counted toward the totals on the Evening Shift); -Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator; -The form may by typed or handwritten. If completed by typewriter or word processor, the recorded information shall be a minimum font size of 12 points. Should the information be handwritten, it must be legibly printed in black ink and must be written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily	F 732		

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F 732	Continued From page 3 staffing information. 1. Observation on 11/13/23 at 12:30 P.M., of the facility staffing sheet posted across from the nurses' station showed the following: -The facility census was 54; -Day shift included three LPNs and seven CNA/CMTs for a total of ten staff; -There was no area to document total staff hours. Observation on 11/13/23 at 3:30 P.M., of the facility staffing sheet posted across from the nurses' station showed the following: -The facility census was 54; -Day shift included three LPNs and six CNA/CMTs for a total of nine staff; -There was no area to document total staff hours. Observation on 11/14/23 at 8:21 A.M., of the facility staffing sheet posted across from the nurses' station showed the following: -The facility census was 54; -Day shift included one RN, three LPNs and eight CNA/CMTs for a total of 12 staff; -There was no area to document total staff hours. Observation on 11/14/23 at 2:20 P.M. and 4:16 P.M, of the facility staffing sheet posted across from the nurses' station showed the following: -The facility census was 54; -Evening shift for all disciplines was blank; -There was no area to document total staff hours. Observation on 11/15/23 at 5:02 A.M., of the facility staffing sheet posted across from the nurses' station showed the staffing sheet from 11/14/23 and there was no evening and night shift staff numbers documented.	F 732		

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F 732	Continued From page 4 Observation on 11/15/23 at 12:30 P.M., of the facility staffing sheet posted across from the nurses' station showed the following: -The facility census was 54; -Day shift included three LPNs and seven CNA/CMTs for a total of ten staff; -There was no area to document total staff hours. Observation on 11/16/23 at 8:35 A.M., of the facility staffing sheet posted across from the nurses' station showed the following: -The facility census was 51; -Day shift included one RN, two LPNs and six CNA/CMTs for a total of nine staff; -There was no area to document total staff hours. During interview on 11/16/23 at 8:45 A.M., LPN D said the following: -There is no specific person assigned to fill out staffing sheet. It is just whoever remembers first; -The numbers listed per RN/LPN/CNA is the number of staff not the number of hours. During interview on 11/16/23 at 9:38 A.M., the Director of Nurses (DON) said the nurses usually fill out the staffing sheet but there is no one specific assigned. If they forget then she will do fill it out. The numbers listed on the staffing sheet are the number of staff for each discipline, not the number of hours. It had been a while since she had read the regulation but the hours should be listed.	F 732		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		

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F 803	Continued From page 5 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure meals were served to meet the nutritional needs of the residents. Staff failed to prepare and serve food according to the diet spreadsheet menu. The facility census was 54. Review of the facility's Diet Orders Policy, 2011 Edition, showed the following: -Guideline: Each resident will have a diet order prescribed by the physician and documented in the health record. All physicians will prescribe diets using the terminology of the house diets and/or terminology in the diet manual. Diet orders	F 803		

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F 803	Continued From page 6	F 803		

received from an admission source that do not conform to the standard language of the facility will be converted to an available diet order offered at the facility;
-Procedure: Diet orders are clearly communicated, using the designated diet order communication form, to dining services; All diet order communication forms received by dining services are confirmed for accuracy by the dining services manager or designee and noted as received in the resident health record; Consult with the Registered Dietitian for further guidance.

1. Review of the Diet Orders, obtained 11/13/23 and 11/14/23, showed ten residents with a physician-ordered consistent carbohydrate (CCHO) diet.

Review of the Diet Spreadsheet, for 11/13/23 (Day 2, Monday) lunch, showed the following:
-Staff were to serve one #6 dip (5.33 ounce) serving of apple crisp to residents with a regular diet;
-Staff were to serve one #12 dip (2.66 ounce) serving of apple crisp to residents with a CCHO diet.

Observation on 11/13/23 at 10:15 A.M., in the walk-in cooler showed a cart containing individual bowls of apple crisp desserts, each of the same portion size serving.

Observation on 11/13/23 at 11:00 A.M., showed a cart containing individual bowls of apple crisp desserts, each of the same portion size serving, outside the kitchen entrance door in the dining room.

Observations on 11/13/23 from 11:13 A.M. to

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F 803	Continued From page 7 12:14 P.M., in the main dining room during the lunch meal service, showed Dietary Aide C served bowls of apple crisp to the residents. All of the bowls contained the same amount of apple crisp. During an interview on 11/13/23 at 4:39 P.M., Dietary Aide C said all residents receive the same serving size of dessert from the dessert cart. Observation of the Special Care Unit on 11/13/23 at 11:40 A.M. showed the following: -Dietary staff delivered a cart with the lunch meal to the special care unit; -Special care unit staff removed items from the cart, including two trays of individually prepared bowls of apple crisp. All of the bowls appeared to contain the same amount of apple crisp. The bowls were not labeled for specific residents. Observation of the lunch meal service on 11/13/23 at 12:25 P.M., in the Special Care Unit, showed staff served residents, including Resident #51 (who was on a physician-ordered CCHO diet), the bowls of apple crisp from the trays. During an interview on 11/13/23 at 12:30 P.M., Licensed Practical Nurse (LPN) A said the following: -Resident #51 was the only diabetic currently on the unit; -All of the desserts were the same; he/she did not know if diabetics were to get something different. During an interview on 11/14/23 at 8:34 A.M., the Dietary Manager said the following: -She did not realize dietary staff served the same portion size of apple crisp to all residents for lunch on 11/13/23;	F 803		

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F 803	Continued From page 8 -She expected dietary staff to follow the diet spreadsheet menus when preparing/serving meals to the residents; -The residents on a CCHO diet should have received a #12 serving of apple crisp, not a #6 serving; -She was responsible for making sure staff followed the diet spreadsheet menus. During an interview on 11/17/23 at 12:02 P.M., the Registered Dietitian said dietary staff should be familiar with and follow the diet spreadsheet menu when preparing/serving food items to residents.	F 803		
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. §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:	F 812		

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F 812	Continued From page 9 Based on observation, interview, and record review, the facility failed to ensure dietary equipment was free of an accumulation of grease, oil, dust and debris, failed to remove damaged food containers from the dry storage room, failed to seal/date opened packages, and failed to ensure an ice machine drain contained a drainage air gap. The facility census was 54. Review of the facility's Cleaning Rotation Policy, 2011 Edition, showed the following: -Guideline - Equipment and utensils will be cleaned according to the following guidelines, or manufacturer's instructions; -Items cleaned after each use included can opener, small food preparation equipment, work tables and counters; -Items cleaned daily included stove top, grill, kitchen and dining room floors, toaster, and exterior of large appliances; -Items cleaned weekly included hoods, filters, shelves, ovens, and cupboards); -Items cleaned monthly included refrigerators and walls). Review of the facility's Ice Handling and Cleaning Policy, 2011 Edition, showed ice will be handled, transported, and stored in such a manner as to be protected against contamination. Ice storage bins shall be drained through an air gap. 1. Observations on 11/13/23 from 9:55 A.M. to 4:39 P.M., in the kitchen, showed the following: -A moderate buildup of oil and debris on the counter-mounted can opener; -A moderate buildup of dust and debris on the two bulb emergency light fixture; -A moderate buildup of grease, dust, and debris on top of the wall-mounted knife holder;	F 812		

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F 812	Continued From page 10 -A moderate buildup of grease and debris on the counter top toaster; -A buildup of grease and debris on surfaces of the Ansul System Unit, metal conduits out of the unit, and to the kitchen hood and Ansul pull station; -A moderate buildup of dust and debris on the eight support pipes above the kitchen hood; -A buildup of dust and debris on the shelving above the three-compartment sink, the back splash, and on the flooring underneath and between the sink and the up-right refrigerator; -The contact paper on the bottom shelving of the three preparation tables was worn and peeling away from the metal surfaces (not easily cleanable); -A moderate buildup of grease, dust, and debris on the metal wall shelving, located above the food preparation counter; -A moderate buildup of grease, debris, and dark stains on the metal back splash, above and to the right side of the griddle top oven; -A buildup of grease, debris, and dark stains on the right side of the griddle top oven; -A moderate buildup of grease and debris on the left side of the stove top oven; -A buildup of grease and debris under stove top burner grates; -A moderate buildup of dust and debris on the left wall in the walk-in cooler. 2. Observation on 11/13/23 at 9:55 A.M., in the dry storage room, showed the following: -Three 6 pound, 10 ounce cans of pineapple tidbits, located on the the shelving with products for use, were dented/damaged; -A 1 pound, 8 ounce package of gelatin dessert, labeled as opened on 10/29/23, was not sealed; -An opened 5 pound package of fudge brownie	F 812		

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F 812	Continued From page 11 mix was not sealed. 3. Observation on 11/13/23 at 2:51 P.M., showed the ice machine, located in the 200 hall clean utility storage room, had no drainage air gap under the machine or entering into the main sink drain. During an interview on 11/13/23 at 10:33 A.M., the Maintenance Supervisor said unaware an ice machine was required to have an air gap. 4. During an interview on 11/14/23 at 8:34 A.M., the Dietary Manager said the following: -She expected staff to clean and sanitize the kitchen and dietary equipment daily and as needed; -Dietary staff should remove dented and damaged cans from the dry food storage room and return the cans to the vendor; -Dietary staff should seal and date open packages of food in the dry food storage room. During interviews on 11/17/23 at 12:02 P.M. and 11/21/23 at 11:00 A.M., the Registered Dietitian said the following: -She expected the dietary or maintenance staff to clean and sanitize the kitchen and dietary equipment daily, weekly and as needed; -She expected dented/damaged cans to be removed and returned to the vendor; -She expected open packages to be sealed and dated. During an interview on 11/14/23 at 2:45 P.M., the Administrator said the following: -She expected the dietary and maintenance staff to clean and sanitize the kitchen and dietary equipment daily, weekly, or as needed;	F 812		

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F 812	Continued From page 12 -She expected the ice machine in the 200 hall clean utility room to have air gaps at the machine's drain locations.	F 812		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to conduct regular inspections of bed frames, mattresses and bed rails to identify areas of possible entrapment and to ensure the bed rails, mattresses and bed frames were compatible for five residents (Residents # 2, #3, #4, #36, #48) with bed rails, in a review of 14 sampled residents. The facility census was 54. Review of the facility's bed assist device policy, updated on 2/20/23, showed maintenance staff will install all bed assist devices using the manufacturer's instructions and regularly check the mattress and assist device for areas of possible entrapment and other safety concerns. Review of the Food and Drug Administration's Guide of Bed Safety, Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, revised April 2010, showed the following: -Potential risks of bed rails may include	F 909		

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	265574	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE CITY MANOR CARE CENTER	1010 HIGHWAY 24 & 36 EAST MONROE CITY, MO 63456

(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 909	Continued From page 13 strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress, more serious injuries from falls when patients climb over rails, skin bruising, cuts, and scrapes, feeling isolated or unnecessarily restricted, and preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet; -Use a proper size mattress or mattress with raised foam edges to prevent patients from being trapped between the mattress and rail; -Reduce the gaps between the mattress and side rails; -A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety; 1. Observation on 11/15/23, at 1:30 P.M., showed 17 beds in the facility (currently in use) had some type of bed rail/side rail device attached to the bed. 2. Review of Resident #3's Continuity of Care Document showed his/her diagnoses included dementia, history of falls, altered mental status, need for assistance with personal cares, muscle weakness and abnormalities of mobility. Review of the resident's annual side rails assessment and consent, dated 4/24/23, showed the following: -Reason for side rail use: bed mobility; -Type of rail used: one side; -Used daily Review of the resident's October 2023 physician order sheet (POS) showed an order documenting	F 909		

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F 909	Continued From page 14 the resident may use bed rail assist rails for safety (original order date of 12/22/18). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/7/23, showed the following: -Functional limitations in range of motion (ROM) in upper and lower extremities on both sides of his/her body; -Required substantial to maximal assistance with mobility when rolling left and right, when sitting to lying, and when lying to sitting. Review of the resident's care plan, last revised 10/24/23, showed the following: -Required assistance with turning and repositioning while in bed; -Safe and appropriate with use of bilateral bed assist rails. Observations on 11/13/23 at 11:31 A.M. and 12:15 P.M., showed the resident lay in his/her bed. The resident had 1/8 bed rails (assist rail that does not raise or lower) on both sides of the bed. Observation on 11/15/23, at 5:05 A.M., showed the resident lay in his/her bed. The resident had 1/8 bed rails on both sides of the bed. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and bed rails to identify areas of possible entrapment. 2. Review of Resident #4's Continuity of Care Document showed his/her diagnoses included multiple sclerosis.	F 909		

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F 909	Continued From page 15 Review of the resident's annual side rail assessment and consent, dated 4/24/23, showed the following: -Reason for side rail usage: bed mobility (assist with turning side-to-side); -Types of rails used: two sides; -Frequency of use: daily. Review of the resident's October 2023 POS showed the resident may use two assist devices to bed (original order date of 9/24/20). Review of the resident's quarterly MDS, dated 8/29/23, showed the resident required substantial to maximal assistance for mobility when rolling left to right. Review of the resident's care plan, last revised 9/5/23, showed the resident had two assistive devices to aid with bed mobility. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and bed rails to identify areas of possible entrapment. Observations on 11/14/23 at 10:40 A.M., 11/15/23 at 5:05 A.M. and 9:25 A.M. showed the resident lay in bed with 1/8 bed rails on both sides of the bed. Observation on 11/15/23 at 12:05 P.M. showed the resident sat in bed eating lunch with 1/8 bed rails on both sides of the bed. 3. Review of Resident #36's Continuity of Care Document showed his/her diagnoses included	F 909		

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F 909	Continued From page 16	F 909		

history of repeated falls, mild cognitive impairment, bilateral primary optic atrophy (condition that affects the optic nerve, which carries impulses from the eye to the brain, characteristics include deficits in central vision, difficulties distinguishing contrast, and loss of visual acuity), and generalized muscle weakness.

Review of the resident's annual side rails assessment and consent, dated 4/24/23, showed the following:
-Reason for side rail use: bed mobility;
-Type of rail used: two sides;
-Used daily.

Review of the resident's October 2023 POS showed the resident may use an assistive device on bed for mobility (original order date of 03/30/22).

Review of the resident's quarterly MDS, dated 10/31/23, showed the following:
-Functional limitations in range of motion (ROM) in upper and lower extremities on one side of his/her body;
-Required supervision or touching assistance when rolling left and right, when sitting to lying and when lying to sitting.

Review of the resident's care plan, last revised 11/06/23, showed the following:
-He/She had two assistance devices to aide with bed mobility;
-He/She was able to turn and reposition himself/herself in bed.

Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and bed rails to

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F 909	Continued From page 17 identify areas of possible entrapment. Observations on 11/15/23, at 5:37 A.M., 5:49 A.M., and 5:57 A.M. showed the resident in his/her bed. The resident had 1/8 bed rails on both sides of the bed. 4. Review of Resident #2's side rails assessment and consent, dated 4/24/23, showed the following: -Medical symptom requiring use of side rails was decreased mobility; -Reason for side rail usage was bed mobility (assist with turning side-to-side); -Rails used on two sides; -Frequency of use was daily. Review of the resident's annual MDS, dated 9/26/23, showed the resident required moderate assist to roll left and right in bed. Review of the resident's care plan, updated 10/3/23, showed the following: -He/She had assistive device bilaterally to aide with bed mobility; -He/She had impaired mobility related to recent right above knee amputation, history of left below knee amputation, and severe morbid obesity. Observation on 11/14/23 at 9:15 AM, showed the resident lay in bed with bilateral half side rails up. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and bed rails to identify areas of possible entrapment.	F 909		

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F 909	Continued From page 18 5. Review of Resident #48's side rails assessment and consent, dated 9/1/23, showed the following: -Medical symptom requiring use of side rails was decreased bed mobility; -Reason for side rail usage was bed mobility (assist with turning side-to-side); -Rails used on two sides; -Frequency of use was daily. Review of the resident's admit MDS, dated 9/5/23, showed the following: -The resident was cognitively intact; -Required moderate assistance with roll left and right in bed and lying to sitting. Review of the resident' care plan, updated 10/18/23, showed the following: -The resident had impaired functional mobility related to unsteady gait and deconditioning; -The resident had two assistive devices to aide with bed mobility. Observation on 11/14/23 at 11:55 AM, showed the resident lay in bed with 1/8 bed rails on both sides of the bed. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and bed rails to identify areas of possible entrapment. 6. During interviews on 11/15/23 at 10:00 A.M., 11:54 A.M. and 1:48 P.M., and on 11/16/23 at 8:29 A.M., the maintenance supervisor said the following: -He does not do any type of assessments on bedrails; he has only checked them when staff tell him they are loose and they need tightened;	F 909		

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F 909	Continued From page 19 -He installed bed rails when nursing staff asked him to do so per residents' physician orders; -He did not conduct bed rail entrapment risk assessments, bed rail inspections, or check compatibility of the bed rails with the bed frames or mattresses; -He was unaware of the manufacturer or model of the bed rails or what the manufacturer's recommendations were for conducting risk assessments or bed frame/mattress compatibility; -He had only worked at the facility four months and could not find any prior bed rail entrapment risk or inspection documentation; -Housekeeping staff conducted monthly inspections of bed rails, frames and mattresses; -The housekeeping supervisor gave him the monthly inspection sheets; he only had September and November 2023 because that's all that he could find. Record review of the September 2023 and November 2023 inspection forms, completed by housekeeping staff, showed the following: -Beds and mattresses: inspect bed rails, bed frames, and bed mattresses; -Beds listed for each room had a pass or fail option; -No measurements or detailed inspection information was listed on the forms; -Staff inspector names for the East Hall inspections conducted on 9/15/23 and 9/16/23 were blank. During an interview on 11/16/23 at 8:29 A.M., the housekeeping supervisor said the following: -Housekeeping staff conducted monthly inspections of resident beds and mattresses to ensure the items were in good working order; -Housekeeping staff did not inspect the bed rails	F 909		

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F 909	Continued From page 20 but made sure there were no big gaps between the rail and mattress; -Housekeeping staff did not follow manufacturer's recommendations for assessing if a bed rail was compatible with the bed frame or mattress or for checking for gaps between the bed rail and mattress. During an interview on 11/16/23 at 9:58 A.M., the nurse manager said she could not locate a bed rail maintenance program, policy, or past inspection documentation. She assumed the bed rails were compatible with the bed frames since many were installed years ago. During an interview on 11/15/23 at 9:38 A.M., and 11/16/23 at 9:13 A.M., the director of nursing said she expected maintenance staff to ensure compatibility with bed frames and mattresses, and follow manufacturer's recommendations for installation and maintenance of bed rails.	F 909		

Missouri Department of Health and Senior Services

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	05473	A. BUILDING: _____ B. WING _____	C 11/16/2023

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MONROE CITY MANOR CARE CENTER	1010 HIGHWAY 24 & 36 EAST MONROE CITY, MO 63456

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A5001	19 CSR 30-85.052(1) Nutritional Needs Met, Assess Res, Inform Dr Each resident shall be served nutritious food, properly prepared and appropriately seasoned, taking into consideration resident food preferences, to provide an adequate diet in accordance with the physician ' s order and as recommended by the National Research Council. Nutritional needs of residents shall be met and shall be based on the individual ' s circumstances, medical condition and goals of treatment as determined and justified by the physician. A qualified professional, such as a dietitian or registered nurse, shall regularly assess these needs and shall keep the physician informed of the nutritional status of the resident. I/II This regulation is not met as evidenced by: Class II Refer to F803	A5001		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire,	A7015		

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A7015	Continued From page 1 flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class II* Refer to F812 *The higher classification merited due to the violation's effect on the residents.	A7015		
A7042	19 CSR 30-87.030(40) Ice Store/Dispense, No Contamination, Air Gap Ice shall be dispensed only with scoops, tongs or other ice-dispensing utensils or through automatic self-service, ice-dispensing equipment. Ice-dispensing utensils shall be stored on a clean surface or in the ice with the dispensing utensil ' s handle extended out of the ice. Between uses, ice transfer receptacles shall be stored in a way that protects them from contamination. Ice storage bins shall be drained through an air gap. III This regulation is not met as evidenced by: Class III Refer to F812	A7042		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed	A7067		

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A7067	Continued From page 2 Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Refer to F812	A7067		

PLAN OF CORRECTION

Provider/Supplier Name:	Monroe City Manor Care Center, Inc.
Street Address, City, Zip:	1010 Highway 24 and 36 East, Monroe City, MO 63456
Date of Survey:	11/13/2023-11/16/2023

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F732	Nursing staffing will be posted at the beginning of each shift on the bulletin board across from the nurses station and accessible to all residents and visitors. Nursing hours form was updated to include census each shift and scheduled hours. All nurses have been educated on updated form and expectations for its use. The completion of the nursing hours form responsibility has been assigned to the West Hall nurse for each shift. This process will be audited for correct and timely completion by the Director of Nursing at least 3 times a week until 8 weeks of compliance has been met. Audits will then be decreased to weekly for the following 4 weeks. Audits will then be monthly by the Director of Nursing. This will be reviewed by the Administrator monthly during walking rounds. This plan will be discussed with the Quality Assurance Committee.	12/8/2023
F803	All dietary and nursing staff have been inserviced on appropriate portion sizes for residents on consistent carb diets as well as importance of all residents receive the proper food items at meals.. A list of all residents on consistent carb or other diabetic diets will be posted in the kitchen in a location visible to all staff. The consistent carb diet desserts will be located on a different portion of the dessert cart than the regular diet desserts. Consistent carb desserts for the special care unit residents will be marked with the residents initials before being sent to the special care unit. This will be audited at least three times a week during varying meals by dietary manager until 8 weeks of consistent compliance has been demonstrated. Audits will then go to weekly for the next 6 months. Auditing of the dessert cart and dessert portions will be completed by the Administrator during walking rounds at least monthly. This plan will be reviewed with the Quality Assurance Committee.	12/8/2023
F812	Counter mounted can opener has been cleaned and is now free from debris. Emergency light fixture in kitchen has been replaced. The wall mounter knife holder has been cleaned and is free from grease, dust, and debris. Counter top toaster has been replaced with a new toaster. The Ansul System Unit and kitchen hood have been cleaned and are free from grease and debris. The support pipes above the kitchen hood have been cleaned	12/31/2023

	and are free from debris. The shelving above the three-compartment sink, the back splash, and the floor underneath have been cleaned and are free from debris. The contact paper on the bottom shelving of the preparation tables has been replaced. The shelving above the food preparation counter has been cleaned and is free from dust and debris. The metal backsplash above the right side of the griddle top oven has been cleaned and is free from grease, debris, and stains. The right side of the griddle top oven has been cleaned and is free from grease, debris, and stains. The left side of the stove top oven has been cleaned and is free from grease and debris. Area under the stove top burner grates has been cleaned and is free from grease and debris. The walls of the walkin cooler have been cleaned and are free from dust and debris. All dented or unsealed food in the dry storage room has been removed and thrown away. The ice machine located in the 200 hall clean utility room has been returned to the company it was rented from. The remaining ice machine in the dining room will be inspected monthly by maintenance supervisor to ensure the drain has an adequate air gap. This will be audited by Administrator walking rounds monthly. The list of cleaning duties and expectations for dietary staff has been updated and all kitchen staff have been inserviced on the updates. Cleanliness of kitchen and surrounding area will be inspected weekly by Administrator for the next 3 months then monthly after that. All dietary staff have been inserviced on food storage and returning dented cans to the vendors. The dry food storage room will be inspected weekly by the Dietary Manager and monthly by the Administrator for the next 3 months. Administrator will inspect all food storage monthly during walking rounds. This plan will be reviewed with the Quality Assurance Committee.	
F909	All beds in the facility have been inspected using the bed entrapment grid and passed this inspection. Maintenance staff will follow manufacturer's recommendations to ensure compatibility and correct installation of all bed components, entrapment assessments, inspections, and maintenance. Maintenance staff and nursing staff have been inserviced on the entrapment grid. Maintenance staff has been inserviced on using the entrapment grid for their inspections. Nursing and housekeeping staff have been inserviced on reporting any abnormality or concern regarding bed and/or rails to the maintenance supervisor. All resident beds will be inspected monthly by the Maintenance department. Beds with any type of assist device will be inspected directly after installing the assist device, monthly, and as needed. This inspection will include the Bed Entrapment Grid. The need for assist devices to bed will be reviewed quarterly by the Social Service Designee for each resident and informed consent will be obtained prior to device being applied. The use of assist devices in the facility will be audited monthly by the social service department. Administrator will review and audit all bed assessment documentation monthly for the next six months. This plan will be reviewed with the Quality Assurance Committee.	12/15/2023
A5001	Refer to Plan of Correction for F803	12/31/23
A7015	Refer to Plan of Correction for F812	12/31/23

A7042	Refer to Plan of Correction for F812	12/31/23
A7067	Refer to Plan of Correction for F812	12/31/23

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.