STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265447	A. BUILDING _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCDONALD COUNTY LIVING CENTER	1000 PATTERSON STREET ANDERSON, MO 64831

(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 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Missouri Department of Health and Senior Services. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 12/09/24 through 12/12/24 Survey Census: 54 Sample Size: 26 Supplemental Residents: 0 Due to a lack of evidence of a deficient practice by the facility, no deficiencies were issued related to Complaint Intakes: MO00243680.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Wells | TITLE: Administrator | (X6) DATE: 1/3/2025

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 686	Continued From page 1	F 686		

Based on observations, interviews, and record review, the facility failed provide pressure ulcer prevention care per standards of practice when staff failed to ensure all staff were aware of a new order for placement of protective heel boots, that the intervention was consistently implemented, and that the new intervention was care planned for one of one sampled residents (Resident #23).

Review of the facility's policy, "Pressure Ulcer, Care and Prevention Of," undated, showed the purpose of the policy was to prevent and treat further breakdown of pressure sores. Treatment of pressure ulcers varies depending on the orders of the attending physician. The nurse was responsible for carrying out the treatment as ordered by the attending physician and for implementing measure to prevent pressure ulcers. Heel protectors was one of the listed interventions.

Review of the facility's policy, "Positioning the Resident," undated, showed the purpose of the policy was to relieve pressure and prevent skin breakdown, to relieve pain, and to promote proper body alignment. Staff to use protective devices as indicated.

1. Review of Resident #23's "Face Sheet," in the Electronic Medical Record (EMR), showed the following:

-Admission date of 06/27/19;
-Diagnoses included unspecified dementia without behavioral disorder and need for assistance with personal care.

Review of the resident's "Significant Change Minimum Data Set (MDS - an federally mandated

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F 686	Continued From page 2	F 686		

assessment tool complete by facility staff)" assessment, dated 11/15/24, showed the following:

-Resident was severely cognitively impaired;
-Resident at risk for developing pressure ulcers;
-Resident had no unhealed pressure ulcers at the time of the assessment.

Review of the resident's "Comprehensive Care Plan," revised 11/15/24, showed the following:

-Resident at risk for pressure ulcer/injury related to limited mobility and a history of urinary incontinence;
-Staff to report any signs of skin breakdown (sore, tender, red, or broken areas).

Review of the resident's nursing progress note dated 12/06/24, at 1:31 A.M., showed heels red, dry area to back of right heel, skin prep applied, and heels elevated on pillow at this time.

Review of the resident's "Active Orders," showed an order, dated 12/06/24, for heel boots while in bed.

Review of the resident's Treatment Administration Record (TAR) showed an order, dated 12/06/24, for "Booties to heels while in bed."

Review of the resident's "Comprehensive Care Plan," revised 11/15/24, showed staff did not update the care plan to reflect the new order for heel boots.

Observation on 12/09/24, at 9:30 A.M., showed the resident in bed with his/her eyes closed. One padded cloth heel boot was lying on the bed near

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F 686	Continued From page 3	F 686		

the resident's left foot. The boot was not on his/her foot.

Observation on 12/09/24, at 2:50 PM, showed the resident was not in his room. Two padded heel boots were visible in the partially open bedside dresser drawer.

Observation on 12/10/24, at 8:39 AM, showed the resident was lying in bed and covered with a blanket. Both of his/her feet were exposed. The resident was not wearing heel boots.

Observation on 12/10/24, at 10:08 AM, showed the resident was in bed and positioned on his right side. The resident was not wearing heel boots. The top drawer of the resident's bedside chest of drawers was partially open and the heel boots were resting in the drawer.

During an interview on 12/10/24, at 3:40 P.M., Certified Nursing Assistant (CNA) 1 said at about 9:00 A.M. yesterday, he/she assisted the resident's hospice nurse with putting him/her back to bed. When asked to open the top drawer of the resident's bedside chest, the CNA confirmed he/she saw the boots in the drawer and he/she thought they were for protection of the resident's heels. He/she said the hospice nurse or one of the nurse managers may have put the heel boots in the resident's drawer, but he/she was unsure. The CNA said he/she had not been directed to place the heel boots on the resident while he/she was in bed. The heel boots were for the prevention of skin breakdown.

During an interview on 12/11/24, at 7:38 AM, CNA 2 said he/she saw the resident's heel boots on his/her dresser this morning, so he/she placed

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F 686	Continued From page 4 them on his heels. Concurrent observation during the interview confirmed the resident was wearing heel boots. CNA 2 said he/she did not have difficulty getting the resident to wear protective heel boots. During an interview on 12/10/24, at 2:30 P.M., Licensed Practical Nurse (LPN) 2 confirmed the resident had an order for protective heel boots, but the resident would kick off the boots when staff tried to place them. During shift change report staff should have learned the resident was supposed to wear heel boots when lying in bed. During an interview on 12/11/24, at 8:11 AM, the Director of Nursing (DON) said the resident was supposed to wear heel boots in bed because he/she did not self-adjust in bed, and he/she had some softness to his/her heels. The boots were for the prevention of skin breakdown. The nurse who added the order to the TAR should have also added the intervention to the Point of Care (PoC) tracking system, under miscellaneous tasks, which would have then been viewable by the CNAs who provided resident care. Facility managers should ensure necessary resident care interventions were in place while conducting daily rounds on their assigned hallways. The resident's comprehensive care plan should have included the heel boots intervention for pressure ulcer prevention. Staff should have ensured the resident's heel boots were on while he was in bed, as directed by the physician's order.	F 686		
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 -	F 812		

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F 812	Continued From page 5 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was protected from possible contamination at all times when kitchen staff failed to air-dried bowls and pans prior to storage for use. This failure had the potential to increase the risk of food borne illness and had the potential to affect all 54 residents who resided in the facility and who received dietary services. Review of the facility's policy titled, "Dishwashing and Storage," undated, showed the following: -Air-dry all items. Never use a towel to dry items. Make sure items are completely dry before stacking or storing them. Store them in a way that will protect them from contamination. 1. Observation and interview on 12/09/24, at 9:45 A.M., showed the following:	F 812		

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F 812	Continued From page 6 -Five soup bowls stacked together that were still wet from washing and had not been allowed to fully air dry; -Cook (C) 1 said the bowls should be dry before they are stacked to help prevent contamination. Observation and interview on 12/09/24, at 9:54 A.M., showed the following: -Four pans, 6 inches by 10 inches by 6 inches deep, had been cleaned and stacked for use and were found to be still wet when they were unstacked. The pans were not allowed to fully air dry. -The pans were wet and staff didn't let them fully air dry before they stacked them.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	F 849		

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F 849	Continued From page 7 (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and	F 849		

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F 849	Continued From page 8 nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the	F 849		

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facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's

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F 849	Continued From page 10 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a system to ensure consistent communication and collaboration of care occurred between the facility and hospice staff for one resident (Resident #39) of one resident reviewed for hospice services. Review showed the facility did not provide a policy related to coordination of hospice services. 1. Review of Resident #39's Face Sheet, located in the electronic medical record (EMR) under the "Face Sheet" tab, showed the following: -Admission date of 06/09/22; -Readmission date of 08/05/22; -Diagnoses included heart failure, lymphedema (tissue swelling caused by an accumulation of	F 849		

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protein-rich fluid that's usually drained through the body's lymphatic system), and palliative (comfort) care.

Review of the resident's Minimum Date Set (MDS - a federally mandated assessment completed by facility staff), with a Assessment Reference Date (ARD) of 09/11/24, located under the "MDS" tab of the EMR, showed the resident was severely cognitively impaired.

Review of the resident's current "Care Plan," located in the EMR under the "Care Plan" tab, showed staff care planned the resident receiving hospice services. Staff noted hospice will work with the facility to ensure goals and approach are appropriate and will work as a team to meet needs, and that I have a peaceful/comfortable end of life.

Review of the resident's EMR showed no documentation of hospice evaluation(s), or hospice visits notes.

Review of the hospice communication book, from current hospice provider, showed no documentation of hospice evaluation, or hospice visit notes.

During an interview on 12/11/24, at 3:15 P.M., the Medical Records (MR) Staff said the current hospice provider began service as of 10/25/24. After reviewing the resident's EMR and hospice communication book, there was no record of an evaluation being completed and no written notes available for review of the care being provided by hospice staff. The only records listed in the communication book was the "visit tracking log" of when they visited.

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F 849	Continued From page 12 During an interview on 12/11/24, at 3:40 P.M., the MR said the hospice staff were supposed to check out with the Administrator when they completed their visits. The Administrator had access to the hospice EMR and could look up their information. The hospice nurses talk with the facility nurses and they will then document the information if needed. The facility staff do not have access to the hospice EMR, and hospice does not document in the facility EMR. The notes that hospice makes are not in the facility EMR. During an interview on 12/11/24, at 4:10 P.M., the Administrator said the Hospice nurse was supposed to check out with the nurse and the nurse manager. The facility staff responded to the information provided. The hospice certified nursing assistant (CNA) are supposed to check out with the nurse and the nurse manager and Administrator. We have a "Journey meeting" (a meeting to discuss the resident's care) with hospice and hospice documents the minutes from these meetings. The facility does not have them. The hospice book for the resident was reviewed and there was no information available to review. The hospice communication book did not have any notes in it.	F 849		

PLAN OF CORRECTION

Provider/Supplier Name:	McDonald County Living Center
Street Address, City, Zip:	1000 Patterson Street Anderson MO 64831
Date of Survey:	12/12/2024

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
F686 SS=D	This Plan of Correction (POC) is submitted under State and Federal Law. The submission of this POC does not constitute an admission on the part of McDonald County Living Center (the facility) as to the accuracy of the surveyor's findings or the conclusions drawn there from. The facility's submission of this POC does not constitute the submission of McDonald County Living Center that the findings cited are accurate, constitute a deficiency, or that the scope and severity regarding the deficiencies cited are correctly applied. The POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date listed in the POC. Compliance will be maintained as provided in the POC. F686 All residents have the potential to be affected. All residents identified as at risk for pressure ulcers will be reviewed to ensure preventive pressure relief interventions are utilized. Resident #23 the DON looked at resident # 23 "active" orders and he/she did have a nursing order for prevention. DON did add this order to the point of care tracking for the Nursing staff to see to ensure it is implemented. Inservice education will be provided to the nursing staff regarding use of preventive pressure relief interventions by January 25, 2025. The DON or designee will audit 3x a week x4, then 2x a month for 30 days, then x1 months of 90 days and ongoing as needed to ensure preventive pressure relief interventions are in place. The DNS or designee will audit "active orders" for preventive pressure sore relieving devices 1x a week x4, then 1x a month for 30 days, then x1 months of 90 days and ongoing as needed.	01-25-2025

	The DON/ or designee will report findings to QA committee monthly. Date of Alleged Compliance: January 25, 2025	
F812 SS=F	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may have discussed this plan of correction. In addition, preparation, and submission of this plan of correction does not constitute agreement of any kind by the facility as to the truth of any facts alleged or correctness of any conclusions set forth in this allegation by the survey agency. The POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date listed in the POC. Compliance will be maintained as provided in the POC. F812 All residents have the potential to be affected The facility will keep food safe from potential contamination with food contact surfaces (wet dishes). The facility will put all equipment, eating equipment, and utensils in a self-draining position that allows air drying. DSM will in-service the Dietary staff on the facility policy on self-draining position that allows air drying. Training to be completed by January 25, 2025. Dietary Manager/ or Designee will audit for proper air drying of the equipment, eating equipment, and utensils 2x a week x4, then 1x a month for 30 days, then x1 months of 90 days and ongoing as needed. The Dietary Manager/ or Designee will report findings to QA committee monthly. Date of Alleged Compliance: January 25, 2025.	01-25-2025
F849 SS=D	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may have discussed this plan of correction. In addition, preparation, and submission of this plan of correction does not constitute agreement of any kind by the facility as to the truth of any facts alleged or correctness of any conclusions set forth in this allegation by the survey agency. The POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved	01-25-25

	no later than the last completion date listed in the POC. Compliance will be maintained as provided in the POC. F849 All residents have the potential to be affected. Resident # 39 chart was audited by hospice services on December 13, 2024 and the lacking documentation was provided for resident # 39 binder located in the nurse's station. Hospice services will be in-serviced by their administrators on placing proper documents into their charts to ensure consistent communication and collaboration of care. DON, Medical Records, and Designee will be in-service to check the charts monthly to ensure proper documentation is in their hospice charts by January 25, 2025. All hospice residents' binders were audited for appropriate documentation on December 13, 2024 and lacking documents were added. The DNS or designee will audit hospice charts to ensure consistent communication and collaboration of care occurs between the facility and hospice staff 1x a month for 90 days and ongoing as needed. The DON/ or designee will report findings to QA committee monthly. Date of Alleged Compliance: January 25, 2025	

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