STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

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F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to complete an accurate Level I Pre-Admission Screening (used to evaluate for the presence of psychiatric conditions to determine if a Pre-admission Screening and Resident Review (PASARR) level II screen is required) as required for two residents (Resident #6 and #56) out of 18 sampled residents with new mental health diagnoses. The facility census was 60. 1. Review of the facility's policy titled "Admission Criteria", revised March 2019, showed staff are directed to use the PASRR to screen all potential admissions to determine if they meet the criteria for mental disorder, intellectual disabilities, or	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey Shavers | TITLE: Administrater | (X6) DATE: 5-2-25

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

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F 644	Continued From page 1 related disorders regardless of payer source. 2. Review of Resident #6's Face Sheet, dated 09/30/22, showed the resident admitted to the facility on 12/04/24 with a diagnosis of Post Traumatic Stress Disorder (PTSD) Review of the resident's medical record showed staff used a Level I Pre-Admission Screening completed at another facility on 09/10/21, which did not contain the diagnosis of PTSD. During an interview on 04/23/25 at 1:23 P.M., the Social Service Designee (SSD) said with the resident's new diagnosis a new Level I Pre-Admission Screening should have been completed. The SSD said he/she did not review the resident's previous Level I screening when he/she was admitted. The SSD said he/she did not know the resident had PTSD. The SSD said he/she did not know he/she should review Level I screenings for residents admitted from different facilities. 3. Review of Resident #56's Significant Change in Status Assessment (SCSA) minimum data set (MDS), a federally mandated assessment tool, dated 03/07/25, showed staff assessed resident as: -Severely cognitively impaired; -Had verbal and physical behaviors one to three days during the look back period; -Diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, Dementia, and anxiety disorder. Review of the residents Level I Pre-Admission Screening dated, 01/14/25 showed the resident	F 644		

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F 644	Continued From page 2 did not have any mental health diagnoses. Review of the resident's medical record, dated 02/10/25, showed the resident transferred to a psychiatric hospital for evaluation and treatment an returned to the facility on 02/21/2025. The record did not contain an updated Level I Pre-Admission Screening. During an interview on 04/23/25 at 1:23 P.M., said he/she did know about the resident's psychiatric evaluation and new diagnosis. 4. During an interview on 04/23/25 at 1:23 P.M., the SSD said he/she is responsible for completing the PASARR's. The SSD said PASRR's should be completed before admission and updated with any change in condition or if the resident is on a leave of absence for greater than 60 days. A change in condition would include being diagnosed with a new mental health diagnosis. The SSD said they were not aware that a new PASRR needed to be completed with a change in condition until this week. During an interview on 04/24/25 at 10:58 A.M., the Director of Nursing (DON) said he/she did not know until this week when a PASRR should be completed. The SSD is responsible for accurately completing PASRR's. During an interview on 04/24/25 at 11:40 A.M., the administrator said the SSD is responsible for completing PASRR's. PASRR's should be completed on admission and with a change in condition. The SSD did not know the requirements and is in the process of learning PASRR's. The resident's PASRR should have been updated after the psychiatric stay and new	F 644		

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F 644	Continued From page 3 diagnosis.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 645		

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F 645	Continued From page 4 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to accurately complete the Pre-Admission Screening and Resident Review (PASRR) process prior to admission for two residents (Residents #18, and #44) out of 18 sampled residents. The facility census was 60.	F 645		

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F 645	Continued From page 5 1. Review of the facility's policy titled "Admission Criteria", dated March 2019, showed all new admissions and readmissions are assessed for mental disorders, intellectual disabilities or related disorders RD per the Medicaid PASSAR process. The facility conducts a Level I PASSAR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for mental disorders, intellectual disabilities or related disorders. 3. Review of Resident 18's Face Sheet, dated 12/04/24, showed the resident admitted to the facility on 12/04/24 with diagnoses of Schizophrenia, Generalized Anxiety Disorder and Mild Cognitive Impairment. Review of the resident's medical record showed staff completed a Level I Pre-Admission Screening, dated 03/18/25, more than three months after the resident had been admitted. During an interview on 04/23/25 at 1:23 P.M., the Social Service Designee (SSD) said the resident admitted from a residential care facility (RCF) and he/she forgot to complete the Level I Pre-Admission screening until the medicaid office called and said they were waiting on one. The SSD said he/she thinks he/she has 30 days to complete the screening. The SSD said he/she did not complete the screening within 30 days of the resident's admission. 4. Review of Resident 54's Face Sheet, dated 11/25/24, showed the resident admitted to the facility on 11/25/24 with diagnoses of Dementia with psychotic disturbance, Major Depressive Disorder, Generalized Anxiety Disorder and Insomnia.	F 645		

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F 645	Continued From page 6 Review of the resident's medical record showed staff completed a Level I Pre-Admission Screening on 03/18/25, more than four months after the resident had been admitted. Review showed staff failed to document the resident's in patient psychiatric stay within the last three months. During an interview on 04/23/25 at 1:23 P.M., the SSD said he/she did not complete the resident's Level I Screening within 30 days of the resident's admission because he/she forgot. During an interview on 04/24/25 at 10:51 A.M., the Director of Nursing (DON) said he/she does not know how long the facility has to complete the Level I Pre-Admission Screening for newly admitted residents. The DON said he/she does not know why it had not been completed for the two residents upon admission. During an interview on 04/24/25 at 11:41 A.M., the administrator said the SSD should complete a Level I Pre-Admission screening upon the residents' admission. The administrator said he/she does not know why the screenings were not completed when the two residents were admitted to the facility, and it should have been done on admission. The administrator said he/she is responsible to ensure the SSD has completed the screenings.	F 645		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		

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F 688	Continued From page 7 range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to provide appropriate treatment and services to prevent further decrease in range of motion (ROM), movement of a joint, for one resident (Resident #23) out 18 sampled residents, who had a contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to the left hand. The facility census was 60. 1. Review of the facility's policy titled, "Resident Mobility and Range of Motion", dated July 2017, showed residents will not experience an avoidable reduction in ROM. Residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction to mobility is unavoidable. The resident's care plan will include specific interventions, exercises	F 688		

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F 688	Continued From page 8	F 688		

and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. Resident will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered, and are outline in the resident's plan of care.

2. Review of Resident #23's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/11/25, showed staff assessed the resident as:

-Severe cognitive impairment;
-ROM impairment to one side of upper and lower extremities;
-Used a wheelchair;
-Diagnoses of Stroke, Aphasia (language disorder that affects a person's ability to communicate, affects a person's ability to express and understand written and spoken language) and Hemiplegia (paralysis, or the ability to move on side of the body).

Review of the resident's care plan, dated 01/30/25, showed staff documented the resident is not on a restorative program, he/she is at his/her potential. Monitor and record any increased stiffness in joints. Provide instruction and assistance during ROM. Restorative Aid provided assistance with ROM.

Review of the resident's Contracture Risk Assessment, dated 01/30/2023, showed staff documented:

-Joint condition has moderate limitation;
-Muscle tone has moderate hypertonicity (muscles are abnormally tight or stiff) or flaccid;

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F 688	Continued From page 9 -Degenerative Disorder (gradual deterioration of tissues); -Restorative program. Observation on 04/21/25 at 12:22 P.M., showed the resident's left hand contracted without an intervention in place. Observation on 04/21/25 at 3:18 P.M., showed the resident's left hand contracted without an intervention in place. Observation on 04/22/25 at 11:01 A.M., showed the resident's left hand contracted without an intervention in place. Observation on 04/23/25 at 8:30 A.M., showed resident propelled self down the hall in his/her wheelchair. Resident attempted to open his/her contracted left hand with his/her right hand. Observation on 04/24/25 at 10:01 A.M., showed the resident propelled self down the hall in his/her wheelchair. The resident's left hand contracted with no intervention in place. During an interview on 04/23/25 at 3:20 P.M., Certified Medication Technician (CMT) M said he/she had not noticed the resident's left hand is contracted. The CMT said he/she doesn't know if staff are doing anything with the resident's left hand, and doesn't know if restorative is working with the resident. During an interview 04/24/25 at 9:21 A.M., Restorative Aide (RA) O he/she does not work with the resident. The RA said when he/she walks by the resident he/she puts a rolled up washcloth in the resident's left hand, but it's probably not on	F 688		

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the resident's care plan. The resident had a carrot (devices placed in hand to prevent further contractures). The RA said he/she does not think any of the staff do the rolled up wash cloth with the resident. The RA said he/she has not talked to staff about rolling up a washcloth for the resident and that's his/her fault. The RA said he/she did not tell the Therapy Department when the resident lost his/her carrot over a year ago. The RA said he/she did not think to tell therapy, because the resident does not receive therapy anymore. The RA said he/she does not provide ROM for the resident and has not seen staff do it either. The RA said he/she has seen the resident pull on his/her fingers on his/her contracted hand, it's probably because he/she needs ROM completed with him/her.

During an interview on 04/24/25 at 9:47 A.M., the Rehabilitation Director said the resident has a contracture to the left hand from a stroke. The Rehabilitation Director said he/she would expect staff to complete ROM when getting the resident dressed. The Rehabilitation Director said to his/her knowledge there has not been a specific splint recommended or anything like that for the resident, and it has not been mentioned to him/her. The Rehabilitation Director said if there is not an intervention in place, the contracture would get worse. The Rehabilitation Director said he/she would have expected staff to let him/her know the resident lost his/her carrot, the Rehabilitation Department has plenty of carrots, or splinting things downstairs.

During an interview on 04/24/25 at 10:16 A.M., CMT M said he/she doesn't know if anything is care planned for the resident's ROM, and he/she doesn't even know if he/she has access to look at

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F 688	Continued From page 11 the care plans. CMT M said he/she hasn't looked at the resident's care plan. During an interview on 04/24/25 at 11:03 A.M., the Director of Nursing (DON) said he/she would expect staff to use a rolled up wash cloth or a carrot in the resident's hand to prevent further contracture. The DON said he/she would expect staff to provide ROM with the resident when they clean his/her hands throughout the day. The DON said if the resident had a carrot and it went missing, he/she would expect staff to report it to restorative therapy, or the charge nurse. The DON said he/she doesn't know why staff are not providing interventions for the resident's contracted hand. During an interview on 04/24/25 at 11:41 A.M., the administrator said he/she would expect staff to follow orders for residents with contractures. The administrator said staff usually keep continuous orders for restorative therapy if a resident has contractures to keep the contractures from getting worse. The administrator said he/she expects staff to report to the charge nurse if a resident has a device and it gets lost, so it can get replaced. The administrator said he/she doesn't know why staff did not report the resident's missing therapy device.	F 688		
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,	F 801		

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F 801	Continued From page 12 individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other	F 801		

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MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

(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 801	Continued From page 13 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 D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services (DFNS) with the appropriate qualifications, when the	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

(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 801	Continued From page 14 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 60. 1. Review of the facility's Dietitian policy, revised November 2022, showed: -If a dietician is not employed full time (35 or more hours per week) a director of food and nutrition services will be designated. The individual will: a. be a certified dietary manager; or b. be a certified food service manager; or c. be nationally certified in food service management and safety; or d. have a associated's (or higher) desgree in food service management or hospitality, if the course study includes food service or restaurant management, from an accredited institution; or e. has two 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 f. receives frequently scheduled consultations from a qualified dietitian or other qualified nutrition professional. -For designations made before November 28, 2016, the director of food and nutrition services will meet the above requirements no later than November 28, 2021. For designations made after November 28, 2016, the requirements will be met no later than November 26, 2017.	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

(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 801	Continued From page 15 Review of the dietary manager's (DM) personnel records showed a hire date for the DFNS position listed as 03/17/25. Review showed the records did not contain documentation of prior experience as a DFNS in a nursing facility and certification or other education required for the director of nutritional services position. During an interview on 04/23/25 at 1:15 P.M., the DM said he/she became the DM on 03/17/25 and he/she did not have a degree or certification related to food service management. The DM said he/she had been a DM in another nursing facility for at least two years, but he/she had not completed any courses of study related to food safety and managment. The DM said the facility enrolled him/her in an online certified dietary manager's course, but he/she had not started the course yet. The DM said the facility's consultant registered dietician (RD) only works part-time and the facility did not have any other clinically qualified nutritional staff employed full-time. During an interview on 04/23/25 at 2:13 P.M., the administrator said the DM had been the DM since March 2025 and he/she did not have a degree or certification related to food service management. The administrator said the DM had been a DM in another nursing facility for at least two years, but he/she had not completed any courses of study related to food safety and managment. The administrator said the facility's consultant RD only works part-time and the facility did not have any other clinically qualified nutritional staff employed full-time. The administrator said they enrolled the DM in an online certified dietary manager's course after his/her hire, but he/she had not started the course yet. The administrator said he/she knew of the qualifications that the DFNS	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

(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 801	Continued From page 16 had to meet by regulation, but he/she thought they just needed to enroll the DM into a course and did not realize that the DM had to meet the qualifications upon hire.	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. §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 failed to thaw frozen meat in a manner to prevent the growth of food-borne pathogens. This failure has the potential to affect all residents. The facility census was 60 . 1. Review of the 2022 United States Food and Drug Administration Food Code, section 3-501.13 Thawing, showed:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

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F 812	Continued From page 17 -Except as specified in paragraph (D) of this section, time/temperature control for safety food shall be thawed: (A) Under refrigeration that maintains the food temperature at 41 degrees Fahrenheit (dF) or less; or (B) Completely submerged under running water: (1) At a water temperature of 70 dF or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of ready-to-eat food to rise above 41 dF, or (4) For a period of time that does not allow thawed portions of a raw animal food requiring cooking as specified under paragraphs 3-401.11(A) or (B) to be above 41 dF for more than 4 hours including: (a) The time the food is exposed to the running water and the time needed for preparation for cooking, or (b) The time it takes under refrigeration to lower the food temperature to 41 dF; (C) As part of a cooking process if the food that is frozen is: (1) Cooked as specified under paragraphs 3-401.11(A) or (B), subsection 3-401.12, or subsection 3-401.15, or (2) Thawed in a microwave oven and immediately transferred to conventional cooking equipment, with no interruption in the process; or (D) Using any procedure if a portion of frozen ready-to-eat food is thawed and prepared for immediate service in response to an individual consumer's order. Observation on 04/23/25 at 9:48 A.M., showed the food preparation sinks in the cook's station contained a 10 pound package of raw ground	F 812		

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	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

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F 812	Continued From page 18 beef and a half cut fully cooked deli-style turkey breast in a plastic resealable bag floating in water without running water on it. Observation also showed a package of frozen blueberries laid in a small amount of 82 degrees Fahrenheit (dF) water. Observation showed the frozen blueberries did not have running water on them. During an interview on 04/23/25 at 9:52 A.M., Cook B said he/she put the hamburger in the sink a little bit ago to thaw for use at lunch, but he/she put the turkey breast in the sink at 7:00 A.M. to thaw for use on the sandwiches for dinner. The cook said he/she just put the package of blueberries in sink to thaw so he/she could make the dessert for lunch. The cook said he/she was trained to pull foods from the freezer to thaw in refrigerator three days a head of time, but staff did not pull the items so they were still frozen. The cook said he/she was not trained how to thaw foods in the sink and he/she had seen other staff thaw frozen foods this way. Observation on 04/23/25 at 10:18 A.M., showed the cook removed the raw hamburger from the sink of water, removed it from the packaging, placed it in a pan on the stove and cooked it to make goulash for the lunch meal. Observation showed the plastic bag of turkey breast and package of blueberries remained in the sinks of water without water running on them. Observation on 04/23/25 at 11:02 A.M., showed the cooked removed the package of blueberries from the sink and used the contents to prepare the dessert for the lunch meal. Observation showed the plastic bag of turkey breast remained in the sink of water without water running on it.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265713	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION CENTER	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

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F 812	Continued From page 19 During an interview on 04/23/25 at 11:02 A.M., the DM said, if thawed in the sink, frozen food should be submerged in cool water with cool water running on it and staff have been trained on how to properly thaw food. The DM said he/she has had to provide a lot of correction and reeducation to staff since he/she became the DM on 03/17/25. During an interview on 04/23/25 at 3:00 P.M., the administrator said the facility did not have a policy for food thawing and in the absence of a policy, staff should follow the current food code requirements. The administrator said, when thawed in the sink, frozen food should be submerged under cool running water and staff have been trained on how to properly thaw food as he/she had just in-serviced staff on the requirements after they recently had to throw away two cases of turkey due to improper thawing.	F 812		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05422	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

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A4081	19 CSR 30-85.042(72) Restorative Nursing, Res Out of Bed Facilities shall provide each resident, according to his/her needs, with restorative nursing to encourage independence, activity and self-help to maintain strength and mobility. Each resident shall be out of bed as desired unless medically contraindicated. II This regulation is not met as evidenced by: Class II Refer to F688	A4081		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III Refer to F644 and F645	A4108		
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	A5014		

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	05422	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER COUNTY CARE AND REHABILITATION	1157 HIGHWAY 17 TUSCUMBIA, MO 65082

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A5014	Continued From page 1 Refer to F801	A5014		
A7035	19 CSR 30-87.030(33) Thawing Potentially Hazardous Foods Potentially hazardous foods shall be thawed in refrigerated units at a temperature not to exceed forty-five degrees Fahrenheit (45°F); or under potable running water at a temperature of seventy degrees Fahrenheit (70°F) or below, with sufficient water velocity to agitate and float off loose food particles into the overflow; or in a microwave oven only when the food will be immediately transferred to conventional cooking facilities as part of a continuous cooking process or when the entire, uninterrupted cooking process takes place in the microwave oven; or as part of the conventional cooking process. II/III This regulation is not met as evidenced by: Class III Refer to F812	A7035		

PLAN OF CORRECTION

Provider/Supplier Name:	Miller County Care and Rehabilitation Center
Street Address, City, Zip:	1157 Highway 17, Tuscumbia MO 65082
Date of Survey:	04/21/25-4/24/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265713

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 644	The facility does and will continue to ensure coordination assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in Subpart C of this part to the maximum extent practicable to avoid duplicative test and effort.	05/25/2025
	The facility will ensure a complete and accurate level I pre-admission screening prior to admission to evaluate for the presence of psychiatric conditions to determine if a level II is required.	
	Social Services Director/Designee, MDS coordinator, Care plan coordinator, audit nurse/mental health nurse, Administrator and Director of Nursing will be in-serviced on requirements of level I screening accuracy of Pre-Admission Screening and Resident Review prior to admission to evaluate the presence of psychiatric conditions with completion by 05/25/25.	
	The Social Services Director/Designee will complete and submit an accurate Level I screening on all residents meeting the requirement of change in status of existing residents in facility that meets requirements with completion by 05/25/2025.	
	MDS Coordinator, Care plan coordinator, audit nurse, mental health nurse, and/or Director of Nursing will ensure to report any new diagnosis in Level II residents, change in ADL in Level II residents, and any psychiatric evaluations and treatments of all residents to the Social Services Director/designee upon change to ensure timely reporting for change in status form to be completed. All IDT team members will be notified upon change and discussed at weekly IDT meetings. This will be tracked with weekly Risk assessment logs.	
	Social Services Director/Designee, MDS coordinator, Care plan coordinator, Audit Nurse, Administrator and Director of Nursing will perform competency to ensure understanding of requirements of Level I and Level II screenings with completion	

	on 05/25/25.	
	All current residents have had an PASRR, determined through audit process of IDT team, completed and an audit will be completed upon admission, re-admission, monthly x3, and quarterly thereafter at QA meetings.	
	The Administrator/Designee will ensure education and compliance will be completed and maintained Quarterly at the QA meetings.	
	The facility plans to monitor its performance to ensure that the solutions are sustained. This plan will be implemented, and the corrective actions will be evaluated for its effectiveness. The plan of correction will be integrated into the QA program.	
F 645	The facility does and will ensure accurate and timely completion of Pre-admission Screening and Resident Review process prior to admission for all residents.	05/25/2025
	Social Services Director/Designee, MDS coordinator, Care plan coordinator, audit nurse/mental health nurse, Administrator and Director of Nursing will be in-serviced on requirements of level I screening prior to admission to evaluate the presence of psychiatric conditions with completion by 05/25/25.	
	The Social Services Director/Designee will complete and submit a Level I screening on all residents meeting the requirements prior to entering the facility as required with completion by 05/25/2025.	
	Social Services Director/Designee, MDS coordinator, Care plan coordinator, Audit Nurse Administrator and Director of Nursing will perform a competency to ensure understanding of requirements of Level I and/or Level II screenings prior to admission with completion on 05/25/25.	
	All current residents have had an audited to meet compliance per regulation and an audit will be completed upon admission, re-admission, monthly x3, and quarterly thereafter at QA meetings.	
	The Administrator/Designee will ensure education and compliance will be completed and maintained Quarterly at the QA meetings.	
	The facility plans to monitor its performance to ensure that the solutions are sustained. This plan will be implemented, and the	

	corrective actions will be evaluated for its effectiveness. The plan of correction will be integrated into the QA program.	
F 688	The facility does and will ensure to provide appropriate treatment and services to prevent further decrease in range of motion (ROM)and movement of joints.	05/25/2025
	The direct care staff will be educated and in-serviced to ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. Also, any resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. All direct care staff will also be educated on how to access care plans in Point of Care where all documentation is available for any treatments and/or devices used for the resident.	
	All direct care staff will complete competence to ensure understanding of requirements, reporting of any missing adaptive supplies, who to report any missing supplies/equipment to, location of where these items would be listed in Point of Care, and how to access resident care plans in POC.	
	MDS Coordinator, Care plan Coordinator, and members of the IDT will ensure the review of any plans of treatment with MDS schedule, significant changes and as needed.	
	All current residents have had an audit completed to ensure equipment is available, orders are in place, care plan is updated to reflect current needs, RNA program in place if required and an audit will be completed upon admission, re-admission, weekly x 4 weeks, monthly x3, and quarterly thereafter at QA meetings.	
	The Administrator/Designee will ensure education and compliance will be completed and maintained Quarterly at the QA meetings.	
	The facility plans to monitor its performance to ensure that the solutions are sustained. This plan will be implemented, and the corrective actions will be evaluated for its effectiveness. The plan of correction will be integrated into the QA program.	
F 801	The facility does and will ensure to designate a person to serve as the Director of Food and Nutrition Services with appropriate qualifications.	05/25/2025

	The facility will educate and in-service the Dietary Supervisor and Administrator on the qualifications that must be held by the Dietary supervisor if the facility does not employ a qualified dietitian or other clinically qualified nutrition professional full-time.	
	The facility will provide a competency of this regulation to the Dietary Supervisor/Designee and Administrator to ensure understanding.	
	The Dietary Supervisor will complete an approved course with completion earning a ServSafe Food Service Manager certification.	
	All current Dietary Supervisors will be audited to ensure qualifications are met and sustained for duration of employment, and an audit will be completed prior to employment, monthly x3, and quarterly thereafter at QA meetings.	
	The Administrator/Designee will ensure education and compliance will be completed and maintained Quarterly at the QA meetings.	
	The facility plans to monitor its performance to ensure that the solutions are sustained. This plan will be implemented, and the corrective actions will be evaluated for its effectiveness. The plan of correction will be integrated into the QA program.	
F 812	The facility does and will ensure facility staff thaw frozen meat in a manner to prevent the growth of food-borne pathogens.	05/25/2025
	All Dietary staff and Administrator will be educated and in-serviced on proper thawing method for frozen meats per updated facility policy.	
	All Dietary staff will complete a performance competency on proper thawing of frozen meats per facility policy by the Dietary Supervisor/Designee.	
	All current Dietary staff will be audited by the Dietary Supervisor/Designee to ensure understanding and compliance, and an audit will be completed weekly x4 weeks, monthly x3, and quarterly thereafter at QA meetings.	
	The Administrator/Designee will ensure education and compliance will be completed and maintained Quarterly at the QA meetings.	

	The facility plans to monitor its performance to ensure that the solutions are sustained. This plan will be implemented, and the corrective actions will be evaluated for its effectiveness. The plan of correction will be integrated into the QA program.	

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

PLAN OF CORRECTION

Provider/Supplier Name:	Miller County Care and Rehabilitation Center
Street Address, City, Zip:	1157 Hwy 17 Tuscumbia MO 65082
Date of Survey:	02/23/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265713

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4081	Refer to F688	05/25/2025
A4108	Refer to F645	05/25/2025
A4108	Refer to F644	05/25/2025
A5014	Refer to F801	05/25/2025
A7035	Refer to F812	05/25/2025

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.