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	265678	A. BUILDING _____ B. WING _____	07/10/2024

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F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Don D. Chance | TITLE: Administrator | (X6) DATE: 07-24-2024

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 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 51. Review of the facility's policy titled, "Homelike Environment," revised February 2021, showed: - Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use personal belongings to the extent possible; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting; - These characteristics include a clean, sanitary and orderly environment; - Staff provide person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. Observations made on 07/07/24 at 8:40 A.M. , 07/08/24 at 9:44 A.M. and 07/09/24 at 8:22 A.M., showed: - Several areas of peeled paint on the walls behind the recliner near the window in Room 103; - A cable plate cover hanging out of the wall and not secured on the left side of the dresser with television in Room 104; - Several areas of exposed sheetrock and peeled paint on the right side of the headboard of bed 1 in Room 106; - Two nails sticking out of the wall with four feet	F 584		

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(ft.) of missing trim by bed 1 near the door in Room 107;
- Exposed sheetrock and peeled paint on the wall near the call-light plate and recliner in Room 112.

Review of the repair sheet log dated 05/23/24 to 07/04/24 showed no documentation of area of concerns addressed.

During an interview on 07/09/24 at 8:40 A.M., Housekeeper A said any environmental concerns are brought to the attention of maintenance supervisor or the administrator. There is also a repair log at the nurse's station that staff can write any needed repairs needed on. He/She has seen environmental concerns and has told maintenance.

During an interview on 07/09/24 at 8:47 A.M., Housekeeper B said he/she verbally tells maintenance or the administrator if there is an environmental concern. There is also a repair log at the nurse's station that staff can write down things that need to be fixed. He/She has not seen any environmental concerns that needed to be addressed.

During an interview on 07/10/24 at 8:20 A.M., Maintenance Supervisor said there is a repair log at the nurse's station for staff to write down any environmental concerns. Staff does verbally inform him/her of repairs needed, but staff also need to write down those concerns on the repair log so he/she doesn't forget when told in passing.

During an interview 07/10/24 at 10:56 A.M., the Administrator said staff should write down any environmental concern on the repair log located at the nurse's station to be addressed in a timely

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manner. He said even if staff verbally tells someone about an area of concern, it should be written down for documentation purposes.

2. Observations made on 07/07/24 showed:
- At 1:30 P.M., rooms 217-228 located in the newer added wing with self-closing devices on the resident room doors;
- At 3:13 P.M., three out of five sampled doors between rooms 217-228 closed quickly, making it difficult to get through the door without it closing.

Observations made on 07/08/24 showed:
- At 10:08 A.M., resident in room #217, leaving his/her room with walker, and door closing onto resident's backside as he/she exited the room;
- At 10:10 A.M., of room #220, a trashcan placed between door and doorframe, keeping it open.

Observation made on 07/09/24 at 8:50 A.M., of room #220, showed:
- Resident asked for help opening his/her door from the inside;
- Resident attempted to open door approximately five times;
- Resident door opened and shut quickly;
- Resident continued to ask for help opening his/her door;
- Resident wheelchair bound and unable to move through the door quick enough to exit the room.

During an interview on 07/08/24 at 2:41 P.M., the resident in room #221 said he/she does not understand why his/her door has to stay shut, and the other rooms on the hall can leave their doors open.

During an interview on 07/08/24 at 2:48 P.M., the Resident in room #225 said he/she has

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complained multiple times that the doors are heavy and difficult to open in the resident's room.

During an interview on 07/09/24 at 11: 01 A.M., the resident in room #220 said he/she has a trash can propping the door open so the resident doesn't miss lunch. The resident said he/she is unable to open the door independently due to being in a wheelchair.

During an interview on 07/10/24 at 9:58 A.M., the Director of Nursing (DON) said facility staff is aware the doors on the newest wing are more difficult to open than the rest of the building because they are equipped with automatic self-closing devices. Before a resident is placed in the newer room, staff does a review of therapy notes, case management and hospital notes to decide if residents are appropriate to be in the rooms with the self-closing devices on the doors. The DON said he/she would expect residents to be capable of going in and out of their room as they please, if they were physically able to do so.

During an interview on 07/10/24 at 11:03 A.M., the Administrator said the doors in the newest addition are equipped with automatic self-closing devices that he was under the impression were required by the Life Safety Code. The Administrator said he would not necessarily expect every resident to be able to go in and out of their rooms as they wished, it would depend on the resident and the scenario. The Administrator said they were aware the doors to the newer rooms could not stay open and would close quicker than the others, so they made an effort to ensure only alert, oriented and capable residents were put back there.

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F 656	Continued From page 5	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

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

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F 656	Continued From page 6 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a care plan with specific interventions to meet individual needs for one resident (Resident #21) out of 13 sampled residents. The facility census was 51. Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," dated December 2016, showed: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; - The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; - The care planning process will include an assessment of the resident's strengths and needs; - The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.	F 656		

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F 656	Continued From page 7 1. Review of Resident #21's medical record showed: - An admission date of 03/17/21; - A diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning). Review of the resident's care plan, dated 06/26/24, showed the care plan did not address specific interventions related to dementia. During an interview on 07/10/24 at 11:25 A.M., the Minimum Data Set (MDS) Coordinator said he/she completes the care plans and would expect dementia to be on the resident's care plan. During an interview on 07/10/24 at 11:28 A.M., the Director of Nursing (DON) said the dementia diagnosis is not new for this resident and she would expect it to be on the resident's care plan.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		

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resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to obtain orders to change the indwelling catheter (a tube inserted into the urinary bladder to drain urine) every 30 days and failed to ensure documentation of the catheter changes were maintained for one resident (Resident #31) and failed to obtain a physicians order for catheter care to be performed every shift for two residents (Residents #31 and #40) out of two sampled residents. The facility census was 51.

Review of the facility's policy, titled, "Catheter Care, Urinary", revised September 2014, showed:
- Policy did not address frequency catheter care should be completed;
- Policy did not address frequency catheter

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should be changed.

1. Review of Resident #31's medical record showed:
- Admission date of 04/06/22;
- Diagnoses of intervertebral disc degeneration, thoracolumbar region (discs between vertebrae with loss of cushioning), Incontinence without sensory awareness (inability to control the flow of urine from the bladder), Acute Respiratory Failure (when the body is unable to exchange oxygen and carbon dioxide), Chronic obstructive pulmonary disease (COPD) (lung disease that makes it difficult to breathe), retention of urine (difficulty emptying the bladder of urine);

Review of the resident's Physician's Order Sheet (POS), dated 06/06/24, showed:
- A telephone order to place foley catheter related to urinary retention;

Review of the POS dated June 2024 and July 2024, showed:
- No orders for catheter care every shift, catheter change frequency and catheter size;

Review of Treatment Administration Record (TAR), dated June 2024 and July 2024, showed:
- No catheter care documented;

2. Review of Resident #40's medical record showed:
- An admission date of 02/02/23;
- Diagnoses of COPD, chronic respiratory failure, retention of urine, and chronic kidney disease, stage 3 (kidneys have mild to moderate damage and are less effective at filtering waste and extra fluid from the body);

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F 690	Continued From page 10 Review of the resident POS, dated July 2024, showed: - No orders for catheter care; Review of residents' TAR dated May 2024 showed blank space on date catheter ordered to be changed; Review of Medication Administration Record (MAR) dated June 2024, showed: - An order for a Urinalysis with culture and sensitivity collected on 06/04/24; - An order for Macrobid (antibiotic) 100mg by mouth two times daily for Urinary tract infection (UTI) for 10 days, dated 06/06/24 During an interview on 07/09/24 at 03:08 P.M. the Assistant Director of Nursing (ADON), said typically when a resident has a urinary catheter, orders are entered into the Electronic Medical Record (EMR) for frequency of change, size and catheter care. During an interview on 07/10/24 at 08:53 A.M., the Director of Nursing (DON), said if on the Treatment Administration Record (TAR) is blank, that means it wasn't charted, so it can be assumed it wasn't done. During an interview on 07/10/24 at 11:30 A.M., the DON said if a resident has a catheter, he/she would expect orders for changing the catheter every 30 days, catheter care every shift and as needed (PRN) and strict output every eight hours. Catheter care should be completed by the Certified Nurses' Aide (CNA).	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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F 758	Continued From page 11 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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F 758	Continued From page 12 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an appropriate diagnosis for the use of an anti-psychotic medication for one resident (Resident #32) out of five sampled residents. The facility census was 51. Review of the facility's policy titled, "Medication Regimen Review," revised April 2007, showed: - The pharmacist will perform Medication Management Review (MMR) for every resident in the facility on a monthly basis; - The pharmacist will evaluate for appropriate dosage, interactions, and adverse consequences; - Findings and recommendations are reported to the Director of Nursing (DON) and the medical director. 1. Review of Resident #32's Physician Order Sheet (POS), dated February 2024 through July 2024 showed: - Diagnoses included dementia (a condition characterized by progressive loss of memory and thinking, sometimes resulting in personality change, resulting from disease of the brain), anxiety disorder (a mental health disorder characterized by feelings of worry, or fear that can be strong enough to interfere with daily activities, and altered mental status (a change in	F 758		

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(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 758	Continued From page 13 mental function); - An order for olanzapine (an anti-psychotic medication) 2.5 milligram (mg) one tablet daily at bedtime; - No documentation of a diagnosis or indication for use. Review of the resident's medical chart showed: - Start date for olanzapine 10/10/22; - Gradual dose reduction (GDR) attempted 04/12/24; - GDR request denied on 04/15/24 due to potential for mood destabilization; - Psychiatric referral made on 04/18/24; - No documentation of a diagnosis or indication for use. During an interview on 7/10/24 at 9:58 A.M., the Director of Nursing (DON) said the diagnosis for olanzapine 2.5 mg was dementia. The DON said the resident has behaviors, like asking for money, asking to drive, and seeing things that are not there. The DON said these are not normal behaviors for dementia. The DON said she would expect another diagnosis for the resident to be on an anti-psychotic. The DON said she just goes off of what the psychiatric physician and the medical directors document.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00440	A. BUILDING: _____ B. WING _____	07/10/2024

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BERTRAND NURSING AND REHAB CENTER	603 HIGHWAY 62 WEST BERTRAND, MO 63823

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A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident. Irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. II/III This regulation is not met as evidenced by: Class III Refer to F758	A4061		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F656 and F690	A4075		
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean Walls and ceilings, including doors, windows and skylights, shall be clean and maintained in good repair. III This regulation is not met as evidenced by: Class III Refer to F584	A6015		

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
	00440	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERTRAND NURSING AND REHAB CENTER	603 HIGHWAY 62 WEST BERTRAND, MO 63823

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PLAN OF CORRECTION

Provider/Supplier Name:	BERTRAND NURSING AND REHAB CENTER
Street Address, City, Zip:	603 HWY 62 WEST, BERTRAND, MISSOURI 63823
Date of Survey:	07-07 2024 THRU 07-10-2024

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
	This Plan of Correction (POC) is submitted as requested under state and federal law. The submission of this POC does not constitute an admission on the part of Bertrand Nursing and Rehab Center as to the accuracy of the survey's findings, nor the conclusion drawn there from. The facility's submission of this POC does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last compliance date identified in the POC. Compliance will be maintained as provided in the Plan of Correction (POC). The POC will be on public display for all Residents, Families, and Visitors to have access and read at their convenience. On behalf of the Staff and Residents of our facility; we would like to express our appreciation to the Survey Team Led by Howard Hardin, for their professionalism, courtesy, and helping Our Team feel comfortable and at ease during the survey of our facility.	
F-584 SS-D A-6015	All staff will be in-service on 08-09-2024 on the proper procedures for reporting repairs and maintenance issues in all areas of the community / facility. The areas identified in the SOD will be prioritized and corrected / repaired in order of greatest risk to Residents, Visitors, and Staff. The Items listed in room 103, room 104, room 106, and room 112 will be addressed first and then all other resident rooms will be inspected for repairs and areas requiring repairs will also be completed. The administrator and or his or her designee will monitor for completion of repairs and randomly check Resident and non-Resident areas weekly for needed repairs for continued compliance for next 60 days.	08-24-2024
F-584 SS-D A-6015	Room 107 was addressed and repaired within 17 minutes of the facility office staff being notified of the issue, due in part because, it had the highest priority, to prevent a resident from being exposed to a potential hazard. The trim was replaced by the administrator on 07-09-2024 at approximately 8:40 am.	07-09-2024

F-584 SS-D A-6015	The self-closing door controls in rooms 217-228 were removed on 07-09-2024 at approximately 11:50 am by the Administrator, Maintenance Supervisor, and Maintenance Helper. The closure was left on the doors and only the mechanical arm was removed so the doors do not automatically close. All doors in the above listed rooms can be either open or closed based on the preferences of the Residents occupying those rooms (217-228); which is the same as all other Resident rooms in the community / facility. Please see the attached documentation supporting the date and time this removal was implemented. All staff will be in-serviced on 08-09-2024 about the remedy to allow the doors in this area of the facility to remain open or closed per the Residents individual choice. The Administrator or his or her designee will in-service and monitor to ensure the closure arms are not reinstalled.	07-09-2024
F-656 SS-D A-4075	On the (1) one resident number (21) Comprehensive Person-Centered Care Plan has been updated after the Resident's family input about the diagnosis of Dementia. As of 07-10-2024 Resident Number (21) MDS and Care Plan has been updated to reflect the diagnosis of Dementia. As a note the diagnosis had been on the resident in question's care plan prior but had been inadvertently left off her current care plan update dated 06-26-2024 after the MDS coordinator for past 10 plus years had resigned without completing resignation notice period, and new MDS coordinator, who had not worked in this area before assumed that role for our community / facility. Our POC implemented as of 07-24-2024 to ensure continued compliance with all residents in our community / facility is to have the MDS coordinator or his or her designee will print a report from our patient care software that will identify all that have a dementia diagnosis to confirm it is properly captured on their individual care plans. Plus, randomly audit new admissions to ensure all diagnosis is properly captured and recorded into their individual care plans 2 times per month for 2 months.	07-10-2024
F-690 SS-D A-4075	The POC for this tag is as follows: Resident number (31) physician orders have been updated to reflect changing the indwelling catheter every 30 days. On Resident number (31) and Resident number (40) their physician orders have been obtained and updated for catheter care to be performed every shift. Our POC being implemented to ensure continued compliance with all residents in our community / facility is as follows: All Nursing staff will be in-serviced on 8-9-2024 for catheter orders to be properly placed on the template for electronic physician orders in our nursing software (PCC); this will automatically push orders to the Medication Administration Record (MAR) and Treatment Administration Record (TAR). The in-service will be conducted by the Director of Nursing, and the Director of Nursing and his or her designee, will monitor randomly for next (2) months to ensure continued compliance. Lastly, the community / facility policy revised 09-2014 will be revised by 08-24-2024 to address frequency of catheter care and frequency of changing a catheter.	07-09-2024 08-24-2024

F-758 SS-D	The POC that is being implemented to ensure continued compliance that all residents are Free from Unnecessary Psychotropic Medications is as follows: Random Audits for antipsychotic medication use on all Residents will be conducted monthly by the consulting pharmacist with findings being shared with Director of Nursing and if there is not a proper diagnosis and or indication of a medication proper use the primary care physician will be notified for revision of medication orders. The (1) resident number 32 has been audited and the order for the antipsychotic medication has been discontinued as of 07-15-2024 per the consulting psychiatric team. This will be monitored by the Director of Nursing and or his or her designee monthly for the next (3) months to ensure ongoing compliance.	08-24-2024

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 Name:	BERTRAND NURSING AND REHAB CENTER
Street Address, City, Zip:	603 HWY 62 WEST, BERTRAND, MISSOURI 63823
Date of Survey:	07-07 2024 THRU 07-10-2024
Provider number:	26-5678

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted under State and Federal Law. This submission of the POC does not constitute an admission on the part of Bertrand Nursing and Rehab Center (facility) as to the accuracy of the surveyor findings, nor the conclusion drawn there from. The facility's submission of the POC does not constitute an admission on the part of the facility that the findings cited are accurate, or that the scope and severity regarding the deficiencies cited are correctly applied. This 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 identified in the POC. Compliance will be maintained as provided in the POC.	
A-6015	**Refer to F-584**	**08-24-2024**
A-4075	**Refer to F-656**	**07-10-2024**
A-4075	**Refer to F-690**	**08-24-2024**
A-4061	**Refer to F-758**	**08-24-2024**

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.