STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 583 SS=B	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to respect the privacy of	F 583		

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

Administrator 8-26-24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 583	Continued From page 1	F 583		

two residents (Resident #14 and #4) out of four sampled residents, when staff failed to provide privacy during wound care and medication administration, and posted care signs for on a wall visible to other residents and visitors in the day room. The facility census was 47.

1. Review of the facility's Patient Bill of Rights, undated, showed residents shall be treated with consideration, respect and full recognition of your dignity and individuality, including privacy in treatment and in care for your personal needs.

2. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/14/24, showed staff assessed the resident with severe cognitive impairment, and received application of non-surgical dressings other than to feet.

Observation on 07/29/24 at 1:50 P.M., showed the Director of Nursing (DON) entered the resident's room and performed wound care to the resident's face, with the privacy curtain and door to the room open to the hallway. Several residents ambulated in the hallway past the room. Staff did not provide privacy to the resident during wound care.

3. Review of Resident #4's annual MDS, dated 05/02/24, showed staff assessed the resident with severe cognitive impairment, and has a feeding tube.

Observation on 07/29/2024 at 2:24 P.M., showed the DON entered the resident's room, administered medications to the resident via feeding tube, with the privacy curtain and door to the room open to the hallway, as a male resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 583	Continued From page 2 wandered past the room. Staff did not provide privacy to the resident during medication administration. 4. Observation on 07/29/24 at 10:40 A.M. showed a sign in the day room with two resident (Resident #14 and #4) names, room number and medical reason for the use of Enhanced Barrier Precautions (EBP) (an infection control intervention) with other residents and visitors in the dayroom. Observation on 07/30/24 at 9:29 A.M. showed a sign in the day room with Resident #14 and #4 names, room number and medical reason for the use of EBP with other residents and visitors in the dayroom. Observation on 07/31/24 at 10:09 A.M. showed a sign in the day room with two Resident #14 and #4 names, room number and medical reason for the use to use of EBP with other residents and visitors in the dayroom. Observation on 08/01/24 at 9:29 A.M. showed a sign in the day room with Resident #14 and #4 names, room number and medical reason for the use of EBP with other residents and visitors in the dayroom. During an interview on 08/01/24 at 123:25 P.M., Certified Nurse Aid (CNA) F said the sign in the dayroom should be in a more private area. During an interview on 08/01/24 at 1:00 P.M., Certified Medication Technician (CMT) G said the list of residents should not be in the dayroom for other residents and visitors to see.	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 583	Continued From page 3 During an interview on 08/01/24 at 1:14 P.M., the DON said the sign with residents' personal information should be at the nurses station and not in an open area for others to see.	F 583		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, facility staff failed to update care plans in regards to	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4 smoking for three (Resident #1, #11, and #13) out of six sampled residents. The facility census was 70. 1. Review of the facility's Care Plan Comprehensive Policy, undated, showed assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition. Review staff were directed to: -Apply current standards of practice in the care plan process; -Update care plans when a significant change in condition has occurred, at least quarterly, and when changes occur that impact the resident's care. 2. Review of the Resident #1's Quarterly Minimum Data Sheet (MDS), a federally mandated assessment tool, dated 05/17/24, showed staff assessed the resident as follows: -Cognitively intact; -Tobacco use, not assessed. Review of the resident's care plan, dated 05/09/24, showed the resident will have supervised smoking in designated areas and will smoke safely throughout the next review. Cigarettes and lighters are kept at nursing station. Observation on 07/30/24 at 3:45 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 8:00 A.M., showed the resident outside without staff smoking a cigarette.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 Observation on 07/31/24 at 9:50 A.M., showed the resident in his/her wheelchair in the hallway with a pack of cigarettes and a lighter in the pocket of his/her shirt. Observation on 07/31/24 at 10:23 A.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 10:28 A.M., showed the resident wheeled into the facility with his/her cigarettes and lighter in their pocket and went to the dinning room for lunch. Observation on 08/01/24 at 8:15 A.M., showed the resident outside without staff smoking a cigarette. 3. Review of Resident #11's Annual MDS, dated 07/03/24, showed staff assessed the resident as: -Cognitively intact; -Independent with care and transfers; -Independent with manual wheelchair; -Current Tobacco user. Review of the resident's care plan, dated 06/28/24, showed resident will: -Have supervised smoking in designated areas; -Smoke in designated smoking area at designated times, staff assigned to assist with residents that smoke. Observation on 07/29/24 at 3:15 P.M., showed the resident outside without staff smoking a cigarette.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 Observation on 07/30/24 at 12:30 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/30/24 at 3:45 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 10:26 A.M., showed the resident outside without staff smoking a cigarette. Observation on 08/01/24 at 8:15 A.M., showed the resident outside without staff smoking a cigarette. 4. Review of Resident #13's Quarterly MDS, dated 05/20/24, showed staff assessed the resident as: -Cognitively intact; -Independent with manual wheelchair; -Tobacco use; not assessed. Review of the resident's care plan, dated 05/16/24, showed resident will: -Have supervised smoking in designated areas; -Smoke in designated smoking area at designated times, staff assigned to assist the resident; -Cigarettes and lighters are kept at nursing station. Observation on 07/30/24 at 12:30 P.M., showed the resident outside without staff smoking a cigarette. Observation on 08/01/24 at 8:20 A.M., showed	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 the resident outside without staff smoking a cigarette. Observation on 07/29/24 at 10:41 A.M., showed resident in his/her room with cigarettes and lighter in vest pocket. Observation on 07/30/24 at 3:30 P.M., showed resident in his/her room with cigarettes and lighter in vest pocket. 5. During an interview on 08/01/24 at 12:30 P.M., the Care Plan Coordinator said resident care plans are updated quarterly, annually, with significate changes, and regularly when something needs to be added. He/She said Resident #1, #11, and #13 keep their cigarettes and light on themselves. He/She said the residents do not need to be supervised when smoking. He/She said he/she was not aware that their care plan said supervised smoking and cigarettes and lighters are kept at nurses station. He/She said he/she expects the care plans to be updated. He/She said it is his/her responsibility to update care plans. He/She said the policy was just updated about three weeks ago and it just didnt get changed in care plan. During an interview on 08/01/24 at 1:08 P.M., the Director of Nursing (DON) said care plans should be updated weekly because things change so quickly. He/She said care plans should be updated. He/She said he/she does not think the residents are allowed to keep their lighter on themselves. He/She said the residents do not need to be supervised while smoking. He/She said he/she was unaware the care plans said residents have to be supervised while smoking. He/She it is the care plan coordinators	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 responsibly to update care plans. He/she said he/she believes it is his/her job to monitor care plans are being updated. During an interview on 08/01/24 at 1:47 P.M., the administrator said care plans are updated quarterly, significant change in condition, or an event happens. He/She said that residents do not need to be supervised when smoking and they can keep cigarettes and lighters on them. He/She said he/she expects the care plans to be updated. He/She said it is the care plan coordinator responsibly to update care plans. He/She said it is the director of nursing and administrator job to monitor to ensure they are being updated.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to maintain professional standards of care, when they failed to check placement of a Gastrostomy Tube ((G-Tube) a tube placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) prior to administration of G-tube feeding, and failed to follow the physician's orders regarding water flushes for one (Resident #4) of one sampled resident with a G-tube. The facility census was 47. 1. Review of the facility's policy for Medication,	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 658	Continued From page 9	F 658		

Administration by Naso-Gastric or Gastrostomy Tube, undated, showed staff are directed:

-Wash hands;
-Verify the recipient with physician orders and medication administration record;
-Check for tube placement;
-Give medications only by gravity. Never force with plunger;
-At completion of medication administration, flush tube with water as ordered;
-If resident is bolus fed, clamp tube and follow physician orders (to include but not limited to amount of formula, amount of water, and time the tube feeding can be off each day).

Review of the facility's policy on Physician Orders, undated, showed staff are directed as follows regarding Tube Feeding:

-Specify the type of feeding, amount, frequency of feeding, frequency for tube change, and rationale if as needed;
-Should always be followed by water.

2. Review of Resident #4's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/02/24, showed staff assessed the resident with a feeding tube, received 51 percent (%) or more total calories via tube feeding, and received 501 cc (cubic centimeter) or more average daily fluid intake via tube feeding.

Review of the resident's plan of care, last updated 05/07/24, showed staff assessed the resident to be dependent on staff for all fluids and nutrition, and directed staff as follows:

-Nothing by mouth related to dysphagia (difficulty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 658	Continued From page 10	F 658		

swallowing);
-Has a G-tube and received all nutrition and fluids per tube. Is dependent on a licensed nurse for this;
-Received all medications per G-tube;
-Ensure patency and placement of G-tube before flushes/feeding by auscultation (using a stethoscope to listen to sounds of the body) or aspiration (withdrawing fluid/substance);
-Ensure head is elevated at least 30 degrees before feedings.

Review of the resident's Progress Notes, dated 07/18/24, showed the Registered Dietician documented:

-Nothy by mouth, received tube feeding for sole nutrition;
-Lactose-reduced food with fiber 1.5 bolus six times daily;
-Flushes increased per recommendation to 100 mililters (ml) before and after bolus feedings.

Review of the resident's Physician's Order Sheet (POS), dated 07/01/24 - 08/01/24, showed a gastrostomy status (presence of a G-tube) and Dysphagia. Review showed nothing by mouth and with tube feedings. Review showed the physician ordered may crush or alter medications unless otherwise indicated. May mix medication and give with feedings. Review showed staff are directed to administer:

-Isosource 1.5 Calorie liquid one carton/240 ml via feeding tube every four hours, at 2 A.M., 6 A.M., 10 A.M., 2 P.M., 6 P.M., and 10 P.M.;
-Flush tube with 100 ml of water before and after bolus feeding. Every four Hours at 2 A.M., 6 A.M., 10 A.M., 2 P.M., 6 P.M., and 10 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 658	Continued From page 11 Observation on 07/29/2024 at 2:24 P.M., showed the Director of Nursing (DON) entered the resident's room with the prepared medications, poured a carton of Isosource 250 ml into a graduated container (used to measure liquids), and filled a separate graduated container with 50 ml of tap water. Observation showed the DON attached a syringe to the resident's G-tube, administered the medications and the bolus feeding of Isosource, flushed with the 50 ml of water, and closed the tube. Staff did not check placement of the resident's G-tube and did not flush the G-tube as ordered by the physician. Observation on 07/30/24 at 10:02 A.M., showed Licensed Practical Nurse (LPN) B entered the resident's room with the prepared medications, poured a carton of Isosource 250 ml into a graduated container, and filled a separate graduated container with 300 ml of tap water. Observation showed the LPN attached a syringe to the resident's G-tube, administered the medications, flushed with approximately 50 ml of water, administered the bolus feeding of Isosource, flushed with approximately 50 ml of water, discarded the remaining 200 ml of water in the sink, washed his/her hands and left the room. Staff did not check placement of the resident's G-tube and did not flush the G-tube as ordered by the physician. During an interview on 07/30/24 at 10:02 A.M., LPN B said the resident's Medication Administration Record (MAR) directs staff on how much water to administer, and he/she "believed" the directions are to give 100 ml. The LPN said he/she had 300 ml of water in the container, but he/she only administered approximately 100 -110	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 658	Continued From page 12	F 658		

ml of water total (100 ml with the feeding and 10 ml with the medications) and discarded the remainder.

Observation on 07/31/24 at 10:50 A.M., showed LPN A entered the resident's room with the prepared medications, retrieved and poured a carton of Isosource 250 ml into a graduated container, filled another graduated container with tap water. Observation showed the LPN checked tube placement by auscultation, administered the medications, flushed with an unknown amount of water, administered the bolus feeding, then flushed with more water, and closed the tube. Staff did not flush the resident's G-tube as ordered by the physician.

During an interview on 07/31/24 at 10:50 A.M., LPN A said he/she flushed the resident's G-tube with approximately 250 ml water.

During an interview on 08/01/24 12:22 P.M., LPN A said he/she should follow physician's orders all the time. The LPN said staff should check for tube placement by auscultation with about 10 ml of air, to ensure the tube is in the stomach before administering any medications or feeding. The LPN said he/she mis-read the physician's order for the water flushes the day prior, and thought it was 120 ml, but he/she realized after he/she administered the feeding, that the order was for 100 ml before and after the bolus feeding.

During an interview on 08/01/24 at 1:23 P.M., the DON said staff does not need to check for placement prior to administering medications or feeding via G-tube. The DON said he/she never checked for placement before feeding via G-tube unless he/she met resistance. However, if he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 658	Continued From page 13 met resistance during medication administration or feeding, he/she would stop, close the G-tube, and check for bowel sounds, or use a syringe to aspirate from the tube for gastric contents. The DON said he/she expects staff to follow physician's orders every time they administer medications or tube feedings to residents. The DON said he/she only flushed the resident's G-tube with 50 ml at the time, by default, because he/she did not remember the exact amount, but he/she later confirmed the physician's order is to flush with 100 ml before and after bolus feeding. During an interview on 08/01/24 at 1:45 P.M., the administrator said he/she expects staff to always follow physician's orders. He/She said staff should always follow physician's orders to give medications and feedings via tube to the resident, and if the order is written to flush with 100 ml of water, he/she expects staff to flush the tube with 100 ml of water.	F 658		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 14 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to complete or post required nurse staffing information, which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis in an area readily accessible to residents and visitors. The facility census was 70. 1. Review of the facility's policies showed staff did not provide a policy for the daily nurse staff posting. 2. Observations on 07/29/24 at 2:00 P.M.,	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 15 showed the facility staff did not post the nurse staffing information. Observation on 07/30/24 at 10:00 A.M., showed the facility staff did not post the nurse staffing information. Observation on 07/31/24 11:00 A.M., showed the facility staff did not post the nurse staffing information. During an interview on 08/01/24 at 12:15 P.M., Licensed Practical Nurse (LPN) A said he/she is aware the nurse staff information should be posted but has not seen it in this facility. The LPN said he/she believes it is the night shift staff that update the posting information. During an interview on 08/01/24 at 12:25 P.M., the Director of Nursing (DON) said he/she was not aware the nurse staff posting needed to be updated and posted daily. He/She is unsure if it is his/her responsibility. The DON said he/she is aware that it is important for it to be posted so they know what staff are in the building each day. During an interview on 08/02/24 at 1:40 P.M., the administrator said it is ultimately his responsibility to make sure the nurse staff posting is updated and posted. No one has been designated to do this duty, there were a couple staff members who would do this, but they stopped and did not inform him.	F 732		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 761	Continued From page 16 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to store medications in a safe and effective manner when staff failed to date and label insulin pens (to treat high blood sugar). The facility census was 47. 1. Review of the facility's Labeling Drugs and Medication policy, undated, shows facility staff were directed as follows: -All drugs and biologicals must be properly labeled and legible at all times; -Labels must be permanently affixed to each container;	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 761	Continued From page 17 -Medications in container having no labels must be destroyed in accordance with the facility procedures governing the destruction of medications; -Labels for individual drug containers must contain: Resident's full name and room number, expiration date (when applicable), and other appropriate information; -No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. Review of Lantus Insulin Pen Instruction insert, dated 06/2023, shows Lantus Insulin pens can only be used up to 28 days after it's first used and throw away the Lantus pen after 28 days, even if it still has insulin left in it. Review of Novolog Insulin Pen Instruction insert, dated 10/2023, shows Novolog insulin pens should be thrown away after 28 days of opening, even if it still has insulin left in it. 2. Observation on 07/29/24 at 7:56 A.M., showed the 100 hall medication cart contained: -Five opened and undated Lantus Insulin Pens; -One opened and undated Novalog Insulin Pen; -One opened and undated Tresiba Insulin Pen. During an interview on 07/29/24 at 8:10 A.M., Certified Medication Tech (CMT) E said when he/she opens a medication he/she labels with open date. He/She said if medication is not dated then you will not know when medication is no longer good. He/She said if medication is not dated it's a risk for the medication to not be effective if it's expired. 3. Observation on 07/30/24 at 1:32 P.M., showed	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 761	Continued From page 18 the Memory Care unit medication cart contained: -Two Fiasp insulin pens without an open date; -One Humalog insulin pen without a patient identifier or an open date; -One Lantus Solostar insulin pen without a patient identifier or an open date. 4. Observation on 07/30/24 at 1:55 P.M., showed a sign in memory care unit medication room directed staff all insulin bottles need to be dated when opened and all insulin expire 28 days after opening, regardless of expiration date on bottle and goes by date opened. 5. Observation on 8/01/24 at 10:45 A.M., showed a sign in the main medication room refrigerator directs staff: -Date all insulin when it is opened; -Good for 28 days, then it must be destroyed; -Insulin expire after it is open and you can not give it after 28 days open. 6. During an interview on 07/30/24 at 1:32 P.M., CMT C said insulin pens expire 30-45 days after they are opened, and any staff who administers insulin to a resident is expected to, and should always check the expiration/discard date prior to administering insulin to a resident. The CMT said any staff who removes the insulin from the refrigerator and opens it, should label the pen with the resident's name, date of birth, open date, and expiration/discard date, there should be someone that does audits, and there should be a system to double check for those things. During an interview on 08/01/24 at 12:20 P.M., CMT D said when opening a new insulin pen, you	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 761	Continued From page 19	F 761		

put the open date on pen. He/She said the insulin pen is usually labeled with resident's name already on pen or if the pens come in a box the label is on the box, a sharpie is used to write the residents name on the insulin pen. He/She said whoever opens the pen is responsible for dating and labeling the pen. He/She said a pharmacy comes in once a month to check for expired medication and make sure medication are labeled. He/She said insulin pens are only good for 28 days after opening. He/She said if insulin is given after 28 days the insulin is expired and the insulin would not be effective. He/She said if he/she found an insulin pen opened and not dated, he/she would discard the pen and get a new on and label and date it.

During an interview on 08/1/24 at 12:25 P.M., License Practical Nurse (LPN) A said when opening a new insulin pen it needs to have open date and expiration date. He/She said the insulin pens should have the resident's name on the pen and the pen cap. He/She said whoever opens the pen is responsible for labeling and dating the pen. He/She said insulin is only good for 28 days after opening. He/She said after the 28 days the insulin may not be effective and not at its full potential. He/She said if insulin pen found with no date or label, he/she would notify the Director of Nursing and the insulin pen would have to be wasted because he/she would be unsure of how long the insulin had been opened.

During an interview on 08/1/24 at 1:12 P.M., the Director of Nursing (DON) said when opening an insulin pen the date that it was opened should be written on the insulin pen along with resident name. He/She said he/she expects that if insulin pens are taken out of original box that it is labeled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 761	Continued From page 20 with resident's name. He/She said it is the CMT's responsibility to make sure insulin pens are dated and labeled. He/She said he/she is unsure of how long insulin pens are good for after opening. He/She said if past expiration date, the insulin would lose its potential and not be effective. During an interview on 08/1/24 at 1:51 P.M., the administrator said insulin pens should be dated when opened and have Resident's name. He/She said its pharmacy's responsibility to label the Insulin pens and the Nurses and CMT's responsibility to ensure open dates are on insulin pens. He/She said after expiration the insulin weakens its effect. He/She said if staff can not verify when insulin pen was opened, not to given insulin and get a new insulin pen. He/She said a pharmacist comes in monthly and checks medication to check expiration dates. He/She said the DON should be monitoring the insulin pens to ensuring dating and labeling of insulin pens are being done.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 880	Continued From page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 880	Continued From page 22 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to change gloves and wash/sanitize hands during wound care for one resident (Resident #14), during medication administration for one resident (Resident #4) and failed to implement the enhanced barrier precautions (EBP) (an infection control intervention) policy developed and educate staff who required EBP and place appropriate personal protective equipment (PPE) in close proximity for two out of four sampled residents, one resident (Resident #14) with a wound and one of one resident (Resident #4) with an indwelling gastrostomy tube ((g-tube) surgically placed tube that enters the stomach to deliver fluids and nutrition, that required EBP). The facility census was 47. 1. Review of the facility's policy on Handwashing, undated, showed the purpose of handwashing is to reduce transmission of organisms from resident to resident, nursing staff to resident, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 880	Continued From page 23 resident to nursing staff. Review of the facility's policy on Hand Cleanser (Antiseptic), undated, showed the purpose is to cleanse the hands between resident contacts during care and to prevent the spread of infection. Review of the facility's policy on Perineal Care, undated, showed the purpose is to cleanse the perineum (area between genitals and anus), to prevent infection and odor, and directed staff: -Wash hands; -Provide male/female perineal care; -Remove gloves and wash hands; -Position resident comfortably. Review of the facility's EBP to infection Control Guidance policy, dated March 2024 showed: -To prevent broader transmission or multidrug-resistance organisms (MDRO), bacteria resistant to antibiotics and/or antifungals, and to help protect residents with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have been resolved or indwelling medical devices have been removed; -Residents who require EBP are those with an indwelling medical device including a feeding tube (g-tube) regardless of their MDRO status and residents with a wound, regardless of their MDRO status; -Staff should use EBP when providing high contact resident care activities such as: bathing/showering, transferring residents from one position to another, providing hygiene, changing briefs or toileting, caring for or using an indwelling medical device, and performing wound	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 880	Continued From page 24	F 880		

care;
-EBP includes the use of gloves and a gown;
-Residents who are placed on EBP should have personal protective equipment (PPE) in close proximity outside the door and a trash can in the resident's room for disposal prior to leaving the room.

Review of the Centers for Disease Control (CDC) website https://www.cdc.gov/hicpac/workgroup/EnhancedBarrierPrecautions.html article, "Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities", dated June 2021, showed:

-Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities;
-Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room).

2. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment, dated 05/02/24 showed staff assessed the resident as follows:

-Severely cognitively impaired;
-Use of a feeding tube.

Observation on 07/29/2024 at 2:24 P.M., showed the Director of Nursing (DON) entered the resident's room with prepared medications, did not wash his/her hands, put on a gown and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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 880	Continued From page 25	F 880		

applied gloves, administered the medications/feeding via G-tube, and wiped up spilled liquid from the bedside table with paper towels. The DON continued to wear the same soiled gloves and administered a medication under the resident's tongue. The DON removed his/her gloves, gown, and bagged the dirty supplies. The DON did not wash his/her hands before he/she left the resident's room.

Observation on 07/30/24 at 9:26 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. .

Observation on 07/30/24 at 10:02 A.M., LPN B entered the resident's room and administered medication, feeding, and fluids to the resident via G-tube with a gown on.

Observation on 07/31/24 at 9:41 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy.

Observation on 08/01/24 at 9:27 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. .

During an interview on 08/01/24 at 1:23 P.M., the DON said he/she should have changed gloves and washed/sanitized hands between the tube feeding and administration of the sublingual medication.

3. Review of Resident #14's quarterly MDS, dated 07/14/24, showed staff assessed the resident as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 880	Continued From page 26 -Cognitively impaired; -Open Lesion; -Application of non surgical dressing. Observation on 07/29/24 at 1:50 P.M., showed the DON entered the resident's room to provide wound care. Observation showed the DON washed his/her hands, placed a gown on and gloves. The DON cleansed the wound on the residents right side face. With the same soiled gloves the DON, cleansed a wound on the residents left side of face, used a clean cotton-tipped applicator to apply vaseline to both wounds and covered both wounds with a dressing. The DON did not wash his/her hands before he/she left the resident's room. Observation on 07/30/24 at 9:26 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. . Observation on 07/31/24 at 9:37 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. . Observation on 08/01/24 at 12:20 P.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. . During an interview on 08/01/24 at 1:23 P.M., the DON said he/she did not realize he/she did not change gloves during wound care and he/she "knew better".	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. BUILDING _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	**601 WEST MORGAN STREET TIPTON, MO 65081**

(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 880	Continued From page 27 5. During an interview on 08/01/24 at 12:19 P.M., Certified Medication Technician (CMT) G said he/she did not know what resident's required EBP. The name plates don't have yellow dots. If they do, it might mean the resident is a fall risk. He/She said, "it is just a smiley sticker". During an interview on 08/01/24 at 12:25 P.M., CNA F said the name plates don't have yellow dots. He/She said no one has told him/her about it or what it means. He/She did not know which resident's required gloves and gowns. During an interview on 08/01/24 at 1:14 P.M., the DON said anyone with an open area, wounds, residents with tube feedings, and anyone with a catheter should be on EBP. Staff should wear gowns and gloves and there should be a stop sign on the door so staff know. The sign at the nurses desk and in the dayroom with only two residents names is incorrect. The sign in the dayroom should not be out in the open. The DON said staff should wear gloves anytime they perform perineal care, wound care, and tube feeding to residents. The DON said staff should change gloves in between dirty and clean tasks, wash hands, dry and apply clean gloves. During an interview on 08/01/24 at 1:45 P.M., the administrator said he/she expects staff to wear gloves when doing cares and treatment to residents, change gloves between dirty & clean tasks, and when switching residents. The administrator said staff should wash hands after they remove gloves, and when hands are visibly soiled.	F 880		

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
	08036	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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) COMPLETE DATE
A4033	19 CSR 30-85.042(29) Employee Hours Documented Facilities shall maintain written documentation on the premises showing actual hours worked by each employee. III This regulation is not met as evidenced by: Class III Refer to F732	A4033		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III See F761	A4064		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F658	A4075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08036	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPTON OAK MANOR	601 WEST MORGAN STREET TIPTON, MO 65081

(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) COMPLETE DATE
A4086	Continued From page 1	A4086		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Refer to F880	A4086		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class III Refer to F583	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Tipton Oak Manor
Street Address, City, Zip:	601 West Morgan Street Tipton, MO 65081
Date of Survey:	Completed 08/01/2024

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 under State and Federal Law. The submission of this POC does not constitute an admission on the part of Tipton Oak Manor (the facility) as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The Facility's submission of this POC does not constitute the submission of Tipton Oak Manor 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. Date of Alleged Compliance: September 12, 2024	09/12/2024
F 583	The facility will respect the privacy of all residents, including resident #14 and #4. Facility staff will provide privacy during wound care and gastronomy tube (G-tube) medication administration. The facility will not post care signs visible to other residents and visitors. All residents that reside on the special care unit are considered at risk of the alleged deficient practice. All nursing staff have been inserviced regarding providing privacy during all cares by pulling privacy curtain and closing resident room door during dressing changes and G-tube medication administration. The EBP list of resident names has been removed from the nurse's station and has been placed in the CNA binder. The DON &/or Administrator will make random, unannounced rounds a minimum of 1 time per shift x 2 weeks, when scheduled to ensure facility staff provide privacy during G-tube medication administration and wound care, and will ensure no	09/12/2024

	resident specific signage related to EBP is posted in the SCU, then 2 times per month thereafter. Any non-compliance will be addressed immediately if/when discovered. The DON will provide a quarterly QAA report related to resident privacy during cares and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: September 12, 2024	
F 657	The facility will update care plans related to resident smoking for all residents that smoke, including resident #1, #11 and #13. All residents that smoke are considered at risk of the alleged deficient practice. Resident #1, #11 and #13 care plans have been updated to reflect current independent smoking status. The MDS Coordinator has completed an audit of all resident care plans related to smoking and all have been updated to reflect current smoking status. The MDS Coordinator will continue to update care plans with change. The DON will work with the MDS Coordinator during weekly Patient at Risk (PAR) meetings and will ensure care plan updates are completed with resident change in status. The DON will monitor care plan updates a minimum of once weekly x 2 weeks to ensure care plan updates are completed, then monthly thereafter to ensure compliance is maintained. The MDS Coordinator will provide a quarterly care plan report to the QAA committee and will follow guidance and recommendations as given by the DON and Administrator. Date of Alleged Compliance: September 12, 2024	09/12/2024
F 658	The facility will ensure licensed nursing staff maintains professional standards of care related to G-Tube feeding and medication administration for all residents with a G-tube, including resident #4. All residents with G-tubes are considered at risk of the alleged deficient practice. The licensed nurses have been inserviced by the DON and Administrator regarding administration of feeding and medication to G-tube including but not limited to: checking for tube placement prior to the administration of feeding, and following physician orders related to water flushes. The DON will monitor each licensed nurse during administration of G-tube medication and feeding to ensure compliance is	09/12/2024

	achieved and randomly once monthly thereafter to ensure compliance is maintained. Retraining will occur if and when non-compliance is identified. The DON will provide a quarterly medication compliance report to the QAA committee and will follow guidance and recommendations as given by the Administrator and the Medical Director. Date of Alleged Compliance: September 12, 2024	
F 732	The facility will post required nurse staffing information which will include the total number of staff, actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis in an area readily accessible to residents and visitors. All residents are considered at risk of the alleged deficient practice. The DON will be responsible for posting the daily nurse staffing information, daily when scheduled. The charge nurses will be given the daily nurse staffing sheet to post for the DON is scheduled days off. The Administrator will monitor the posting daily when scheduled x 2 weeks to ensure compliance is achieved and 2 times per month thereafter to ensure compliance is maintained. The DON will provide a quarterly staffing report to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: September 12, 2024	09/12/2024
F 761	The facility will store medications in a safe and effective manner. The licensed staff will date and label insulin pens. All residents requiring the usage of insulin pens are considered at risk of the alleged deficient practice. All licensed nurses and certified medication technicians (CMT's) have been inserviced by the DON regarding proper labeling, storage and putting open dates on insulin pens. All open insulin pens without label or date have been destroyed. The DON will monitor the insulin pens daily when scheduled x 2 weeks to ensure all insulin pens have labels and open dates, then weekly thereafter to ensure compliance is maintained. Any non-compliance will be addressed immediately upon discovery.	09/12/2024

	The DON will provide a medication compliance report to the QAA committee quarterly and will follow recommendations and guidance as given by the Administrator and Medical Director. Date of Alleged Compliance: September 12, 2024	
F 880	The facility will use appropriate infection control procedures to prevent the spread of bacteria or other infections causing contaminants. Staff will change gloves during wound care, during medication administration and will implement enhanced barrier precautions (EBP) and educate staff related to residents on EBP and personal protective equipment (PPE) for residents requiring EBP, for all residents that reside on the SCU including resident #4 and #14. All residents on EBP that reside in the SCU are considered at risk of the alleged deficient practice. All nursing staff that work in the SCU will be inserviced regarding: washing hands and putting on proper PPE in resident rooms that require EBP, washing hands and changing gloves in between clean and dirty tasks, keeping PPE available in close proximity to each resident room for those on EBP and informing staff who is on EBP. All nursing staff that work in the SCU will have skills checkoff on handwashing. The updated EBP list of residents that reside in the SCU has been placed in the CNA book and staff have been alerted to what the yellow sticker on the resident door means. Residents on EBP that reside in the SCU will have PPE in close proximity to the resident room. The DON and/or Administrator will make walking rounds in the SCU a minimum of once per day, when scheduled x 2 weeks to ensure the SCU staff are aware of who is on EBP and using appropriate PPE as needed during cares, PPE is readily available outside of room, yellow dots are in place on resident rooms and the CNA book remains updated with the residents on EBP. Once compliance is achieved the DON/Administrator will make rounds 2 times monthly thereafter. The DON will provide a quarterly infection control report to the QAA committee and will follow recommendations and guidance as given by the Administrator and Medical Director. Date of Alleged Compliance: September 12, 2024	09/12/2024
K 345	The facility will inspect, test, and maintain the fire alarm system in accordance with the 2010 Edition of NFPA 72. All residents are considered at risk of the alleged deficient practice. The facility has completed sensitivity testing for the smoke detectors with complete and verifiable documentation for the annual inspection by a qualified individual. The facility has completed complete and verifiable	09/12/2024

	emergency generator in accordance with the 2010 Edition of NFPA 110. The facility will provide complete and verifiable documentation of a four-hour load bank test every three years. The facility will inspect and test the essential electrical systems (EES) in accordance with the 2012 Edition of NFPA 99. The facility will conduct an annual main & circuit breaker assessment. All residents are considered at risk of the alleged deficient practice. The four-hour load bank test has been completed and will be completed once every three years. The annual main and circuit breaker assessment has been completed and will be completed annually hereafter. The Maintenance Supervisor will work directly with the Administrator to ensure required generator testing is scheduled when needed to comply with the state and federal regulations. The Maintenance Supervisor will provide a quarterly plant maintenance report to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: September 12, 2024	
A4033	Refer to F 732	09/12/2024
A4064	Refer to F 761	09/12/2024
A4075	Refer to F 658	09/12/2024
A4086	Refer to F 880	09/12/2024
A8030	Refer to F 583	09/12/2024

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.