STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 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 — TITLE — (X6) DATE

Jennie Owens LPN LNHA — 3/25/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

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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 54. Review of the facility's policy titled, "Homelike Environment," revised February 2021, showed: - Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their 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 such as a clean, sanitary and orderly environment. Observations on 03/04/25 at 10:21 A.M., and 03/05/25 at 8:15 A.M., of Room 302 showed: - A buildup of dust and dirt on the air filter inside the air conditioner unit; - Several long dark markings on the wall near the light switch by the door; - Two areas of exposed sheetrock and peeled paint on the wall near the recliner; - Several long dark markings along the wall next to the bed near the window. Observations on 03/04/25 at 10:24 A.M., and 03/05/25 at 8:21 A.M., of Room 303 showed: - Several long dark markings with areas of exposed sheetrock and peeled paint on the wall near the door.	F 584		

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	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 2	F 584		

Observations on 03/04/25 at 10:29 A.M., and 03/05/25 at 8:25 A.M., of Room 306 showed:
- A large area of exposed sheetrock and peeled paint next to the nightstand.

Observations on 03/04/25 at 10:51 A.M., and 03/04/25 at 8:32 P.M., of Room 312 showed:
- A buildup of dried food and dirt on the resident's wheelchair cushion, seat, foot pedals, and the sides;
- A buildup of dirt and grime on the Hoyer lift next to the bed near the window.

Observations on 03/04/25 at 10:59 P.M., and 03/05/25 at 8:42 A.M., of Room 316 showed:
- Long dark markings on the bottom part of the wall next to the bed near the window.

Observations on 03/04/25 at 11:09 A.M., and 03/05/25 at 8:53 A.M., of the resident private phone room showed a missing square vent cover on the ceiling near the sprinkler head.

Review of February 2025 Resident Council Meeting Minutes showed:
- A concern with resident wheelchairs not being cleaned or washed by staff.

During an interview on 03/07/25 at 10:03 A.M., the Maintenance Supervisor (MS) said he/she was aware there were a lot of things that needed to be repaired and painted. It was hard at times to keep up with maintenance duties when he/she was verbally told when something needed to be addressed by staff in passing. It would be nice if staff would write down the environmental concerns on the maintenance log to be addressed in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

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F 584	Continued From page 3 During an interview on 03/07/25 10:21 A.M., the Administrator said she was aware the facility had a lot of environmental concerns that needed to be addressed. Staff should be writing down any environmental issues on the maintenance log instead of verbally telling the MS in passing so he/she didn't forget throughout the day.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

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F 607	Continued From page 4	F 607		

retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow their policy and procedure to complete Criminal Background Checks (CBC) for one employee (Employee I) prior to hire and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused or neglected, misappropriated funds or property from a resident) periodically for six employees (Employees G, I, J, K, L, and M) out of ten sampled employees. The facility census was 54.

Review of the facility's policy titled, "Employee Disqualification List (EDL)," dated February 2022, showed:
- At the time of consideration of employment, the designated employee shall access the EDL website and check the EDL;
- The designated employee will review the EDL list on the EDL website to make certain the name of the employee has not been placed on the the EDL since the initial checking requirement;
- The annual and quarterly information is found on the same website as the individual information;
- The annual list is updated each January.
- Each quarter, names are added and deleted;
- The designated employee should check and print the list each quarter and annually, check it against the current employee list, and file in a folder called EDL quarterly checklist.

Review of the facility's policy titled, "Criminal Background Checks Policy and Procedure," dated February 2022, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

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F 607	Continued From page 5 - The facility shall perform criminal background checks on all employees hired after August 28, 1997; - After an employment application has been received by Administration and it is determined the applicant will be offered employment, the designated facility employee will complete an online Criminal Background Request; - Print the request for the employee record. In addition, a copy of the disclosure of the applicant's rights under the Fair Credit Reporting Act shall be given to the applicant. Both requirements shall be completed the same day as the decision to hire, and prior to allowing any person contact with a resident. The responsibility for completing this requirement shall remain with the Administrator even if the task shall be delegated to a designee; - The reply for Criminal Background Request will be emailed with a notice that there is no match or that a follow-up is being mailed, which will indicate a criminal history and this applicant shall not be started to work until such time as the Administrator, or designee, shall receive the response and determine whether or not the applicant is to be disqualified; - There will be no exceptions to this policy. 1. Review of Employee G's personnel file showed: - A hire date of 04/09/24; - The last EDL list check was 04/09/24; - The facility did not check a quarterly EDL list check. 2. Review of Employee I's personnel file showed: - A hire date of 12/24/21; - No documentation the CBC was completed before the employee's hire date;	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 607	Continued From page 6	F 607		

- The most recent EDL list check was 09/16/22;
- The facility did not check a quarterly or annual EDL list check.

3. Review of Employee J's personnel file showed:
- A hire date of 10/02/24;
- The last EDL list check was 09/30/24;
- The facility did not check a quarterly EDL list check.

4. Review of Employee K's personnel file showed:
- A hire date of 08/23/24;
-The last EDL list check was 08/19/24;
-The facility did not check a quarterly EDL list check.

5. Review of Employee L's personnel file showed:
- A hire date of 11/20/24;
- The last EDL list check was 11/06/24;
- The facility did not check a quarterly EDL list check.

6. Review of Employee M's personnel file showed:
- A hire date of 03/07/24;
- The last EDL list check was 02/15/24;
- The facility did not check a quarterly or annual EDL list check.

During an interview on 03/07/25 at 4:00 P.M., the Human Resources (HR) staff said he/she was not aware it was required for the facility to check the EDL list except at the time of hire.

During an interview on 03/07/25 at 4:38 P.M. the Administrator said the CBC and EDL checks should be completed prior to employment and she thought at least quarterly after employment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 638	Continued From page 7	F 638		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		

§483.20(c) Quarterly Review Assessment
A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to electronically transmit quarterly Minimum Data Set (MDS) assessments, a federally mandated assessment instrument completed by the facility, in a timely manner and in accordance with the guidelines for two residents (Residents #37 and #40) out of 14 sampled residents and two residents (Residents #38 and #42) outside the sample. The facility's census was 54.

Review of the facility's policy titled, "Resident Assessments," dated October 2023 showed:
- A comprehensive assessment of each resident is completed at intervals designated by Omnibus Budget Reconciliation Act (OBRA) regulations and Protective Payment System (PPS) requirements. Data from the MDS is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required.
- OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and Medicaid certified nursing homes. OBRA assessments include:
a. Admission assessment;
b. Quarterly assessment;
c. Annual assessment;
d. Significant change in status assessment;
e. Significant correction to prior comprehensive assessment;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 638	Continued From page 8	F 638		

f. Significant correction to prior quarterly assessment;
g. Discharge assessment.
- PPS Assessments are conducted (in addition to the OBRA required assessments) for residents for whom the facility receives Medicare Part A Skilled Nursing Facility benefits;
- Comprehensive MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessments (CAA) process and care planning. Comprehensive MDS, include admission, annual, and significant changes.
- The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.

Review of the facility's policy titled, "MDS Completion and Submission Timeframes," dated October 2023, showed:
- Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes;
- Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual;
- Submission of MDS records to the iQIES is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of 15 months from the date submitted.

1. Review of Resident #37's MDS assessments showed:
- Admitted on 07/30/24;
- An admission assessment, dated 08/24/24;
- A quarterly MDS, dated 10/31/24;
- The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 638	Continued From page 9 2. Review of Resident #38's MDS assessments showed: - Admitted on 02/10/23; - A quarterly MDS, dated 10/31/24; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. 3. Review of Resident #40's MDS assessments showed: - Admitted on 08/09/23; - A quarterly MDS, dated 10/31/24; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. 4. Review of Resident #42's MDS assessments showed: - Admitted on 07/25/24; - A quarterly MDS, dated 10/31/24; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. During an interview on 03/06/25 at 10:10 A.M., the MDS Coordinator said he/she just started in the position but was aware there were some MDS assessments that were behind and/or late. During an interview on 03/07/25 at 4:31 P.M., the Administrator said she would expect the MDS's to be completed on time. During an interview on 03/07/25 at 4:35 P.M., the Regional Nurse Consultant said she was told all of the MDS's were up to date.	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 640	Continued From page 10	F 640		

requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 640	Continued From page 11	F 640		

initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to electronically transmit a Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) in a timely manner and in accordance with guidelines for two residents (Residents #17 and #41) out of 14 sampled residents. The facility's census was 54.

Review of the facility's policy titled, "MDS Completion and Submission Timeframes," dated October 2023, showed:
- Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes;
- Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual;
- Submission of MDS records to the to the Internet Quality Improvement Evaluation System (iQIES) is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of 15 months from the date submitted.

1. Review of Resident #17's MDS record showed:
- Admitted on 04/16/20;
- A quarterly MDS, dated 01/29/25, completed but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 640	Continued From page 12 not transmitted; - The facility did not transmit the MDS within 14 days of the completion date. 2. Review of Resident #41's MDS assessment showed: - Admitted on 10/09/23; - A quarterly MDS, dated 01/29/25, completed but not transmitted; - The facility did not transmit the MDS within 14 days of the completion date. During an interview on 03/06/25 at 10:10 A.M., the MDS Coordinator said he/she just started in this position, but was aware there were some MDS assessments that were behind and/or late. During an interview on 03/07/25 at 4:31 P.M., the Administrator said she would expect the MDS's to be submitted on time. During an interview on 03/07/25 at 4:35 P.M., the Regional Nurse Consultant said she was told all of the MDS's were up to date.	F 640		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 655	Continued From page 13	F 655		

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to include an admitting diagnosis of post traumatic stress disorder (PTSD - psychological distress following a traumatic event) with specific interventions on the baseline care plan upon admission for one resident (Resident #158) out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 655	Continued From page 14	F 655		

two sampled residents. The facility census was 54.

Review of the facility's policy titled, "Care Plans - Baseline," revised March 2022, showed:
- A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission;
- The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident;
- The baseline care plan is used until the staff can conduct the comprehensive assessment and develop interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission);
- The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.

1. Review of Resident #158's medical record showed:
- An admission date of of 02/17/25;
- Diagnoses of PTSD, paranoid schizophrenia (a long term mental disorder that causes distrust, affects a person's ability to think, feel, and behave clearly, and sometimes including delusions or hallucinations, schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), major depression disorder (long-term loss of pleasure or interest in life), irritability, and anger.

Review of the resident's Baseline Care Plan, dated 02/18/25, showed:
- PTSD with specific interventions not addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 655	Continued From page 15 During an interview on 03/05/25 at 2:19 P.M., the resident said he/she was in the military and witnessed people that were killed. Loud noises triggered the PTSD. During an interview on 03/05/25 at 2:56 P.M., the Social Service Director (SSD) said the resident was asked about his/her PTSD a few days after being admitted to the facility and he/she avoided the question. During an interview on 03/07/25 at 3:42 P.M., the Director of Nursing said if a new resident was admitted to the facility with a PTSD diagnosis, it should be included on the baseline care plan with specific interventions. During an interview on 03/07/25 at 4:42 P.M., the Administrator said if a new resident was admitted to the facility with a diagnosis of PTSD, the resident's baseline care plan should include specific interventions along with other admission diagnoses documented on the admission paperwork.	F 655		
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, the facility failed to obtain and/or follow physician's orders for three residents (Residents	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 658	Continued From page 16	F 658		

#15, #37 and #158) out of five sampled residents and one resident (Resident #2) outside the sample. The facility census was 54.

Review of the facility's policy titled, "Medication and Treatment Orders," dated July 2016, showed:
- Orders for medication and treatments will be consistent with principles of safe and effective order writing;
- Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state;
- Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record;
- Drugs and biological orders shall be recorded on the physician's order sheet (POS) in the resident's chart;
- Such orders are reviewed by the pharmacy consultant on a monthly basis.

1. Review of Resident #2's medical record showed:
- Admitted on 02/16/24;
- Diagnoses of bipolar disorder (a mental disorder that causes unusual shifts in mood) and major depressive disorder (long-term loss of pleasure or interest in life).

Review of the resident's February 2025 Physician Order Sheet (POS) showed:
- An order for Invega Trinza (an antipsychotic medication) intramuscularly (IM -injection administered into the muscle) 819 milligram (mg)/2.63 millimeter (ml) every three months, starting on the 6th February/May/August/November related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 17	F 658		

schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), dated 07/06/24.

Review of the resident's November 2024 MAR showed:
- Invega scheduled for administration on 11/06/24;
- The facility failed to administer the medication.

Review of the resident's February 2025 MAR showed:
- Invega scheduled for administration on 02/06/25;
- The facility failed to administer the medication.

2. Review of Resident #15's medical record showed:
- Admitted on 03/14/24;
- Diagnoses of dementia (a serious medical illness that negatively affects how you feel, the way you think and how you act), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and emphysema (a lung disease where the tiny air sacs in the lungs make it hard to breathe).

Review of the resident's March 2025 POS showed:
- No order for oxygen.

Review of the resident's progress note, dated 03/04/25, showed:
- Difficulty breathing;
- Breathing treatment administered;
- Oxygen level at 99% via oxygen concentrator in use at 2 liters (L) per nasal cannula (tubing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 18	F 658		

inserted into the nostrils for supplemental oxygen).

Observation on 03/04/25 at 10:21 A.M., showed the resident lay in his/her bed with an oxygen concentrator in use at 2 L per nasal cannula.

Observations on 03/04/25 11:01 A.M., and 03/07/25 at 10:11 A.M., showed the resident sat upright in his/her chair with an oxygen concentrator in use at 2 L per nasal cannula.

During an interview on 03/04/25 at 11:06 A.M., the resident said he/she had difficulty breathing at times and needed oxygen.

During an interview on 03/04/25 at 11:26 A.M., the Director of Nursing (DON) said Resident #15 did not have an oxygen order on his/her current POS. There should be a physician's order for oxygen.

During an interview on 03/04/25 at 11:47 A.M., the Administrator said she would expect a resident who required oxygen to have a physician's order on his/her current POS.

3. Review of Resident #37's medical record showed:
- Admitted on 05/15/24;
- Diagnoses of hypertension (HTN-high blood pressure), congestive heart failure (CHF- heart muscle weak and cannot pump properly), and atrial fibrillation (a-fib - an irregular, often rapid heart rate causes poor blood flow);
- No order for hospice care.

Review of the resident's hospice binder showed:
- Resident admitted to hospice on 07/22/24;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 19 - Diagnosis of CHF. During an interview on 03/07/25 at 4:22 P.M., Licensed Practical Nurse (LPN) F said the resident did not have an order for hospice until 03/05/25. During an interview on 03/07/25 at 4:35 P.M., the Administrator said any resident on hospice needed an order for the hospice care. 4. Review of Resident #158's medical record showed: - Admitted on 02/17/25; - Diagnoses of post traumatic stress disorder (PTSD - psychological distress following a traumatic event), paranoid schizophrenia (a long term mental disorder that causes distrust, affects a person's ability to think, feel, and behave clearly, and sometimes including delusions or hallucinations), schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), major depression disorder, irritability, and anger. Review of the resident's February 2025 POS showed: - An order for Invega Sustenna IM 234 MG/1.5 ml one time a day starting on the 23rd and ending on the 23rd every month for schizoaffective disorder, depressive type dated 02/17/25. Review of the resident's February 2023 MAR showed: - Invega scheduled for administration on 02/23/25; - The facility failed to administer the medication. Review of the resident's progress note, dated	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 20 02/27/25, showed: - The resident involved in a resident-to-resident altercation; - No injuries noted for either resident; - Administrator notified of the incident. During an interview on 03/05/25 at 2:30 P.M., the Regional Nurse Consultant said she would expect nursing staff to document when medications were given and to follow the physician's orders. During an interview on 03/07/25 at 4:45 P.M., the Administrator said she would expect nursing staff to follow physician's orders.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 692	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement, monitor and modify interventions to maintain acceptable parameters of nutritional status for two residents (Residents #19 and #40) out of four sampled residents. The facility census was 54. Review of the facility's policy titled, "Weight Assessment and Intervention," dated March 2022 showed: - Resident weights are monitored for undesirable or unintended weight loss or gain; - Residents are weighed upon admission and at intervals established by the interdisciplinary team; - Any weight change of 5% or more since the last weigh assessment is retaken the next day for confirmation; - Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time; - The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. one month - 5% weight loss is significant; greater than 5% is severe; b. three months - 7.5% weight loss is significant; greater than 7.5% is severe; c. six months - 10% weight loss is significant; greater than 10% is severe; - If the weight is desirable, this is documented; - An undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met; - The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia (reduction in appetite and food intake), weight loss or increasing the risk of	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 692	Continued From page 22	F 692		

weight loss.

1. Review of Resident #19's medical record showed:
- Admitted on 11/13/24;
- Diagnoses of anemia (low red blood cells), heart failure (when the heart muscle is weakened and cannot pump blood effectively), hypertension (high blood pressure), anxiety, and depression;
- An order for a regular diet, mechanical soft texture, thin liquids, dated 01/09/25;
- No order for a health shake.

Review of the resident's weights showed:
- On 11/14/24, 148.0 pounds (lbs.);
- On 12/05/24, 145.4 lbs.
- On 01/09/25, 140.0 lbs.
- On 02/07/25, 136.0 lbs.
- On 03/06/25, 138.0 lbs.
- From 11/14/24-02/07/25, the resident had a severe weight loss of 8.11% in three months.

Review of the resident's RD Nutritional Assessment, dated 12/04/24, showed:
- A recommendation to add ice cream two times daily.

Review of the resident's RD Assessment and Recommendations, dated 01/09/25, showed:
- A health shake/house supplement two times daily.

Review of the resident's RD Assessment and Recommendations, dated 02/17/25, showed:
- Add a health shake/house supplement two times daily and provide encouragement to improve intake.

The facility failed to address the RD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 692	Continued From page 23	F 692		

recommendations.

Observations on 03/05/25 at 12:24 P.M., 03/06/25 at 12:08 P.M., and 03/07/25 at 12:19 P.M., showed the resident with a divided plate and ate 50% of the meal with no assistance. Staff did not encourage the resident to eat his/her meals. Ice cream nor health shakes were provided to the resident.

2. Review of Resident #40 medical record showed:
- Admitted on 08/09/23;
- Diagnoses of hypertension, gastrointestinal esophageal reflux disease (GERD-a stomach acid being forced back into the throat region), diabetes mellitus (DM- a condition that affects the way the body processes blood sugar), and congestive heart failure (CHF);
- An order for a regular diet, regular texture, no concentrated sweet (NCS) for diabetes mellitus, dated 06/05/24;
- No order for a health shake.

Review of the resident's weights showed:
- On 10/07/24, 186.6 lbs.;
- On 11/04/24, 184.6 lbs.;
- On 12/05/24, 183.4 lbs.;
- On 01/09/25, 175.4 lbs.;
- On 02/07/25, 163.2 lbs.;
- On 03/06/25, 166.0 lbs.
- From 01/09/25 - 02/07/25, the resident had a severe weight loss of 6.9% in one month;
- From 10/07/24 - 03/06/24, the resident had a severe weight loss of 11.3% in six months.

Review of the resident's RD Assessment and Recommendations, dated 01/15/25, showed:
- Increase the health shake from two times daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 692	Continued From page 24 to three times daily and to discontinue the low concentrated sweet diet to allow more food choices. Review of the resident's RD Assessment and Recommendations, dated 02/10/25, showed: - Liberalize the diet to a regular diet due to weight loss, increase the health shake to three times daily, and provide encouragement at meals. The facility failed to address the RD recommendations. Observations on 03/06/25 at 12:10 P.M., and on 03/07/25 at 12:16 P.M., showed the resident ate 100% of his/her meal and the ice cream provided with the meal. During an interview on 03/07/25 at 11:00 A.M., the Regional Nurse Consultant said staff weigh the residents. If there was a discrepancy, then the resident was weighed the next day to validate the weight. Nursing was notified and the nursing department would notify the provider of the weight loss. After the RD visited the facility, he/she sent a report to the facility, and the nursing department followed up with the provider with any recommendations. During an interview on 03/07/25 at 3:07 P.M., the Dietary Manager (DM) said he/she received a weight variance report from the RD after his/her facility visit. The DM could look at the residents' medical records after nursing had put the orders in for diet changes and/or supplements.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 755	Continued From page 25 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for three out of three medication carts. This practice had the potential	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 755	Continued From page 26	F 755		

to affect all residents. The facility census was 54.

The facility did not provide a policy on narcotic reconciliation documentation.

1. Review of the 100 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:
- For 6 A.M.-6 P.M. shift on 02/03/25-02/24/25, the staff missed 13 out of 44 opportunities to reconcile the narcotic medications;
- For 6 A.M.-6 P.M. shift on 02/25/25-03/07/25, the staff missed 6 out of 21 opportunities to reconcile the narcotic medications.

2. Review of the 200 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:
- For 6 P.M.-6 A.M. shift on 02/10/25-03/07/25, the staff missed 22 out of 47 opportunities to reconcile the narcotics medications.

3. Review of the 300 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:
- For 6 A.M.-6 P.M. shift on 02/15/25-03/07/25, the staff missed 20 out of 42 opportunities to reconcile the narcotic medications.

4. Review of the Medication Room Narcotic Count Log for Controlled Substances showed:
- For 6 A.M.-6 P.M. shift on 01/23/25-02/10/25, the staff missed 10 out of 35 opportunities to reconcile the narcotic medications;
- For 6 P.M.-6 A.M. shift on 02/10/25-02/27/25, the staff missed 13 out of 35 opportunities to reconcile the narcotic medication;
- For 6 A.M.-6 P.M. shift on 02/28/25-03/07/25, the staff missed 4 out of 13 opportunities to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 755	Continued From page 27 reconcile the narcotic medications. During an interview on 03/07/25 at 3:47 P.M., Licensed Practical Nurse (LPN) D said two staff members, the on-coming and off-going staff, count the narcotic medications in the cart or the medication room and signed the narcotic log book. During an interview on 03/07/25 at 4:30 P.M., the Regional Nurse Consultant said the on-coming and off-going staff should count the narcotic medications together and sign the narcotic count log. During an interview on 03/07/25 at 4:35 P.M., the Administrator said the on-coming staff and off-going staff should do a narcotic medications reconciliation and sign the narcotic log book.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §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	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 28	F 758		

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 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 a psychotropic (medications that affect a person's mental status) medication for three residents (Residents #1, #15, and #20) out of five sampled residents. The facility census was 54.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 29	F 758		

Review of the facility's policy titled, "Antipsychotic (a medication that affects the brain activities associated with mental processes and behavior) Medication Use," revised July 2022, showed:
- Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective;
- The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others;
- Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions):

a. Schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations);

b. Schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions);

c. Schizophreniform disorder (a mental illness similar to schizophrenia but symptoms last for a shorter period);

d. Delusional disorder (a mental disorder marked by false beliefs);

e. Mood Disorders (any mental disorder with a disturbance of mood) (e.g. bipolar disorder (a mental disorder that causes unusual shifts in mood), depression with psychotic features (combination of a loss of interest with hallucinations and delusions), and treatment refractory major depression (depression does not respond to standard treatments);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 30	F 758		

f. Psychosis in the absence of dementia (a state where an individual experiences a loss of touch with reality, marked by symptoms like delusions and hallucinations, without dementia);

g. Medical illness with psychotic symptoms and/or treatment related psychosis or mania (state of extreme highs such as intense energy and excitement);

h. Tourette's Disorder (a neurological disorder that causes people to make sudden, involuntary movements or sounds);

i. Huntington's Disease (a genetic progressive brain disorder that causes nerve cells to break down, leading to uncontrolled movements);

j. Hiccups (not induced by other medications); or;

k. Nausea and vomiting associated with cancer or chemotherapy;

- Diagnoses alone do not warrant the use of antipsychotic medication. In addition, to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met:

a. The behavioral symptoms present a danger to the resident or others; and:

1. the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity; or;

2. behavioral interventions have been attempted and included in the plan of care, except in an emergency;

- Antipsychotic medications will not be used if the only symptoms are one or more of the following: wandering, poor self-care, restlessness, impaired memory, mild anxiety, insomnia, inattention or indifference to surroundings, sadness or crying alone that is not related to depression or other psychiatric disorders,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 31	F 758		

fidgeting, nervousness, uncooperativeness.

1. Review of Resident #1's March 2025 Physician's Order Sheet (POS) showed:
- Admission date of 03/13/23;
- Diagnoses of Alzheimer's disease (a disease that destroys memory and other important mental functions), anxiety disorder, major depressive disorder (long-term loss of pleasure or interest in life), and unspecified dementia without psychosis (memory loss where the specific underlying cause cannot be identified);
- An order for Seroquel (an antipsychotic medication) 25 milligram (mg) by mouth at bedtime for unspecified dementia, dated, 08/08/24;
- The facility did not provide an appropriate diagnosis for the Seroquel.

2. Review of Resident #15's March 2025 POS showed:
- Admission date of 03/14/24;
- Diagnoses of atherosclerotic heart disease, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), depression (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and dementia;
- An order for Seroquel 37.5 mg by mouth two times a day for behaviors, dated 06/28/24;
- The facility did not provide an appropriate diagnosis for the Seroquel.

3. Review of Resident #20's March 2025 POS showed:
- Admission date of 06/14/24;
- Diagnoses of major depressive disorder and dementia;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 32 - An order for Seroquel 25 mg by mouth two times a day for psychosis, dated 01/03/25; - The facility did not provide an appropriate diagnosis for the Seroquel. During an interview on 03/07/25 at 4:50 P.M., the Regional Nurse Consultant said dementia was not an appropriate diagnosis for Seroquel. During an interview on 03/07/25 at 4:50 P.M., the Administrator said dementia was not an appropriate diagnosis for Seroquel.	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store and distribute	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 812	Continued From page 33	F 812		

food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These deficient practices had the potential to affect all residents. The facility census was 54.

Review of the facility's policy titled, "Refrigerators and Freezers," dated November 2022, showed:
- The facility will ensure safe refrigerator and freezer temperatures, and sanitation, and will observe food expiration guidelines;
- Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures;
- Food service supervisors or designated employees check and record refrigerator and freezer temperatures with first opening and at closing in the evening;
- Use by dates are completed with expiration dates on all prepared food in refrigerators;
- Expiration dated on unopened food and observed and use by dates are indicated once food is opened.

Review of the facility's policy titled, "Food Preparation and Service," dated November 2022, showed:
- Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices;
- When verifying food temperatures, staff use a thermometer which is both clean, sanitized, and calibrated to ensure accuracy;
- Proper hot and cold temperatures are maintained during food distribution and service;
- The temperatures of foods held in steam tables are monitored throughout the meal service by food and nutrition service staff;
- The policy did not address food temperature tracking sheets for meals served.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 812	Continued From page 34	F 812		

Review of the facility's policy titled, "Sanitation," revised November 2022, showed:
- The food service area is maintained in a clean and sanitary manner;
- All kitchens, kitchen areas, and dining areas are kept clean, free of garbage and debris, and protected from rodents and insects;
- All equipment, food contact services, and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.

Observation on 03/04/25 at 9:22 A.M., of the meal time food temperature logs showed:
- No food temperature logs for 02/22/25 - 03/04/25, with 42 missed opportunities out of 42 opportunities.

Observation on 03/04/25 at 9:22 A.M., of the refrigerator temperature logs showed:
- No refrigerator temperature logs for 03/01/25 - 03/04/25, with eight missed opportunities out of eight opportunities.

Observation on 03/04/25 at 9:28 A.M., of refrigerator 1 showed:
- A bag of opened biscuits undated and not labeled;
- Four bags of frozen pancakes undated and not labeled;
- A large opened bag of French fries undated.

Observations on 03/04/25 at 9:39 A.M., and 03/05/25 at 9:51 A.M., of the dishwasher machine showed a build up of debris, crumbs, and a hard white substance on the top surface.

Observation on 03/05/25 at 9:34 A.M., of the refrigerator near the Dietary Manager's (DM) door showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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 812	Continued From page 35 - A clear container of red jello undated and not labeled; - An opened bag of boiled eggs undated and not sealed; - A bag of shredded cheese opened and undated; - A half-used stick of butter opened, unwrapped, undated, and not sealed. During an interview on 03/05/25 at 10:31 A.M., the DM said the food temperature logs should be checked with each meal. The refrigerator temperature logs should be checked daily. The kitchen equipment should be cleaned daily and as needed. All foods should be labeled, dated, and secured to prevent any type of contamination. During an interview on 03/05/25 at 10:37 A.M., the Registered Dietician (RD) said food temperatures should be checked before each meal. The refrigerator temperatures should be checked and logged daily per policy. The kitchen equipment should be cleaned on a daily basis for sanitary purposes. All foods should be labeled, dated, and secured to prevent any type of contamination. During an interview on 03/05/25 at 10:52 A.M., the Administrator said she would expect kitchen staff to check food temperature logs before serving the food to the residents. Refrigerator temperature logs should be checked every day by the kitchen staff. The kitchen equipment should be clean at all times. All foods should be labeled, dated, and secured to prevent any type of contamination.	F 812		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07057A	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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
A4017	19 CSR 30-85.042(17) Criminal Background Check Request Effective August 28, 1997, each facility shall, not later than two (2) working days of the date an applicant for a position to have contact with residents is hired, request a criminal background check, as provided in sections 43.530, 43.540 and 610.120, RSMo. Each facility must maintain in its record documents verifying that the background checks were requested and the nature of the response received for each such request. The facility must ensure that any applicant who discloses prior to the check of his/her criminal records that he/she has been convicted of, plead guilty or nolo contendere to, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, will not be allowed to work in contact with patients or residents until and unless a check of the applicant ' s criminal record shows that no such conviction occurred. II/III This regulation is not met as evidenced by: Class III Refer to F607	A4017		
A4054	19 CSR 30-85.042(45) Written Orders; Restraints No medication, treatment, or diet shall be given without a written order from a person lawfully authorized to prescribe such and the order shall be followed. No restraint shall be applied except as provided in 13 CSR 15-18.010, Resident Rights. I/II This regulation is not met as evidenced by: Class II	A4054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07057A	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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
A4054	Continued From page 1 Refer to F758	A4054		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II Refer to F755	A4055		
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 and F692	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07057A	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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
A6019	19 CSR 30-87.020(19) List Fixtures, Vent Covers, Décor Cleanable Light fixtures, vent covers, wall-mounted fans, decorative materials and similar equipment attached to walls and ceilings shall be easily cleanable and shall be maintained clean and in good repair. III This regulation is not met as evidenced by: Class III Refer to F584	A6019		
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers Unless its identity is unmistakable, bulk food, such as cooking oil, syrup, salt, sugar or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by common name. III This regulation is not met as evidenced by: Class III Refer to F812	A7019		
A7020	19 CSR 30-87.030(18) Refrigerator Temperatures, Thermometers Enough conveniently located refrigeration facilities or effectively insulated facilities shall be provided to assure the maintenance of potentially hazardous food at required temperatures during storage. Each mechanically refrigerated facility storing potentially hazardous food shall be provided with a numerically scaled indicating	A7020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07057A	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTON POINT LIVING CENTER	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867

(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
A7020	Continued From page 3 thermometer, accurate to plus or minus three degrees Fahrenheit (±3°F), located to measure the air temperature in the warmest part of the refrigerated facility and located to be easily readable. Recording thermometers, accurate to plus or minus three degrees Fahrenheit (±3°F), may be used in lieu of indicating thermometers. III This regulation is not met as evidenced by: Class III Refer to F812	A7020		
A7028	19 CSR 30-87.030(26) Hazardous Food Cooking Temperatures Potentially hazardous foods requiring cooking shall be cooked to heat all parts of the food to a temperature of at least one hundred forty degrees Fahrenheit (140°F), except that poultry, poultry stuffings, stuffed meats and stuffings containing meat shall be cooked to heat all parts of the food to at least one hundred sixty-five degrees Fahrenheit (165°F) with no interruption of the cooking process. Pork and food containing pork shall be cooked to heat all parts of the food to at least one hundred fifty degrees Fahrenheit (150°F); rare roast beef shall be cooked to an internal temperature of at least one hundred thirty degrees Fahrenheit (130°F); and rare beef steak shall be cooked to a temperature of one hundred thirty degrees Fahrenheit (130°F) unless otherwise ordered by the resident. II/III This regulation is not met as evidenced by: Class III Refer to F812	A7028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07057A	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7085	19 CSR 30-87.030(83) Dishwashing Machine Clean Daily/As Needed All dishwashing machines shall be thoroughly cleaned at least once a day or more often when necessary to maintain them in a satisfactory operating condition. III This regulation is not met as evidenced by: Class III Refer to F812	A7085		

PLAN OF CORRECTION

Provider/Supplier Name:	COTTON POINT LIVING CENTER
Street Address, City, Zip:	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867
Date of Survey:	03/07/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 265859	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F584 SS=D	Safe/Clean/Comfortable Homelike-Environment CFR(s): 483.10(i)(1)-(7)	
	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 54.	
	Room 302 • A buildup of dirt and dust on the air filter inside the air conditioning unit – the air filter was replaced in the unit. • Several long dark markings on the wall near the light switch by the door -the area with the dark markings was painted • Two areas of exposed sheetrock and peeled paint – the sheetrock was repaired and the area painted • Several long dark makings along the wall next to bed – the areas of dark markings were painted Room 303 • Areas with dark markings and exposed sheetrock and peeled paint were repaired and area painted Room 306 • An area with exposed sheetrock and peeled paint was repaired and area painted. Room 312 • The resident's wheelchair seat, cushion, foot pedals and side were cleaned • The Hoyer lift(s) were cleaned and dirt and grime removed.	4/17/25

	(continued) Room316 • The long dark marking on the wall were painted. Resident private phone call room • The vent cover was replaced in the telephone room ceiling. • The maintenance supervisor will utilize a working paper tool to identify all areas of concern and need of repair in the building. • The administrator or designee will review the work order tool to identify areas of priority within the facility weekly for 4 weeks and monthly for 4 months. • The administrator or designee will provide education to the employees on how to complete the maintenance work log, what should be recorded and location of log. • Any discrepancies will be corrected at the time of discovery and reviewed in the monthly QAPI meeting.	

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PLAN OF CORRECTION

Provider/Supplier Name:	COTTON POINT LIVING CENTER
Street Address, City, Zip:	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867
Date of Survey:	03/07/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	
	Based on interview and record review the facility failed to follow their policy and procedures to complete criminal background checks (CBC) for one employee prior to hire and to check the employee disqualification list (EDL) for six other employees out of ten sampled employees. The facility census was 54.	
	EDL will be ran on all employees followed by quarterly EDLs.	4/17/25
	• The administrator or designee will provide education to the human resources personnel and all department heads on the requirement to run an EDL on every new hire prior to beginning employment and quarterly • The administrator or designee will provide education to the human resources personnel and all department heads on the requirement to run a criminal background check on every new hire prior to beginning employment. • The administrator or designee will review each new hires packet for the EDL and CBC prior to the employee beginning employment weekly for 12 weeks quarterly for EDL for one year. • Any discrepancies will be corrected at the time of discovery and reviewed in the monthly QAPI meeting.	4/17/25

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F638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	
	The facility failed to electronically transmit quarterly Minimum Data Set (MDS) assessments, a federally mandated assessment instrument completed by the facility, in a timely manner and in accordance with the guidelines for two residents (Residents #37 and #40) out of 14 sampled residents and two residents (Residents #38 and #42) outside the sample. The facility's census was 54.	
	Resident #37 MDS quarterly assessments will be submitted. Resident #38 MDS quarterly assessments will be submitted. Resident #40 MDS quarterly assessments will be submitted. Resident # 42 MDS quarterly assessments will be submitted.	4/17/25
	• The administrator or designee will provide education to the MDS on the requirement to complete all quarterly MDS assessments within the 92 days of the last MDS. • The administrator or designee will monitor weekly for four weeks and monthly for four months to ensure all MDS quarterly assessments are up to date. • Any areas of concern identified will be reviewed at the monthly QAPI meeting.	4/17/25

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PLAN OF CORRECTION

Provider/Supplier Name:	COTTON POINT LIVING CENTER
Street Address, City, Zip:	609 SOUTH RAILROAD STREET MATTHEWS, MO 63867
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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	
	The facility failed to electronically transmit a Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) in a timely manner and in accordance with guidelines for two residents (Residents #17 and #41) out of 14 sampled residents. The facility's census was 54.	
	• Resident #17 MDS quarterly assessments will be transmitted. • Resident #41 MDS quarterly assessments will be transmitted .	4/17/25
	• The administrator or designee will provide education to the MDS on the requirement to transmit all quarterly MDS assessments within the 14 days of the completion date. • The administrator or designee will audit to ensure all quarterly assessments are up to date. • The administrator or designee will monitor weekly for four weeks and monthly for four months to ensure all MDS quarterly assessments are completed. • Any discrepancies will be corrected at the time of discovery and reviewed in the monthly QAPI meeting.	4/17/25

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Provider/Supplier Name:	COTTON POINT LIVING CENTER
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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 265859		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
F655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	
	The facility failed to include an admitting diagnosis of post traumatic stress disorder (PTSD - psychological distress following a traumatic event) with specific interventions on the baseline care plan upon admission for one resident	
	Resident #158 – the care plan was updated to reflect PTSD and the triggers for PTSD	4/17/25
	• The administrator or designee will provide education to the Director of Nursing and the social worker on the required elements of the baseline care plan which include post-traumatic stress disorder. • The director of nursing or designee will review the baseline care plan on new admissions to ensure care plan is thorough and completed weekly for four weeks and monthly for four months to ensure all baseline care plans are completed with required components. • Any areas of concern identified will be reviewed at the monthly QAPI meeting.	4/17/25

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 265859	

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F658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	
	The facility failed to obtain and/or follow physician's orders for three residents (Residents #15, # 37, #158, & #2)	
	Resident #2 – the medication administration was not documented, during investigation nurses state given and resident believed it to be given – no documentation to support Resident #15 – An order was obtained and entered in POS for the PRN administration of oxygen Resident #37 – an order for Hospice was obtained and entered for Hospice care Resident #158 – the medication administration was not documented	4/17/25
	• The Director of Nursing or designee will provide education to the nursing staff on the requirement to follow physician's orders and document medication administration on the MAR/TAR. • The director of nursing or designee will provide education to the nursing staff on the requirement to obtain a physician order prior to implementation of treatments, medication, oxygen, etc. • The Director of Nursing or designee will monitor new orders daily (Monday- Friday) in the daily clinical meeting daily for two weeks, weekly for two weeks and monthly for two months. • The Director of Nursing will monitor the medications not given section in PCC daily Monday – Friday for two weeks, weekly for two weeks and monthly for two months. • Any discrepancies will be corrected at the time of discovery and reviewed in the monthly QAPI meeting.	4/17/25

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 265859		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
F692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	
	The facility failed to implement, monitor and modify interventions to maintain acceptable parameters of nutritional status for two residents (Residents #19 and #40) out of four sampled residents. The facility census was 54.	
	Resident #19 – meal card updated to include registered dietitians recommendations, Resident #40 – meal card updated to include the registered dietitians recommendations	4/17/25
	• The administrator or designee will provide education to the Director of Nursing and the dietary manager on receiving, implementing and following through on RD recommendations • The administrator or designee will provide education on the weight loss policy. • The director of nursing or designee will monitor weights weekly for 4 weeks and monthly for 4 months to ensure all weights are completed and follow-up is implemented when indicated. • The director of nursing or designee will audit RD recommendations weekly for 4 weeks and monthly for 4 months to ensure all recommendations are implemented. • Any discrepancies will be corrected at the time of discovery and reviewed in the monthly QAPI meeting.	4/17/25

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F755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/ Records CFR(s): 483.45(a)(b)(1)-(3)	
	The facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for three out of three medication carts. This practice had the potential to affect all residents.	
	The narcotic count logs on the 100 Hall, 200 Hall, 300 Hall and Medication room had numerous shifts lacking narcotic reconciliation. Findings were historical and could not be corrected.	
	• The director of nursing will provide education to the nursing staff of the requirement to reconcile narcotic counts at the end of each shift by the oncoming and off going nurses. • The director of nursing or designee will audit the 4 narcotic books daily (Monday- Friday) daily for 4 weeks, weekly for 4 weeks to ensure narcotic reconciliation occurs between the oncoming and off-going nurses. • Failure to reconcile narcotic at end of shift will result in counseling of oncoming and off going nurses. • Any areas of concern identified will be addressed upon finding and reviewed at the monthly QAPI meeting.	4/17/25

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F758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	
	The facility failed to ensure an appropriate diagnosis for the use of a psychotropic (medications that affect a person's mental status) medication for three residents (Residents #1, #15, and #20) out of five sampled residents.	
	Resident #1 – Seroquel – did not have appropriate diagnosis – provider will be notified to determine appropriate diagnosis or implement gradual dose reduction if indicated. Resident #15 – Seroquel – did not have appropriate diagnosis - provider will be notified to determine appropriate diagnosis or implement gradual dose reduction if indicated. Resident #20 – Seroquel – did not have appropriate diagnosis - provider will be notified to determine appropriate diagnosis or implement gradual dose reduction if indicated.	4/17/25
	• Director of Nursing (DON) will provide education to the nursing staff on the psychotropic medication policy. • DON or designee will conduct an audit of all Psychotropic medications to ensure an appropriate diagnosis as well as non-pharmacological interventions in place on each resident receiving psychotropic medications. • The consulting pharmacist will be provide with copy of the psychotropic medication policy. • This audit will be conducted weekly x 4, then twice monthly x 2, and then monthly x 1.	4/17/25

	• All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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F812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	
	The facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These deficient practices had the potential to affect all residents.	
	• Mealtime food temperature logs incomplete – Coaching completed with the manager of food service • Refrigerator temperature logs incomplete-coaching completed with the manager of food service • Foods opened and not dated disposed of upon findings • Dishwasher will be cleaned and all residue removed • Jello, eggs, cheese and butter not dated disposed of upon findings	4/17/25
	• Dietary and Nursing Personnel were educated on the requirements of F812 as it pertains to the requirement to maintain a safe and sanitary environment in which food is prepared, stored, and distributed. Examples from this citation were used within the content of this education • The administrator or designee will conduct an audit of all the kitchen and refrigerators to ensure food temperature and refrigerator temperatures are checked, that food is labeled and dated and the kitchen area is clean.	4/17/25

PLAN OF CORRECTION

Provider/Supplier Name:	Cotton Point Living Center
Street Address, City, Zip:	609 South Railroad Street Matthews, MO 63867
Date of Survey:	March 7, 2025

07057A

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4017	19 CSR 30-85.042(17) Criminal Background Check Request Please refer to F607	4/17/25
A4054	19 CSR 30-85.042(45) Written Orders; Restraints Please refer to F758	4/17/25
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System Please refer to F755	4/17/25
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Please refer to F658 & F692	4/17/25
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean Please refer to F584	4/17/25
A6019	19 CSR 30-87.020(19) List Fixtures, Vent Covers, Décor Cleanable Please refer to F584	4/17/25
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers Please refer to F812	4/17/25
A7020	19 CSR 30-87.030(18) Refrigerator Temperatures/thermometers Please refer to F812	4/17/25
A7028	19 CSR 30-87.030(26) Hazardous Food Cooking Temperatures Please refer to F812	4/17/25
A7085	19 CSR 30-87.030(83) Dishwashing Machine Clean Daily/As Needed Please refer to F812	4/17/25

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