STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265862	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA SOUTH NURSING & REHABILITATION	640 COLONEL GEORGE E DAY PARKWAY SIKESTON, MO 63801

(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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	LNHA	11/22/24

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

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the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to consistently document a code status for one resident (Resident #101) out of 14 sampled residents. The facility census was 53.

Review of the facility's policy titled, "Advanced Directives," dated 2001, showed:
- The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy;
- The facility defines the Do Not Resuscitate (DNR - in case of respiratory cardiac failure, the resident, legal guardian, health care proxy, or representative has directed that no cardiopulmonary resuscitation (CPR - an emergency life-saving procedure done when someone's breathing or heartbeat has stopped)) or other life-sustaining treatments or methods are to be used;
- Prior to or upon admission of a resident, the Social Services Director or designee inquires of the resident, his/her family members and/or his/her legal representative, about the existence of any written advance directives.

1, Review of the Resident #101's medical record showed:
- An admission date of 10/21/24;
- The face sheet, dated November 2024, showed a full code status;
- A DNR status indicated by a red dot on the outside spine of the resident's hard chart;
- The Physician's Order Sheet (POS), dated

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F 578	Continued From page 2 November 2024, showed a full code status; - A DNR form signed by the resident and the physician on 03/13/24. During an interview on 11/06/24 at 9:25 A.M., Medical Records Staff E said green dots indicated a full code status and the red dots indicated a DNR. During an interview on 11/06/24 at 9:30 A.M., the Director of Nursing (DON) said he did not have an explanation for the code status being different. During an interview on 11/06/24 at 9:45 A.M., the Social Services Director (SSD) said he/she did not know how the DNR sheet got in the resident's chart, due to it being dated on 03/13/24. The resident had been admitted and discharged previously. The form was in the admission packet and when someone was admitted, he/she and the resident or resident representative discussed the code status. The resident was considered a full code status. The SSD remembered the resident and a family member being in his/her office at the time of admission and no one signed a DNR form. During an interview on 11/06/24 at 10:20 A.M., the resident said he/she wanted to be a full code. During an interview on 11/07/24 at 1:00 P.M., the Administrator said she would expect the code status to be documented accurately and consistently throughout the resident's medical record.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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§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

§483.10(i)(7) For the maintenance of comfortable

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sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, 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 26.

The facility did not provide a homelike environment policy.

1. Observations on 11/04/24 at 1:41 P.M., 11/05/24 at 8:47 A.M., 11/06/24 at 3:22 P.M. and 11/07/24 at 8:06 A.M., showed an unhung shower curtain lay on top of a shower chair in the shower area located in Room 107.

2. Observations on 11/04/24 at 1:55 at P.M., 11/05/24 at 3:22 P.M., 11/06/24 at 3:02 P.M., and 11/07/24 at 11:06 A.M., of the 200 Hall showed several small dried dark areas on the floor in front of the decorative table and the beside recliner located in front of the window in Room 207.

3. Observation on 11/04/24 at 2:46 P.M., of the 400 Hall showed a large hole and missing sheetrock on the resident closet door located in Room 417.

4. Observations on 11/06/24 9:58 A.M., 11/07/24 at 11:50 A.M., of the 300 Hall showed:
- Six medium-sized stuffed animals on top of the over-the-bed light located in Room 302;
- A six inch (in.) x one foot (ft.) ceiling tile with a large brown stain near Room 310.

5. Observation on 11/06/24 at 1:20 P.M., of the 100 and 200 Hall nurses' station showed:

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- Several areas of exposed sheetrock located on the front side panel;
- Several long black lines and scraped areas located on the the side panel near the 200 Hall entrance.

During an interview on 11/07/24 at 9:04 A.M., Housekeeper A said if there was anything that needed to be fixed in the facility, he/she told the Maintenance Supervisor. There was also a daily rounds sheet that could be filled out and given to his/her supervisor. He/She had not seen anything during rounds that needed to be addressed in terms of the environment.

During an interview on 11/07/24 at 9:14 A.M., Housekeeper B said if there was anything that needed to be fixed in the facility, he/she told the Maintenance Supervisor. There was also a daily rounds sheet kept on the housekeeping cart that could be filled out if there was a repair needed. He/She had not seen any environmental issues during his/her rounds that needed to be addressed.

During an interview on 11/07/24 at 11:34 A.M., the Maintenance Supervisor said staff normally told him/her when something needed repaired or fixed. There used to be a maintenance log for staff to write down issues or concerns but was no longer used. He/She did not keep copies of the housekeeping sheets with environmental concerns made during daily rounds for documentation.

During an interview on 11/07/24 at 12:46 P.M., the Administrator said she would expect department heads to address any environmental concerns during the morning meetings. She

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F 584	Continued From page 6 would expect housekeeping to address and document any environmental concerns as well as line staff so the Maintenance Supervisor could address the issues in a timely manner.	F 584		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §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 four residents (Residents #7, #19, #28 and #35) outside of the 14 sampled residents. The facility's census was 53. Review of the facility's policy titled, "MDS Completion and Submission Timeframes," dated July 2017, showed: - The facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes; - The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to Centers of Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines; - Timeframes for completion and submission of	F 638		

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assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual.

1. Review of Resident #7's medical record showed:
- Admitted to the facility on 06/04/24;
- An admission MDS, dated 06/17/24, completed and submitted;
- The next scheduled quarterly MDS, not submitted (49 days late), and over 120 days from the last MDS, dated 06/17/24.

2. Review of Resident #19's medical record showed:
- Admitted to the facility on 09/01/19;
- A quarterly MDS, dated 06/23/24, completed and submitted;
- The next scheduled quarterly MDS, not submitted (43 days late), and over 120 days from the last MDS, dated 6/23/24.

3. Review of Resident #28's medical record showed:
- Admitted to the facility on 12/28/22;
- An annual MDS, dated 07/03/24, completed and submitted;
- The next scheduled quarterly MDS, not submitted (33 days late), and over 120 days from the last MDS, dated 07/03/24.

4. Review of Resident #35's medical record showed:
- Admitted to the facility on 06/17/22;
- An annual MDS, dated 07/01/24, completed and submitted;
- The next quarterly MDS, dated 10/01/24, not submitted (35 days late), and over 120 days from the last MDS, dated 07/01/24.

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F 638	Continued From page 8 During an interview on 11/07/24 at 10:20 A.M., the Social Service Director (SSD) said he/she was a Licensed Practical Nurse (LPN) and completed what he/she could on the MDS's. The Registered Nurse (RN) reviewed, completed, and submitted the MDS's. During an interview on 11/07/24 at 12:50 P.M., the Administrator said she did not know much about the MDS's and the facility had an off-site MDS Coordinator. During an interview on 11/15/24 at 9:20 A.M., the Director of Nursing (DON) said he does not know anything about the MDS's and when they should be submitted.	F 638		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide proper incontinent care for two residents (Residents #1 and #19) and failed to provide scheduled showers for one resident (Resident #37) for activities of daily living (ADLs) outside the 14 sampled residents. The facility census was 53. Review of the facility's policy titled, "Activities of Daily Living," revised March 2018, showed: - Residents will be provided with care, treatment and services as appropriate to maintain or	F 677		

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improve their ability to carry out ADLs;
- Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene;
- The policy did not address incontinent care and showers.

Review of the Perineal Care Return Demonstration check sheet, undated, showed:
- Clean the front peri area;
- Proceed to clean the rectal and buttocks area.

Review of the facility's policy titled, "Bath, Shower/Tub," revised February 2018, showed:
- Documentation: the date and time the shower/tub bath was performed; the name and title of the individual(s) who assisted the resident with the shower/tub bath; all assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath; if the resident refused the shower/tub bath, the reason(s);
- Reporting: notify the supervisor if the resident refused the shower/tub bath; notify the physician of any skin areas that may need to be treated; report other information in accordance with facility policy and professional standards of practice.

1. Review of Resident #1's admission Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 08/05/24, showed:
- Impairment on one side of the upper and lower extremity;
- Always incontinent of bowel and bladder;
- Required partial to moderate assist of staff for toileting and personal hygiene.

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Observation on 11/07/24 at 11:42 A.M., of the resident's incontinent care showed:
- Certified Nurse Assistant (CNA) D cleaned the resident's front peri area;
- CNA D rolled the resident to his/her right side and removed the urine soaked brief;
- CNA D cleaned the resident's rectal area, left buttock and left hip;
- CNA D failed to clean the resident's right hip or right buttock.

2. Review of Resident #19's annual MDS, dated 10/24/24, showed:
- Always incontinent of bowel and bladder;
- Required maximum assist of staff for toileting and personal hygiene.

Observation on 11/06/24 at 9:58 A.M., of the resident's incontinent care showed:
- CNA M clean resident's rectal area, buttocks, and hips of fecal material;
- CNA M applied barrier cream to the resident's buttocks;
- CNA M placed a clean brief on the resident;
- CNA M failed to clean the resident's front peri area.

During an interview on 11/06/24 at 10:07 A.M., CNA M said when providing peri care, should clean from front to back.

During an interview on 11/07/24 at 12:45 P.M., CNA D said he/she was nervous and knew he/she had not provided appropriate incontinent care to the resident.

During an interview on 11/07/24 at 12:56 P.M., the Administrator said any skin that was dirty should be washed. The resident's peri area

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should be washed from front to back when providing incontinent care for the resident.

3. Review of Resident #37's medical record showed:
- An admission date of 11/04/22;
- Diagnoses of congestive heart failure (an inability of the heart to pump sufficient blood flow to meet the body's needs), urinary tract infection, acute kidney failure (the kidneys suddenly stop working properly), anemia (low blood levels of iron) and dislocations (separation of two bones) of unspecified parts of the left shoulder girdle (shoulder blade, upper arm and collar bone).

Review of the resident's quarterly MDS, dated 09/05/24, showed:
- Partial/moderate assistance for shower/bathing;
- Supervision or touching assistance for tub/shower transfer.

Review of the resident's care plan, revised 06/13/24, showed:
- Did not address showers/bathing frequency;
- Did not address assistance required.

Review of the shower schedule, dated November 2024, showed the resident received showers on Wednesdays and Saturdays.

Review of the resident's shower sheets, dated 10/02/24 through 11/02/24, showed:
- No documentation of scheduled showers on 10/12/24, 10/16/24, 10/19/24, 10/23/24 and 11/02/24;
- Five missed out of 10 opportunities for scheduled showers.

During an interview on 11/04/24 at 2:18 P.M., and

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11/06/24 at 3:40 P.M., the resident said he/she was supposed to get showers on Wednesdays and Saturdays. He/She did not always get showers on Saturdays and was sometimes not asked if he/she would like a shower. A CNA told him/her this past Saturday there was not enough staff to give him/her a shower, but he/she knew other residents had received a shower. His/Her family came to visit on Sunday and gave him/her a shower.

During an interview on 11/07/24 at 10:27 A.M., CNA C said on the days a resident was scheduled to receive a bath/shower, a shower sheet should be completed to show the resident received a shower or if the resident refused. There should be a shower sheet for every time a resident was scheduled a shower.

During an interview on 11/07/24 at 10:29 A.M., CNA D said on the days a resident was scheduled to receive a bath/shower, a shower sheet should be completed to show the resident received a shower or if the resident refused. If a resident refused a shower, he/she would go back and ask the resident again later.

During an interview on 11/07/24 at 10:44 A.M., the Assistant Director of Nursing (ADON) said showers should be documented. There should be documentation that showers had been given and/or if a resident had refused a bath/shower. Staff should be asking residents if he/she wanted a shower and if refused, another attempt should be made and documented.

During an interview on 11/06/24 at 11:15 A.M., the Director of Nursing (DON) said he would expect a shower sheet to be filled out for each resident

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F 677	Continued From page 13 who received a bath/shower by the person who gave the shower. It should also be documented when a resident refused a shower. Residents should be given bath/showers on the days scheduled. During an interview on 11/06/24 at 12:24 P.M., the Administrator said residents should be given a bath/shower on the days scheduled. She would expect a shower sheet to be filled out for each resident who received a bath/shower by the person who gave the shower. If a resident refused a shower, staff should be going back and asking the resident again if he/she wanted a bath/shower. It should also be documented when a resident refused a shower.	F 677		
F 755 SS=D	Complaint #MO00243948 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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	F 755		

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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 observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately administered, documented, disposed of, and reconciled for one resident (Resident #8) outside of the seven sampled residents. The facility census was 53.

Review of the facility's policy titled, "Controlled Substances," revised November 2022, showed:
- Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up;
- Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count;
- The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services;
- The Director of Nursing (DON) services documents irreconcilable discrepancies in a

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report to the administrator;
- Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed;
- Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation.

1. Review of Resident #8's medical record showed:
- An admission date of 09/30/21;
- An order for lorazepam (a controlled medication used to treat anxiety) 0.5 milliliter (ml) every hour for terminal restlessness and shortness of breath, dated 12/07/23, with a stop date of 02/02/24.

Review of the Controlled Substance Record Book showed no individual controlled substance records for Resident #8's lorazepam 0.5 ml every hour for terminal restlessness/shortness of breath.

Observation on 11/06/24 at 4:27 P.M., of the locked refrigerator in the main medication room showed one bottle of opened liquid lorazepam 2 milligram (mg) per ml with 28 ml left in the 30 ml bottle for Resident #8.

During an interview on 11/06/24 at 4:33 P.M., Licensed Practical Nurse (LPN) F said there should have been dates with the doses and a signature of the nurse administering the medication written in the narcotic count book for Resident #8's lorazepam. When residents were discharged, the unused controlled medications were given to the DON.

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F 755	Continued From page 16 During an interview on 11/06/24 at 4:40 P.M., the DON said he was unsure why the doses for Resident #8's lorazepam were not documented when they were given. The DON did not know why the lorazepam had not been brought to him for destruction. During an interview on 11/07/24 at 12:35 P.M., the Administrator said the nurse who received the order to discontinue the medication should remove the medication from the cart. Two nurses should witness the destruction of the medications and document. She was unsure why the medication was still being counted and in the facility.	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 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 17 §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 and to identify specific behaviors and monitor the behaviors for the use of a psychotropic (drugs that can affect mood or mental state) medications for two residents (Residents #2 and #14) out of five sampled residents. The facility census was 53. Review of the facility policy titled, "Antipsychotic Medication Use," revised on July 2022, showed:	F 758		

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F 758	Continued From page 18 - Residents will only receive antipsychotics medications when necessary to treat specific conditions for which they are indicated and effective; - Antipsychotic (medications used to treat psychosis-related conditions and symptoms) medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Review of the facility policy titled, "Behavioral Assessment, Intervention and Monitoring," revised March 2019, showed: - Behavioral or psychological symptoms of dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attribute to a specific medical or psychiatric cause. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors and those that cannot; - Current guidelines recommend the use of non-pharmacological interventions for BPSD; - New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. 1. Review of Resident #2's medical record showed: - An admission date of 10/29/19; - Diagnoses of Alzheimer's (a progressive disease that destroys memory and other mental function) and dementia (memory loss that interferes with daily functioning) severe with agitation; - An order for risperidone (an antipsychotic	F 758		

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medication) 0.5 milligram (mg) once a day for behaviors, dated;
- No documentation of an appropriate diagnosis for the risperidone;
- No documentation of any identified specific behaviors and monitoring of the behaviors for the use of the risperidone.

2. Review of Resident #14's medical record showed:
- An admission date of 01/19/21;
- Diagnoses of major depressive disorder (a mental disorder having persistent depressed mood or loss of interest) with psychotic features and Alzheimer's;
- An order for Abilify (an antipsychotic medication) 5 mg once a day for depression, dated 08/06/24;
- An order for sertraline (an antidepressant medication) 200 mg once a day for depression, dated 07/09/24;
- An order for mirtazipine (an antidepressant medication) 15 mg at bedtime, dated 10/02/24; for diagnosis of dementia;
- No documentation of an appropriate diagnosis or behaviors for the Abilify;
- No documentation of any identified specific behaviors and monitoring of the behaviors for the use of the Abilify, sertraline, and mirtazipine.

Review of the manufacturer recommendations for Abilify state drug is not approved for the treatment of patients with dementia-related psychosis and review of the manufacturer recommendations for Risdperidone (Risperdal) state drug is not approved for treatment of patients with dementia-related psychosis.

During an interview on 11/06/24 at 10:01 A.M., Certified Medication Technician (CMT) G said

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F 758	Continued From page 20 he/she was unsure why Resident #2 received risperidone because the resident didn't have behaviors. During an interview on 11/06/24 at 1:50 P.M., the Director of Nursing (DON) said Resident #2's behaviors were yelling out at times. He said there was no documentation of the behaviors or any pharmacological or non-pharmacological routes taken for Resident #2. The facility didn't have any kind of monitoring process in place for the residents taking psychotropic medications. Resident #14's behaviors were confusion and yelling out on occasions. He would expect an appropriate diagnosis for a resident to be on an antipsychotic medication but he was new and was under the impression that the residents did have appropriate diagnoses. During an interview on 11/07/24 at 12:26 P.M., the Administrator said she would expect residents taking an antipsychotic medication to have an appropriate diagnosis supporting the medication. She would expect there to be some kind of monitoring system in place for residents that were taking an antipsychotic medication and appropriate charting of the behaviors.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 759		

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review, the facility failed to maintain an error rate of less than five percent (%) when medications were given. There were 30 opportunities with four errors made, for an error rate of 13.33%. This affected two residents (Residents #10 and #45) out of six sampled residents and had the potential to affect all residents. The facility census was 53.

Review of the facility's policy titled, "Documentation of Medication Administration," revised November 2022, showed:
- A nurse of certified medication technician (CMT), where applicable, documents all medications administered to each resident on the resident's Medication Administration Record (MAR);
- Administration of medication is documented immediately after it is given.

Review of the facility's policy titled, "Administering Oral Medications," revised October 2010, showed:
- Verify that there is a physician's medication order for this procedure;
- Place the MAR within easy viewing distance;
- Check the label on the medication and confirm the medication name and dose with the MAR.

1. Review of Resident #10's Physician Order Sheet (POS), dated November 2024, showed:
- An order for Macrobid (an antibiotic medication) 100 milligrams (mg) by mouth two times daily for 10 days, dated 11/03/24, with a discontinue date of 11/04/24;
- An order for Refresh Plus Ophthalmic Solution (a medication used for itchy, burnings eyes) instill one drop in the right eye three times a day, dated 09/18/24;
- An order for Flonase Allergy Relief Nasal

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Suspension (a medication used for seasonal allergies) 50 microgram (mcg) one spray in both nostrils two times a day for allergy relief, dated 09/18/24.

Review of the resident's MAR, dated November 2024, showed:
- Macrobid documented not administered on 11/06/24;
- Refresh Plus documented administered on 11/06/24;
- Flonase Nasal spray documented administered on 11/06/24.

Observation of Resident #10's medication administration on 11/06/24 at 9:10 A.M., showed:
- CMT G administered Macrobid;
- CMT G did not administer the Refresh eye drops;
- CMT G did not administer the Flonase nasal spray.

During an interview on 11/06/24 at 10:46 A.M., Resident #10 said he/she was not on an antibiotic anymore and he/she usually got the eye drops and nasal spray with the morning medication pass.

During an interview on 11/06/24 at 11:51 A.M., CMT G said he/she was nervous and administered the Macrobid by mistake.

During an interview on 11/07/24 at 12:45 P.M., the Director of Nursing (DON) said he would expect staff to only administer medications as ordered.

During an interview on 11/07/24 at 12:35 P.M., the Administrator said it was expected the staff

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F 759	Continued From page 23 not to chart medications that had not been administered. 2. Review of Resident #45's POS, dated November 2024, showed: - An order for Prevagen (a dietary supplement that aids in mild memory loss) 10 mg by mouth daily, dated 05/18/24. Observation of Resident #45's medication administration on 11/06/24 at 8:51 A.M., showed: - CMT G did not administer the Prevagen medication. During an interview on 11/06/24 at 9:00 A.M., CMT G said the family provided the medication. The medication wasn't in the medication cart to give. When medications were not in the medication cart, the charge nurse was notified. During an interview on 11/06/24 at 11:15 A.M., Licensed Practical Nurse (LPN) F said CMT G had not informed him/her of any medications not being in the medication cart. During an interview on 11/07/24 at 12:45 P.M., the DON said she expected staff to follow physician's orders for medication administration.	F 759		
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	F 812		

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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 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 53.

Review of the facility's policy titled, "Sanitation," revised November 2022, showed;
- Kitchen areas are kept clean, free from garbage and debris;
- All kitchen equipment is kept clean.

Review of the facility's policy titled, "Food Receiving and Storage," undated, showed;
- All foods stored in the refrigerator or freezer are covered, labeled and dated;
- Refrigerated foods are labeled, dated and monitored so they are used by their use-by date;
- Partially eaten food is not kept in the refrigerator.

1. Observations on 11/04/24 at 10:33 A.M., and 11/05/24 at 8:48 A.M., of the right side walk-in freezer showed;

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F 812	Continued From page 25 - An opened box of frozen and exposed catfish undated located on the left side; - An opened bag of frozen dinner rolls with no label and undated located on the left side; - An opened bag of frozen hushpuppies with no label and undated located on the left side; - A box of miscellaneous and unidentified frozen food items located on the bottom left shelf with no label and undated; - Five frozen corn dogs not in a sealed container with a buildup of frost lay on top of a box of miscellaneous food items with no label and undated. 2. Observations on 11/04/24 at 10:36 A.M., and 11/05/24 at 8:51 A.M., of the left side standup refrigerator showed; - Two sponge cakes with no label and undated; - A chocolate dessert in a styrofoam to-go container with no label and undated; - A half-eaten hot fudge sundae in an opened plastic container with a spoon inside with no label and undated. 3. Observations on 11/04/24 at 10:43 A.M., and 11/05/24 at 8:54 A.M., of the dishwashing room showed; - An empty paper towel dispenser located at the hand washing sink; - An empty soap dispenser located at the handwashing sink; - A storage crate with several dishes, a bottle of grease spray, a large drink dispenser, and grease wipes lay cluttered and stacked up between a metal shelf and the handwashing sink; - A buildup of dirt and debris on a beverage dispenser lay on a cart located under the three compartment-sink; - A buildup of a hard white substance located on	F 812		

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	265862	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA SOUTH NURSING & REHABILITATION	640 COLONEL GEORGE E DAY PARKWAY SIKESTON, MO 63801

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F 812	Continued From page 26 the top and side surfaces of the dish machine; - Miscellaneous glass tumblers and a squeegee lay on top of the dish machine. 4. Observations on 11/04/24 at 10:57 A.M., and 11/05/24 at 8:59 A.M., of the kitchen equipment showed; - A buildup of grime located on the side surfaces of the plate warmer cart; - A buildup of grease and grime located on the stove/oven; - A buildup of grease located on the side surfaces of the double-fryer; - A buildup of grease and dirt located on the floor between the double fryer and the oven. During an interview on 11/04/24 at 11:02 A.M., Kitchen Employee I said he/she would expect open items in the freezers and/or refrigerators to be labeled and dated. There was no daily check off for cleaning in the kitchen and all the kitchen staff just looked around and do what needed to be done. The equipment should be free of grease, grime, be free of clutter, and organized. During an interview on 11/06/24 at 2:09 P.M., the Dietary Manager said he/she would expect clutter to be sorted and put away. There was a cleaning schedule that was hung up, but staff did not sign off daily because they all just knew what they should be doing and work together. He/She would not expect equipment to be greasy and grimey. He/She would expect any food items placed in the freezers and/or refrigerators that had been opened to be labeled, dated and in a sealed container. During an interview on 11/07/24 at 11:09 A.M., the Administrator said she would expect the kitchen	F 812		

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F 812	Continued From page 27 staff to clean on a daily basis and the kitchen to be free of grease and grime on the the equipment and floors. She would expect the kitchen to have the paper towel and soap dispenser refilled as needed, be free of clutter. All foods once opened, should be labeled, dated, in a sealed container, and placed into the freezers and/or refrigerators.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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F 880	Continued From page 28	F 880		

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record

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F 880	Continued From page 29	F 880		

review, the facility failed to perform hand hygiene and glove changes during incontinent care for three residents (Residents #1, #19 and #251) outside the six sampled residents. The facility census was 53.

Review of the facility's policy titled, "Handwashing/Hand Hygiene," dated 2001, showed:
- The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections;
- All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections;
- All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors;
- Hand hygiene is indicated: immediately before touching a resident; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the resident's environment; before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal;
- The use of gloves does not replace hand washing/hand hygiene;
Applying and Removing Gloves: Perform hand hygiene before applying gloves; when gloves are removed, then perform hand hygiene.

1. Observation on 11/07/24 at 11:42 A.M., of Resident #1's incontinent care showed:
- Certified Nursing Assistant (CNA) D entered the resident's room;
- CNA D performed hand hygiene and put on gloves;

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F 880	Continued From page 30 - CNA D cleaned the resident's front peri area; - CNA D did not change gloves, did not perform hand hygiene, rolled the resident to his/her right side, and removed the urine soaked brief; - CNA D did not change gloves, did not perform hand hygiene, touched the peri wash bottle, and sprayed the peri wash on the resident's back peri area; - CNA D did not change gloves, did not perform hand hygiene, and cleaned the resident's rectal area, the buttock, and the left hip; - CNA D did not change gloves, did not perform hand hygiene, and placed a clean brief under the resident; - CNA D did not change gloves, did not perform hand hygiene, rolled the resident to his/her back and fastened the brief; - CNA D did not change gloves, did not perform hand hygiene, touched the resident linens, and the over the bed table. 2. Observation on 11/06/24 at 9:58 A.M., of Resident #19's incontinent care showed: - CNA M entered the resident's room; - CNA M performed hand hygiene and put on gloves; - CNA M clean the resident's rectal area, buttocks, and hips of fecal material; - CNA M did not change gloves, did not perform hand hygiene, and applied barrier cream to the rectal area and buttocks; - CNA M did not change gloves, did not perform hand hygiene, and placed a clean brief on the resident; - CNA M did not change gloves, did not perform hand hygiene, rolled the resident to his/her back, and fastened the brief; - CNA M did not change gloves, did not perform hand hygiene, and pulled the resident's pants up.	F 880		

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F 880	Continued From page 31	F 880		

3. Observation on 11/07/24 at 11:45 A.M., of Resident #251's incontinent care showed:
- CNA C entered the resident's room;
- CNA C did not perform hand hygiene and put on gloves;
- CNA C cleaned the resident's front peri area;
- CNA C did not perform hand hygiene and changed gloves;
- CNA C rolled the resident and cleaned the rectal area and buttocks;
- CNA C did not change gloves, did not perform hand hygiene, and applied a new brief;
- CNA C pulled the resident's pants back up.

During an interview on 11/06/24 at 10:07 A.M., CNA M said he/she should've changed gloves between dirty and clean care.

During an interview on 11/07/24 at 12:45 P.M., CNA D said he/she was nervous and knew he/she had messed up by not changing his/her gloves.

During an interview on 11/07/24 at 12:55 P.M., the Director of Nursing (DON) said he expected staff, while performing incontinent care, to change gloves when going from dirty to clean care and to clean from front to back when cleansing the peri area of a resident.

During an interview on 11/07/24 at 12:56 P.M., the Administrator said any skin that was dirty should be washed. The resident's peri area should be washed from front to back when providing incontinent care for the resident. The gloves should be changed between dirty and clean tasks.

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F 880	Continued From page 32 During an interview on 11/07/24 at 1:09 P.M., CNA C said that he/she should have washed hands before starting peri care and should have changed gloves before applying a clean brief.	F 880		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30584	A. BUILDING: _____ B. WING _____	C 11/07/2024

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DELTA SOUTH NURSING & REHABILITATION	640 COLONEL GEORGE E DAY PARKWAY SIKESTON, MO 63801

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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 and F759	A4055		
A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident. Irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. II/III This regulation is not met as evidenced by: Class III Refer to F758	A4061		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F677	A4075		

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A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Refer to F880	A4086		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: Class III Refer to F584	A6012		

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A6015	Continued From page 2	A6015		
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		
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		
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning Surfaces of equipment not intended for contact with food, but which are exposed to splash or food debris or which otherwise require frequent cleaning, shall be designed and fabricated to be smooth, washable, free of unnecessary ledges, projections or crevices, and readily accessible for cleaning, and shall be of such material and in a repair as to be easily maintained in a clean and sanitary condition. III	A7056		

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A7056	Continued From page 3 This regulation is not met as evidenced by: Class III Refer to F812	A7056		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's *right* to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by:	A8010		

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A8010	Continued From page 4 Class III Refer to F578	A8010		

PLAN OF CORRECTION

Provider/Supplier Name:	Delta South Skilled Nursing & Rehabilitation Center, LLC
Street Address, City, Zip:	640 Colonel George E Day Parkway, Sikeston, MO, 63801
Date of Survey:	11/07/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F578	The facility will consistently document a code status for all	12/17/2024
	Residents.	
	Code status has been corrected for resident #101.	
	The facility will complete audit of all current resident charts to	
	Ensure correct code status is documented in the resident care	
	Plan, resident chart, resident face sheet, and all required	
	Physician orders are present.	
	The Social Service Director and Medical Records Director	
	Will be in-serviced on process to ensure all resident code status'	
	Are correct and documented appropriately.	
	Administrator and/or his/her designee will address resident	
	Code status changes daily in morning meeting and ensure	
	Changes in documentation are implemented immediately.	
	The Director of Medical Records will complete monthly audit for	
	6 months to ensure process implementation.	
	This plan will be presented to the facility QAPI committee for	
	Approval and reviewed quarterly for continued compliance.	

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

PLAN OF CORRECTION

Provider/Supplier Name:	Delta South Skilled Nursing & Rehabilitation Center, LLC
Street Address, City, Zip:	640 Colonel George E Day Parkway, Sikeston, MO, 63801
Date of Survey:	11/07/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
F584	The facility will provide safe, clean, and comfortable, homelike	12/17/2024
	Environment.	
	The shower curtain in room 107 will be hung up.	
	The floor in room 207 will be cleaned and spots removed.	
	The sheetrock will be repaired and closet door replaced in room	
	417.	
	The stuffed animals have been removed from above lights in	
	Room 302.	
	The ceiling tile has been replaced near room 310.	
	The 100 and 200 hall nurses station will be repaired and black	
	Lines and scrape areas cleaned and repaired.	
	The facility will begin using Maintenance Repair Log that will	
	Be located at the nurses station for all staff to note damages	
	And/or needed facility repairs.	
	All facility staff will be in-serviced on use of Maintenance Repair	
	Log.	
	Maintenance Supervisor will review daily for needed repairs	
	And make repairs as needed.	
	Facility administrator will review weekly to ensure repairs are	
	Made.	
	This plan will be presented to facility QAPI committee for	
	Approval and reviewed quarterly for continued compliance.	

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

PLAN OF CORRECTION

Provider/Supplier Name:	Delta South Skilled Nursing & Rehabilitation Center, LLC
Street Address, City, Zip:	640 Colonel George E Day Parkway, Sikeston, MO, 63801
Date of Survey:	11/07/2024

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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**
F638	The facility will electronically transmit quarterly Minimum Data	12/17/2024
	Set (MDS) assessments in a timely manner.	
	Resident #7 MDS submitted 11/20/24.	
	Resident #19 MDS submitted 11/11/24.	
	Resident #28 MDS submitted 11/11/24.	
	Resident #35 MDS submitted 11/11/24.	
	Facility will complete audit of all MDS's to ensure current	
	Resident MDS's are completed and submitted timely.	
	The MDS Coordinators will be in-serviced on completing	
	MDS's timely.	
	Monthly, MDS's Coordinator will provide administrator with	
	MDS Due list. The facility administrator and/or his her	
	Designee will monitor weekly to ensure MDS's are completed	
	and submitted timely.	
	This plan will be presented to facility QAPI for approval and	
	Reviewed quarterly for continued compliance.	

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PLAN OF CORRECTION

Provider/Supplier Name:	Delta South Skilled Nursing & Rehabilitation Center, LLC
Street Address, City, Zip:	640 Colonel George E Day Parkway, Sikeston, MO, 63801
Date of Survey:	11/07/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F677	The facility will provide proper incontinent care and scheduled	12/17/2024
	Showers to all residents of the facility.	
	Residents #1 and #19 will receive proper peri-care.	
	Resident #37 will receive scheduled showers.	
	All nursing staff will be in-serviced on providing proper peri-care	
	To include cleaning front and back peri area, left and right hips	
	And right and left buttocks.	
	All Certified Nurse Aids will be checked off on providing proper	
	Peri-care.	
	The Director of Nursing and/or his/her designee will monitor	
	Weekly through observation of peri care and educate as needed	
	All nursing staff will be in-serviced on providing showers as	
	Scheduled to residents, to include proper documentation of	
	Showers and reporting resident refusals to charge nurses.	
	The Director of Nursing and/or his/her designee will monitor	
	Daily through the review of facility shower sheets and resident	
	Interview.	
	The administrator and/or his/her designee will monitor weekly	
	In morning meeting by reviewing facility shower sheets and	
	Director of Nursing rounds.	
	This plan will be presented to the facility QAPI committee for	
	Approval and will be reviewed quarterly for continued	
	Compliance.	

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PLAN OF CORRECTION

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F755	The facility will implement procedures to ensure medications	12/17/2024
	Are accurately administered, documented, disposed of, and	
	Reconciled.	
	The lorazepam for resident #8 has been discarded.	
	All licensed nursing staff will be in-serviced on proper	
	Documentation required when administering narcotics.	
	All licensed nursing staff will be in-serviced on procedure for	
	Disposing of narcotics and all other medications when they are	
	Discontinued.	
	The Director of Nursing and/or his/her designee will monitor	
	weekly through review of narcotic count sheets and completion	
	Of medication room and medication cart audits.	
	The administrator will monitor weekly through review of	
	Completed medication room and cart audits.	
	This plan will be presented to the facility QAPI committee for	
	Approval and reviewed quarterly to ensure compliance.	

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F758	The facility will ensure an appropriate diagnosis and to	12/17/2024
	Identify specific behaviors and monitor the behaviors for the use	
	Of a psychotropic medications for all residents.	
	Resident #2 will start dose reduction of riperidone until	
	Discontinued. Behaviors will be documented with weekly recap	
	And as incident occurs.	
	Resident #14 will start dose reduction of Abilify until	
	Discontinued. Adequate diagnosis will be obtained for use of	
	Mirtazipine.	
	Behaviors will be documented with weekly recap and as incident	
	Occurs.	
	All facility residents' medication will be reviewed. Any	
	Resident on a psychotropic medication will have weekly	
	Behavior documentation completed along with as incident	
	Occurs.	
	All licensed nursing staff will be in-serviced on obtaining proper	
	Diagnosis with all psychotropic medications and the behavior	
	Documentation.	
	The Director of Nursing and/or his/her designee will monitor	
	Documentation and correct diagnosis weekly through review of	
	Documentation and resident record review.	
	The administrator will review weekly through review of Director	
	Of Nursing documented reviews.	

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F758	This plan will be presented to the facility QAPI committee for Approval and reviewed quarterly for continued compliance.	12/17/2024

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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**
F759	The facility will maintain an error rate of less than 5% when Medications are given. Residents #10 and Resident #45 as prescribed by the physician. All certified medication technicians (CMT) will be in-serviced On proper medication administration to include the 5 rights of Medication pass. All CMT's will receive skills checks as part of in-service and will Be re-educated as needed. The Director of Nursing and/or his/her designee will monitor Weekly through observation of medication pass. The administrator will monitor weekly through review of Director of Nursing observations. This plan will be presented to the facility QAPI committee for Approval and reviewed quarterly for continued compliance.	12/17/2024

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F812	The facility will store and distribute food under sanitary	12/17/2024
	Conditions.	
	The food on right side of walk in freezer will be stored, labeled,	
	And dated correctly.	
	The food on the left side of standup refrigerator will be stored,	
	Labeled, and dated correctly.	
	The paper towel and soap dispenser will be filled at	
	Handwashing sink.	
	The storage crate in the dishwasher room will be removed	
	And items stored appropriately.	
	The beverage dispenser has been cleaned and removed from	
	The dish room and stored appropriately.	
	Miscellaneous items will be removed from dish machine and	
	Dish machine cleaned to remove all buildup, as well as the plate warmer, stove/oven,double fryer,and the floor between the fryer and oven.	
	All dietary staff will be in-serviced on proper storage of food to	
	Include storage, labeling, and dating.	
	All dietary staff will be in-serviced on cleaning schedules and	
	Storage of items, drinking dispensers, tumblers, etc. in the	
	Appropriate areas.	
	The dietary manager will monitor weekly through kitchen rounds.	
	The administrator will monitor weekly through kitchen rounds.	
	This plan will be presented to facility QAPI committee for	
	Approval and reviewed quarterly for continued compliance.	

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F880	The facility will perform hand hygiene and glove changes	12/17/2024
	During incontinent care.	
	All certified nurse aids (C.N.A.) will be in-serviced on performing	
	Proper incontinent care to include hand hygiene and glove	
	Changes.	
	All CNA's will receive skill checks and further education of	
	Performing proper incontinent care.	
	The Director of Nursing and/or his/her designee will monitor	
	Weekly through observation and provide continued education	
	As needed.	
	The administrator will monitor weekly through review of	
	Director of Nursing observations.	
	This plan will be presented to the facility QAPI committee for	
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A4055	Refer to F755 and F759	12/17/2024
A4061	Refer to F758	
A4075	Refer to F677	
A4086	Refer to F880	
A6012	Refer to F584	
A6015	Refer to F584	
A7019	Refer to F812	
A7056	Refer to F812	
A8010	Refer to F578	

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