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	265225	A. BUILDING _____ B. WING _____	C 07/17/2024

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ST JAMES LIVING CENTER	415 SIDNEY STREET, SAINT JAMES, MO 65559

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F 584 SS=E	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: Administrator | (X6) DATE: 8/9/24

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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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, facility staff failed to provide a comfortable and homelike environment for residents, when the staff failed to maintain walls, floors, windows, showers and equipment in resident rooms clean and in good repair. Facility staff failed to provide an environment free of pests. The facility census was 48. 1. Review of the facility's policy's showed the facility did not provide a policy for staff to report environmental concerns. 2. Observation on 07/14/24 at 10:00 A.M., showed the water station in front of the nurse's station between the memory care unit and 400 hall contained a dried orange/brown spot on the wall behind and above the trash can. 3. Observation on 07/14/24 at 10:01 A.M., showed the shared bathroom in occupied resident rooms 403 and 405 contained yellow stained toilet seat with two cracks in the back side at the hinges. Observation showed a bed pan and a dirty toilet riser on the floor on either side of the toilet between the wall. The bathroom walls dirty and contained black and brown smudges. The inside of the door to room 405 contained a large area of chipped paint with exposed green paint underneath and black marks along the lower portion of the door. 4. Observation on 07/14/24 at 10:02 A.M., showed occupied resident room 103 with multiple areas of the floor peeled up and three pieces of	F 584		

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F 584	Continued From page 2 duct tape used to hold the floor together. 5. Observation on 07/14/24 at 11:00 A.M., showed occupied resident room 407 had three gouges in the floor next to the bed by the door. The inside of the bedroom door and inside of the bathroom door had chipped paint which exposed green paint underneath. During an interview on 07/14/24 at 11:00 A.M., Resident #35 said he/she had asked someone in administration for the doors to be painted but was told the request wouldn't "make it through corporate". 6. Observation on 07/14/24 at 2:45 P.M. showed occupied resident room 206 contained missing drywall and paint behind the headboard of bed b, and drywall debris hanging from the wall, electric outlet, and on the floor. Observation showed half of the room had not been painted. During an interview on 07/14/24 at 2:45 P.M., Resident #1 said staff started repainting the room, but did not finish the front half and they only painted around the edges. The resident said it looks bad, and he/she is not happy that is has been over two months since it was initially started. The resident said the maintenance guy quit and no one had finished the room. 7. Observation on 07/15/24 at 8:23 A.M., showed occupied resident Room 104's air conditioning (AC) unit without a cover and the AC line exposed. Observation showed the toilet seat had chipped paint. Observation showed the sanitizer pump was broken, with the front of the pump open and hanging down, with two pieces of tape used to hold it closed.	F 584		

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F 584	Continued From page 3 8. Observation on 07/15/24 at 9:24 A.M., showed occupied resident Room 409 with trim peeled off the wall in front of the cabinet by the windwn. The inside of the bathroom door and the resident room door had paint gone and gouges and black marks along the bottom. 9. Observation on 07/15/24 at 9:38 A.M., showed occupied resident Room 204's bathroom door had chipped paint. Both interior doors and door frames had scratches and paint was gone. 10. Observation on 07/15/24 at 9:47 A.M., showed occupied resident Room 203's shower with duct tape on the tiles and over the shower handles. 11. Observations on 07/17/24 during the facility tour, showed: -Sections of missing paint and drywall on the walls by the beds in resident rooms 303, 304, 309, 406 and in the 300 hall conference room; -The cove base (a trim piece used in the transition space between a wall and floor) peeled away from the walls by the windows in resident rooms 308, 404, 506, and 509 and away from the walls in the activity room; -A hole in the 400 shower wall and an unidentifiable black speckled substance lined the area between the shower wall and floor. During an interview on 07/17/24 at 2:30 P.M., the maintenance director said he/she is responsible for maintenance of the facility's physical environment. The maintenance director said when he/she became the maintenance director in April 2024, the facility did not have a maintenance	F 584		

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director for a period of time and there was a backlog of multiple things that needed repaired or replaced. The maintenance director said if there is something that needs repaired or replaced, staff are supposed to fill out a work order and give it to him/her so that he/she knows about the issues. The maintenance director said he/she had not received any work orders for the paint gouges, peeling cove base or 400 hall shower room and did not know about those issues.

During an interview on 07/17/24 at 2:45 P.M., the administrator said the facility did not have a written policy for facility maintenance, but staff are expected to comply with state and federal guidelines. The administrator said prior to his/her employment, the facility did not have a maintenance director for a period of time and they found that the former maintenance director had not been fulfilling his/her job duties so there were a lot of things that needed attention. The administrator said if there is something that needs repaired or replaced, staff are supposed to fill out a work order and give it to maintenance director so that he/she knows about the issues and can prioritize his/her work.

During an interview on 07/22/24 at 3:28 P.M., Certified Nurse Aide (CNA) U said staff fill out a work order for maintenance to fix issues. The CNA said he/she had noticed some missing paint on doors and room walls and did not report it because he/she figured maintenance already knew about it. The CNA said he/she never noticed any issues with the floors and has not noticed duct tape on floors of the rooms. The CNA said he/she has not noticed damage to toilet seats or paint.

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During an interview on 07/22/24 at 3:35 P.M., the Minimum Data Set (MDS) Coordinator said staff have a form to fill out and put in the maintenance door box and maintenance checks the box every day he/she is here. The MDS Coordinator said staff have not brought missing paint on the doors and walls to his/her attention and no one has told him/her of any damage on the residents' walls. The MDS Coordinator said staff have not told him/her about missing paint on toilet seats. The MDS Coordinator said he/she does recall seeing duct tape on the floor and he/she did not report it to maintenance.

During an interview on 07/22/24 at 3:41 P.M., the Administrator said he/she expects staff to put work orders in with maintenance and maintenance to prioritize the issues based on severity and safety concern. The administrator said he/she is aware of the missing paint on the resident doors, but has not had the time to go in all of the rooms. The administrator said staff has not reported any issues with toilet seats.

During an interview on 07/22/24 at 3:49 P.M., the Maintenance Director said staff should fill out a work order and put it in a box on the maintenance door. There has been no work orders in regard to paint on the doors or walls. The maintenance director said he/she has noticed the scratched paint on doors and walls of resident rooms. There has been no work orders in regard to pain on the toilet seats, but he/she does get a lot of work orders about broken toilet seats. He/She has not seen and is not aware of duct tape on the floor of resident rooms and staff has not reported it.

12. Observations on 07/17/24 during the facility tour showed the windows in resident rooms 101,

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F 584	Continued From page 6 102, 103, 105, 106, 107, 109, 202, 203, 205, 208, 210, 403, 404, 405, 407, 408, 409, 410, 501, 502, 503, 504, 506, 507, 508, 509 sealed and did not open. During an interview on 07/17/24 at 10:10 A.M., the resident who occupied room 408 said his/her window did not open and he/she would like to be able to open it. During an interview on 07/17/24 at 10:50 A.M., the resident who occupied room 504 said his/her window did not open and he/she would like to be able to open it. During an interview on 07/17/24 at the maintenance director said he/she knew the windows in the resident rooms did not open and when he/she questioned facility management about the windows, the management told him/her that they were sealed closed during the pandemic and were okay to remain that way. During an interview on 07/17/24 at 2:45 P.M., the administrator said the facility did not have a written policy for the maintenance of windows, but staff are expected to comply with state and federal guidelines. The administrator said the maintenance director is responsible to inspect the windown monthly and make repairs as needed. The administrator said the windows in resident rooms should open and he/she did not know that they were sealed shut. 13. Observation on 07/14/24 at 10:00 A.M., showed Resident #12 in bed with several flies around the room and on the resident. Observation on 07/14/24 at 12:40 P.M., showed	F 584		

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the resident sat on the side of his/her bed as he/she ate. Five flies flew around the resident and landed on the resident's food. The resident swatted at the flies on his/her food.

Observation on 07/15/24 at 10:24 A.M., showed three flies on the resident as he/she laid in his/her bed.

During an interview on 07/15/24 at 10:33 A.M., the resident said he/she complained about the flies several months ago and staff did not do anything about it.

Observation on 07/15/24 at 10:45 A.M., showed six flies sat around the resident's feet, and one dead fly on the bed sheet beside the resident's feet.

Observation on 07/16/24 at 8:34 A.M., showed two flies on the door frame at the entrance to the resident's room. Multiple flies flew around the resident's room and landed on the resident's breakfast, which sat on the bedside table.

14. Observation on 07/14/24 at 10:06 A.M., showed Resident #36 not in his/her room. Observation showed the sheet contained a large brown stain on the sheet. Flies were observed crawling around on the stains on the sheet and flew around the room.

15. Observation on 07/14/24 at 12:10 P.M., showed Resident #26 sat in a chair in a community area of the facility. Multiple flies landed on the resident's arms and legs. The resident slapped at the flies as they landed on him/her.

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F 584	Continued From page 8 Observation on 07/15/24 at 9:38 A.M., showed the resident entered his/her room and flies landed on the resident. During an interview on 07/15/24 at 9:40 A.M., the resident said he/she doesn't notice the flies. 16. Observation on 07/14/24 at 12:34 P.M., showed Resident #30 sat in a recliner in his/her room. The resident had a bedside table in front of him/her, with his/her lunch on it and a fly swatter. The resident swatted at flies that landed on his/her food. During an interview on 07/14/24 at 12:23 P.M., the resident said he/she has a problem with all the flies. Observation on 07/15/24 at 10:08 A.M., showed the resident swatted at flies in his/her room with a fly swatter. During an interview 07/15/24 at 10:08 A.M., the resident said he/she has to swat at the flies with the fly swatter to keep them off of his.her food. "They're terrible". 17. Observation on 07/15/24 at 9:47 A.M., showed Resident #8 laid on his/her bed in his/her room. Three flies flew around the room. During an interview on 07/15/24 at 9:47 A.M., the resident said he/she notices the flies, and they bother him/her. 18. Observation on 07/15/24 at 3:25 P.M., showed Resident #2 in his/her bed. Flies flew around the room and landed on the resident.	F 584		

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F 584	Continued From page 9 During an interview on 07/22/24 at 3:28 P.M., CNA U said he/she has noticed the flies in the facility and resident rooms and brought it to maintenance and the administrators attention. The CNA said maintenance said they had to call somebody to get it treated. The CNA said he/she is not aware of anyone coming in to treat for flies. The CNA said he/she is still seeing flies in the facility. During an interview on 07/22/24 at 3:35 P.M., the MDS Coordinator said he/she did notice residents with more odors had flies in their rooms. The MDS Coordinator said he/she reported the flies to maintenance and is not sure what maintenance did about the flies. During an interview on 07/22/24 at 3:41 P.M., the administrator said no one has reported an issue with flies. The administrator said he/she has seen the flies around the offices, but has not really been in rooms to witness it himself/herself. The administrator said he/she is sure if the flies are in building, the flies are in the rooms. The administrator said he/she has contacted pest control about the flies and the pest control company said there is nothing they can do. During an interview on 07/22/24 at 3:49 P.M., the Maintenance Director said he/she has not had any reports of flies in resident rooms or hallways. He/She has seen flies in the halls but not in resident rooms.	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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F 625	Continued From page 10 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy prior to transfer for four (Residents #2, #8, #19 and #41) of 23 sampled residents. The facility census was 48. 1. Review of the facilities policy titled "Discharge/Transfer of Resident", undated, showed:	F 625		

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F 625	Continued From page 11 -The purpose is to provide safe departure from the facility and to provide sufficient information for aftercare of the resident; -Explain and give copy of bed hold form to the resident and/or representative. 2. Review of Resident #2's medical record showed staff documented the resident had been transferred to the hospital on 05/09/24 and returned to the facility on 05/10/24. The resident's medical record did not contain documentation which showed staff notified the resident and/or the representative of the facility's bed hold policy at time of the resident's transfer. 3. Review of Resident #8's medical record showed staff documented the resident had been transferred to the hospital on 03/23/24 and returned to the facility on 03/24/24, transferred to the hospital again on 04/17/24 and returned to the facility on 04/20/24. The resident's medical record did not contain documentation which showed staff notified the resident and/or the representative of the facility's bed hold policy at time of the resident's transfer. 4. Review of Resident #19's medical record showed staff documented the resident had been transferred to the hospital on 04/10/2024 and returned on 04/13/2024, transferred on 05/3/2024 and returned on 05/3/2024, transferred on 06/23/2024 and returned on 06/23/2024, and transferred on 06/24/2024 and returned on 06/27/2024. The residents medical record did not contain documentation staff notified the resident and/or representative of the facilities bed hold policy at the time of either transfer. 5. Review of Resident #41's medical record	F 625		

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F 625	Continued From page 12	F 625		

showed staff documented the resident had been transferred to the hospital on 01/04/24 and returned to the facility on 01/08/24. The resident's medical record did not contain documentation which showed staff notified the resident and/or the representative of the facility's bed hold policy at time of the resident's transfer.

6. During an interview on 07/16/224 at 2:20 P.M., the business office manger (BOM) said the nursing staff is responsible for providing bed hold information upon resident transfer. The BOM said there is a bed hold policy in the admission packet, but he/she does not do anything further with bed holds.

During an interview on 07/16/24 at 3:30 P.M., the Director of Nursing (DON) said he/she took over the position in late February and prior to this staff were unaware of what a bed hold was. The DON said the nurses are responsible for providing the bed holds and having the residents sign before transfer. The DON said social services may have some of the bed holds.

During an interview on 07/16/24 at 3:43 P.M., the activities director (AD) and former social services director said he/she does not have the signed bed holds.

During an interview on 07/16/24 at 4:20 P.M., the administrator said he/she had been uploading the bed holds to the facility's software program. The administrator said the nursing staff had not been giving him/her bed holds, probably because they haven't been providing the beds holds to the residents on transfer.

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F 625	Continued From page 13	F 625		
F 637 SS=D	Freeman, Lauren Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to complete a Significant change in Status Assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, for three residents (Resident #2, #8 and #41) out of 23 sampled residents. The facility census was 48. 1. Review of the Resident Assessment Instrument (RAI) Manual, dated 10/1/23, shows a "significant change" is a major decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";	F 637		

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F 637	Continued From page 14 -Impacts more than one area of the resident's health status; -Requires interdisciplinary review and/or revision of the care plan. 2. Review of Resident #2's SCSA MDS, dated 05/15/24, showed staff assessed the resident as: -Independent with eating, oral hygiene and bed mobility; -Required setup assistance from staff for toilet hygiene, dressing, personal hygiene and transfers; -Required supervision from staff for bathing; -Did not fall; -Did not have ulcers or wounds. Review of the resident's Quarterly MDS, dated 06/15/24, showed staff assessed the resident as follows: -Required setup assistance from staff for eating; -Required maximal assistance from staff for oral hygiene, dressing, personal hygiene, bed mobility and transfers; -Dependent on staff for toilet hygiene and bathing; -Fall with injury; -Open lesion on foot. Review showed facility staff did not complete a SCSA for a decline in two or more areas of function. 3. Review of Resident #8's Admission MDS, dated 03/25/24, showed staff assessed the resident as: -Moderate cognitive impairment;	F 637		

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F 637	Continued From page 15 -Rejected care one to three days out of the seven day look back period (period of time used to complete the assessment); -Required set up assistance from staff for eating and oral hygiene; -Required maximal assistance from staff for dressing, personal hygiene, transfers and to propel wheelchair 150 feet; -Required moderate assistance from staff for bed mobility; -Weighed 254 pounds; -Had one stage 2 pressure injury and one unstageable pressure injury; -Did not have a diagnosis of Depression; -Did not receive an antidepressant. Review of Resident #8's Quarterly MDS, dated 06/25/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Rejected care four to six out of seven days during the look back period; -Independent with oral hygiene, transfers, bed mobility and to propel wheelchair 150 feet; -Required setup assistance only from staff for dressing and personal hygiene; -Weighed 228 pounds, a significant weight loss; -Two stage 2 pressure injuries; -New diagnosis of Depression; -Received antidepressant medication seven of the seven days in the look back period. Review showed facility staff did not complete a SCSA for multiple declines and improvements in two or more areas of function. 4. Review of Resident #41's SCSA, dated 02/28/24, showed staff assessed the resident as	F 637		

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F 637	Continued From page 16 follows: -Had verbal behaviors directed towards others one to three days during the seven day look back period; -Had other behaviors not directed at others one to three days during the seven day look back period; -Wandered four to six days during the seven day look back period; -Required supervision from staff for eating; -Required moderate assistance from staff for oral hygiene; -Required maximal assistance from staff for toilet hygiene, bathing, dressing, personal, hygiene, bed mobility and transfers; -Frequently incontinent of bowel and bladder; -Did not fall; -Weighed 130 pounds. Review of the resident's quarterly MDS, dated 05/30 24, showed staff assessed the resident as follows: -Did not exhibit behaviors; -Did not wander; -Required maximal assistance from staff for eating; -Dependent on staff for oral hygiene, toilet hygiene, bathing, dressing, personal hygiene, bed mobility and transfers; -Always incontinent of bowel and bladder; -Two or more non-injury falls; -Weighed 118, a significant weight loss. Review showed facility staff did not complete a SCSA for multiple declines and improvements in two or more areas of function. 5. During an interview on 07/17/24 at 1:34 P.M.	F 637		

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F 637	Continued From page 17 the MDS Coordinator said he/she is responsible for completing all significant change MDS assessments, and a significant change should be completed if a resident is admitted to hospice care. The MDS coordinator said he/she does not know what the RAI manual says about significant changes and when a significant change assessment is required. The MDS coordinator said he/she works the floor as a charge nurse at times, and resident #2, #8, and #41 had a significant change in status, but he/she did not know an assessment should be completed. The MDS coordinator said he/she has signed up for MDS training. During an interview on 07/17/24 at 2:45 P.M., the Director of Nursing (DON) said he/she does not know how many areas of care have to change, to trigger a significant change MDS.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to document a complete and accurate Minimum Data Set (MDS), a federally mandated assessment tool, when staff did not accurately code weight loss for one resident (Resident #8), restraints for one resident (Resident #34), and anticoagulant and hypnotic medication use for one resident (Resident #16) out of 23 sampled residents. The facility census was 48.	F 641		

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F 641	Continued From page 18	F 641		

1. Review of the facility's policy titled, "MDS and Care Planning Guidelines", dated 10/01/2015, showed it is the policy of the facility to use the most current Centers for Medicare and Medicaid (CMS) MDS Resident Assessment Instrument (RAI) manual, any published interim RAI manual errata documents, and applicable federal guidelines as the authoritative guide for completion of MDS, Care Area Assessments (CAAs), and resident care planning.

2. Review of Resident #8's Admission MDS, dated 03/25/24, showed staff assessed the resident weight as 254 pounds.

Review of the resident's Quarterly MDS, dated 06/25/24, showed staff assessed the resident weight as 228 pounds. Staff did not document this weight loss as significant.

During an interview on 07/17/24 at 1:34 P.M., the MDS Coordinator said if a resident has a significant weight loss, it should be coded on the MDS. The MDS Coordinator said the resident had a significant weight loss and he/she must have "overlooked it."

During an interview on 07/17/24 at 2:45 P.M., the Director of Nursing (DON) said the resident should have a significant weight loss on his/her MDS. The DON said the MDS Coordinator is responsible to add the information to the MDS an ensure it is accurate.

3. Review of Resident #34's Quarterly MDS, dated 04/17/24, showed staff assessed the resident as follows:

-Severely cognitively impaired;

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F 641	Continued From page 19 -Limb restraints used less than daily. Review of the resident's medical record showed medical record did not contain an order for restraint use. Observation on 7/14/24 at 12:10 P.M. showed the resident did not have limb restraints. Observation on 7/15/24 at 1:24 P.M. showed resident did not have limb restraints. Observation on 7/16/24 at 3:13 P.M. showed the resident did not have limb restraints. During an interview on 07/16/24 at 4:38 P.M., Certified Medication Technician (CMT) N said he/she was not aware of restraints ever being used on the resident. During an interview on 07/16/24 at 4:40 P.M., Certified Nurse Aide (CNA) O said he/she has worked at the facility for over a year and has never seen the resident use restraints, and has never seen a limb restraint on the resident. During an interview on 07/16/24 at 4:45 P.M., the MDS Coordinator said the resident has never had restraints and does not use them. During an interview on 07/17/24 at 1:34 P.M., the MDS Coordinator said he/she coded restraints for the resident due to bed rail use, and it was done in error. The MDS Coordinator said he/she has been in this position since November 2023 and was not fully trained, but is signed up for training in August 2024. During an interview on 07/17/24 at 2:45 P.M., the	F 641		

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F 641	Continued From page 20 Director of Nursing (DON) said the resident does not use restraints and it should not be on the MDS. 4. Review of Resident #16's MDS, 05/28/24, showed staff assessed the resident received hypnotic (a medication used to induce or prolong sleep) and an anticoagulant (a medication used to thin the blood). Review of residents medical record showed the medical record did not contain an order for hypnotic or anticoagulant medication. During an interview on 07/17/24 at 2:00 P.M., MDS coordinator says he/she coded the resident as taking a hypnotic due to the use of amitriptyline, and he/she is unaware that it is not a hypnotic medication. The MDS coordinator said he/she coded the resident as taking an anticoagulant due to the use of Aspirin, and said he/ she is unaware it is not an anticoagulant medication. The MDS Coordinator said he/she is responsible to ensure the MDS is coded correctly.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		

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F 657	Continued From page 21 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to ensure the comprehensive care plans were updated for oxygen use for two residents (Resident #2, and #41), depression for one resident (Resident #8), behaviors for one resident (Resident #34), wandering for one resident (Resident #36), weight loss for one resident (Resident #41), and for Activities of Daily Living (ADLs) for one resident (Resident #45) out of 23 sampled. The facility census was 48. 1. Review of the facility's policy titled, "Care Plan Comprehensive", undated, showed staff were directed as follows: -An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being;	F 657		

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F 657	Continued From page 22 -The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to, the Minimum Data Set (MDS), a federally mandated assessment tool; -Assessment of each resident is an ongoing process and the care plan will be revised as changes occur in the resident's condition; -The interdisciplinary care plan team is responsible for the periodic review and updating of care plans: -When a significant change in the resident's condition has occurred; -At least quarterly; -When changes occur that impact the resident's care (i.e. change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment). 2. Review of Resident #2's Quarterly MDS, dated 06/15/24, showed staff assessed the resident received oxygen. Review of the resident's care plan, dated 06/17/24, showed the care plan did not address the resident's oxygen use. Review of the resident's Physician Order Sheet (POS), dated 07/01/24, showed an order for oxygen two to four Liters Per Minute (LPM) through nasal cannula continuously, to maintain oxygen saturation above 92%, on every shift, with a start date of 05/30/24. Observation on 07/15/24 at 3:27 P.M., showed the resident with his/her oxygen on per nasal nasal cannula. During an interview on 07/17/24 at 1:31 P.M., the	F 657		

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F 657	Continued From page 23 MDS Coordinator said oxygen should be care planned. The MDS coordinator said he/she overlooked the oxygen. During an interview on 07/17/24 at 2:45 P.M., the Director of Nursing (DON) said if a resident uses oxygen it should be on the care plan. 3. Review of Resident #8's Quarterly MDS, dated 06/25/24, showed staff assessed the resident had a new diagnosis of depression and received antidepressant medication seven out of seven days in the look back period. Review of the resident's care plan, dated 06/27/24, showed the care plan did not contain information related to the resident's diagnoses of depression or antidepressant medication use. Review showed the care plan did not contain symptoms for staff to monitor for or non-pharmacological interventions to use. The care plan did not show the side affects of the antidepressant the staff should monitor the resident for. Review of the resident's POS, dated 07/01/24, showed the physician order for Zoloft (antidepressant medication) 50 milligram (mg) daily for a diagnosis of depression, with a start date of 06/22/24. During an interview on 07/17/24 at 1:34 P.M., the MDS Coordinator said a diagnosis of depression and antidepressant use should be care planned. The MDS coordinator said it was overlooked. The MDS Coordinator said he/she is supposed to revise the care plans quarterly, and he/she sometimes forgets to revise the care plan.	F 657		

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F 657	Continued From page 24	F 657		

During an interview on 07/17/24 at 2:45 P.M., the DON said a diagnosis of depression, and antidepressant use should be care planned, as well as non-pharmacological interventions staff should use. The DON said he/she does not know why it was not done, it is the responsibility of the MDS coordinator to ensure it is updated.

4. Review of Resident #34's Quarterly MDS, dated 04/17/24, showed staff assessed the resident as follows:

-Severely cognitively impaired;
-Had hallucinations and delusions;
-Rejected care one to three days out of the seven day look back period;
-Verbal behaviors occurred one to three days out of the seven day look back period;
-Diagnosis of major depressive disorder.

Review of resident's care plan, dated 04/24/24, showed the care plan did not address the resident's physical and verbal behavioral care needs with appropriate interventions.

Review of the resident's nurses notes showed staff documented the resident had aggressive physical and verbal behaviors toward staff on 07/13/24, 07/08/24, 06/10/24, 5/29/24, 5/23/24, and 5/23/24.

During an interview on 07/17/24 at 1:34 P.M., the MDS Coordinator said he/she is aware of the resident's aggressive behaviors and the behaviors should have been care planned but he/she overlooked it. The MDS Coordinator said he/she is supposed to revise the care plans quarterly, and he/she sometimes forgets to revise the care plan.

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F 657	Continued From page 25	F 657		

During an interview on 07/17/24 at 2:45 P.M., the Director of Nursing (DON) said the resident's aggressive behaviors should be on the care plan, and the care plans should be reviewed with significant changes, changes in care, and based on triggers for the annual and quarterly assessments. The DON said he/she does not know why it was not done.

5. Review of Resident #36's Quarterly MDS, dated 04/01/24, showed staff assessed the resident as follows:

-Cognitive assessment unable to be completed;
-Rarely/never understood;
-Wanders daily;
-Diagnoses of non-traumatic brain dysfunction, cerebral palsy (a group of conditions that affect movement and posture), seizures, anxiety, and depression.

Review of the resident's Elopement Assessment, dated 07/02/24, showed the resident scored at high risk for elopement/wandering. The interventions listed are frequent monitoring and care plan.

Review of the resident's care plan, dated 07/10/24, did not address the resident's wandering or elopement risks.

Observation on 07/14/24 at 11:50 A.M. showed the resident wandered near the dining rooms and front entrance area.

Observation on 07/15/24 at 8:40 A.M. showed the resident wandered near the dining rooms and front entrance area.

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F 657	Continued From page 26 Observation on 07/16/24 at 9:20 A.M. showed the resident wandered near the dining rooms and front entrance area. Obseravtion on 07/17/24 at 10:40 A.M. showed the resident wandered near the dining rooms and front entrance area. During an interview on 07/17/24 at 1:34 P.M., the MDS Coordinator said he/she is aware of the resident's wandering and thought that he/she had it care planned. He/She said wandering should be care planned. The MDS Coordinator said he/she is supposed to revise the care plans quarterly, and he/she sometimes forgets to revise the care plan. During an interview on 07/17/24 at 2:45 P.M., the DON said the resident's wandering should be on the care plan and care plans should be reviewed with a significant change, change in care, and based on triggers for the annual and quarterly assessments. 6. Review of the Resident #41's quarterly MDS, dated 05/30 24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Required maximal assistance from staff for eating; -Dependent on staff for oral hygiene, toilet hygiene, bathing, dressing, personal hygiene, bed mobility and transfers; -Always incontinent of bowel and bladder; -Two or more non-injury falls; -Significant weight loss;	F 657		

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F 657	Continued From page 27 -Did not require oxygen. Review of the resident's care plan, dated 05/22/24, showed it did not contain the resident's significant weight loss, interventions put in place for the weight loss, use of mechanical lift or the resident's oxygen use. Review of the resident's POS, dated 07/01/24, showed staff should apply oxygen at two LPM for shortness of breath, with a start date of 05/02/24. Observation on 07/15/24 at 8:34 A.M., showed Certified Nurse Aide (CNA) E and CNA F used a mechanical lift to transfer the resident from his/her chair to his/her bed. The resident did not provide any assistance with the transfer. Observation showed the resident received continuous oxygen. During an interview on 07/17/24 at 1:31 P.M., the MDS Coordinator said oxygen should be on the resident's MDS and it should be care planned. The MDS coordinator said he/she overlooked the oxygen. The MDS Coordinator said weight loss should be care planned. The MDS Coordinator said he/she is supposed to revise care plans quarterly, but sometimes he/she forgets to revise the care plans. During an interview on 07/17/24 at 2:45 P.M., DON said if a resident uses oxygen, it should be on the care plan. The DON said a significant weight loss and interventions should be care planned. 7. Review of Resident #45's Quarterly MDS, dated 06/19/24, showed staff assessed the resident as:	F 657		

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F 657	Continued From page 28 -Severely cognitively impaired; -Required substantial/maximal assist to shower/bathe self; -Required partial/moderate assist for upper/lower body dressing, and putting on/taking off footwear; - Diagnoses of non-traumatic brain dysfunction, cognitive communication deficit, dementia (a group of thinking and social symptoms that interferes with daily functioning), and anxiety. Review of the resident's care plan, dated 07/01/24, showed it did not address the resident's Activities of Daily Living (ADL) needs and assistance levels. Observation on 07/14/24 at 3:20 P.M., showed the resident wore a gray cardigan, dark teal pants, and light blue T-shirt with flowers. Observation on 07/15/24 at 8:25 A.M. showed the resident wore the same gray cardigan, dark teal pants, and light blue T-shirt with flowers. During an interview on 07/17/24 at 1:34 P.M., the MDS Coordinator said the resident's ADL needs and assistance level should be care planned. The MDS Coordinator said he/she is supposed to revise the care plan quarterly, and he/she sometimes forgets to revise the care plan. During an interview on 07/17/24 at 2:45 P.M., the DON said the resident's care plan should have what ADL assistance they need. Care plans should be reviewed with a significant change, change in care, and based on triggers for the annual and quarterly assessments. The care plans should be updated or it would not reflect where the resident is now.	F 657		

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, facility staff failed to provide safe hydraulic lift (a mechnical lift used to assist with transferring a resident) transfers for two (Resident #41 and #47) of 23 sampled residents when staff did not ensure the base of the lift was open and stabalized. The facility census was 48. 1. Review of the facility policy titled "Hydraulic lift", undated, showed, -The purpose of the policy is to enable one individual to lift and move a resident safely; -The fist step in operating the hydraulic lift is to open lift to the widest point and set the brakes. Review of the facility's hydraulic lift user manual, undated, showed: -When using an adjustable base lift, the legs must be in the maximum opened/ locked position before lifting the patient; -During transfer, with resident suspended in a sling attached to the lift, do not roll caster base over uneven surfaces that could cause the patient lift to tip over; -The legs of the lift must be in the maximum open	F 689		

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F 689	Continued From page 30 position and the shifter handle locked in place for optimum stability and safety. 2. Observation on 07/15/24 at 8:34 A.M., showed Certified Nurse Aide (CNA) E and CNA F entered resident #41's room with the hydraulic lift. CNA E opened the legs to the hydraulic lift, propelled it forward around the resident's wheelchair. CNA E and CNA F connected the resident's sling straps to the hydraulic lift. CNA E lifted the resident from the wheelchair, and as he/she backed the lift up he/she closed the legs of the lift. CNA F backed the resident's wheelchair up and did not guide the resident in the sling when CNA E turned the lift towards the resident's bed. Observation showed the resident swayed side to side while in the hydraulic lift sling. CNA E reached around the lift and grabbed a strap on the resident's sling, and pulled the lift towards the resident's bed which resulted in the resident to sway forwards and backwards. CNA F came around the resident's chair and grabbed the resident's legs to stabilize the resident. CNA E tried to push the legs to the hydraulic lift under the bed where a mat was placed and the resident swayed back and forth in the lift sling several times until CNA E pushed the legs of the lift over the mat. CNA E and and CNA F lowered the resident to his/her bed. Staff did not transfer the resident with the base of the lift in the maximum open position. During an interview on 07/15/24 at 1:24 P.M., CNA E said staff should go in the resident's room with the mechanical lift, open the legs of the mechanical lift, strap resident in and take resident to bed. The CNA said staff should close the legs on the mechanical lift, when the resident is in air, or staff could trip over the legs of the mechanical lift and get hurt. CNA E said the resident rocked	F 689		

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F 689	Continued From page 31	F 689		

in the mechanical lift, because the resident was slanted in the sling. He/She grabbed the resident to try and prevent the resident from falling out of the sling. CNA E said he/she should have pulled the mat out from under the bed, but he/she forgot it was under there and the mechanical lift got stuck on the mat. CNA E said he/she did not know the lift legs should be kept open to help with balance. The CNA said he/she had never been trained to keep the legs of the mechanical lift open during transfers.

3. Observation on 07/15/24 at 1:28 P.M., showed CNA E and CNA F entered resident #47's room to provide care. CNA E and CNA F opened the base of the hydraulic lift and moved it in front of the resident. The CNA's attached the sling to the lift, CNA E lifted the resident, pulled the lift away from the chair and closed the legs of the lift. CNA E moved the lift over the resident's bed and lowered the resident in to his/her bed. Staff provided care and raised the resident in the hydraulic lift with the base of the lift closed and the resident held on to the cross bar of the lift. CNA opened the legs of the lift to position the resident over his/her wheelchair. Staff did not transfer the resident with the base of the lift in the maximum open position, and did not ensure the resident did not touch the lift when in use.

During an interview on 07/15/24 at 1:36 P.M., CNA E said the legs of the lift are only to be opened when it is needed to get around furniture, such as a chair. The CNA said staff should close the legs of the lift all the way when the resident is in the air to prevent a tripping hazard for staff during the transfer.

During an interview on 07/15/24 at 1:37 P.M.,

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F 689	Continued From page 32 CNA F said the legs of the lift are to stay open while transporting the resident in the lift. 4. During an interview on 07/17/24 at 9:48 A.M., Minimum Data Set (MDS) coordinator said the legs of the lift should be open during the entire transfer to keep the lift stable. During an interview on 07/17/24 at 10:04 A.M., the Director of Nursing (DON) said during a hydraulic lift transfer he/she would expect staff to have the legs of the lift open. The DON said this is to create a wide base and spread out the gravity of the resident so they do not tip.	F 689		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 48.	F 727		

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F 727	Continued From page 33 1. Review of the facility's policies showed the facility did not provide a policy for RN coverage. Review of the Payroll Based Journal (PBJ), a method to collect auditable and verifiable staffing data from nursing facilities, report for Fiscal Year 2024, Quarter 2 (January 1 through March 31) showed triggers for no RN hours for 01/22/24, 02/10/24, 02/11/24, 03/03/24, 03/16/24, 03/17/24, and 03/24/24. 2. Review of the facility's payroll staff hours, dated January 2024, showed the facility did not have an RN in the building for eight consecutive hours on 01/09/24 and 01/14/24. 3. Review of the facility's payroll staff hours, dated February 2024, showed the facility did not have an RN in the building for eight consecutive hours on: -Saturday 02/10/24; -Sunday 02/11/24; -Sunday 02/18/24; -Sunday 02/25/24. 4. Review of the facility's payroll staff hours, dated March 2024, showed the facility did not have an RN in the building for eight consecutive hours on: -Friday 03/01/24 -Sunday 03/03/24; -Saturday 03/09/24 -Saturday 03/16/24; -Sunday 03/17/24; -Sunday 03/24/24. 5. During an interview on 07/17/24 at 2:14 P.M.,	F 727		

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F 727	Continued From page 34 the Director of Nursing (DON) said there should be an RN daily for 8 hours. The DON said he/she started in February as DON, and until the end of February and part of March he/she had one RN on nights, but then he/she was the only RN. The DON said they are offering sign on bonuses, going to job fairs and sending out postcards for recruiting. The DON said the facility does not use agency nursing staff, they do have two RN's who work for corporate that will try to help when needed. The DON said he/she did not know there were days of no RN coverage during that time, and took over the DON position in mid-February, and had been working doubles on the weekend. The DON said if there was not an RN, he/she would be the one to come in if needed for changing a Peripherally Inserted Central Catheter ((PICC), a long flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart, line dressing or intravenous infusions). During an interview on 07/17/24 at 2:29 P.M., the administrator said he/she started May 1st and did not know of the missing coverage for that quarter. The facility struggles to get RN's hired and we are doing a job fair tomorrow. The administrator said the facility would not be able to meet the residents care needs if they did not have an RN.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		

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F 732	Continued From page 35 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to post the required nurse staffing information, which included the total number of staff and the actual hours worked, by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, and on a daily basis. The facility staff also failed	F 732		

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F 732	Continued From page 36	F 732		

to keep the required daily staffing records for eighteen months. The facility census was 48.

1. Review of the facility's policies showed the facility did not have a policy for Daily Nurse staff posting.

Review of the facility's records showed the facility did not retain completed nurse staff posting for 4/13/23 through 4/16/23, 6/1/23 through 6/14/23, 6/17/23, 6/18/23, 7/5/23 through 7/16/23. Review showed nurse staff form not available for 4/1/23, 6/12/23, 6/30/23, 11/10/23 through 12/31/23.

Review of the facility's records showed the facility did not retain completed nurse staff posting 1/13/24, 1/14/24, 1/21/24, 2/2/24, 2/4/24, 2/13/24, 2/24/24, 4/13/24, 5/25/24; 6/13/24, and 7/8/24. Review showed nurse staff form not available 01/22/24 through 1/31/24 and 5/22/24.

During an interview on 07/17/24 at 2:39 P.M, the DON said the daily nurse staff posting should be kept for a couple of years.

During an interview on 07/17/24 at 2:39 P.M., the administrator said he/she did not know the appropriate amount of time keep the nurse staff posting.

Observation on 07/14/24 at 11:46 A.M. showed the daily nurse staff post, dated 07/11/24, did not contain the current daily nurse staff posting until 3:17 P.M.

Observation on 07/15/24 at 8:22 A.M. showed the nurse staff post did not contain the required day shift nurse staffing information.

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F 732	Continued From page 37 Observation on 07/16/24 at 8:17 A.M. showed the daily nurse staff post did not include evening and night shift staff and hours, and did not contain Certified Nurse Aide (CNA) hours for the day shift. Observation on 07/17/24 at 8:37 A.M. showed the nurse staff post did not contain the required day shift nurse staffing information. During an interview on 07/17/24 at 2:39 P.M., the Director of Nursing (DON) said the day shift charge nurse should be posting the nurse staff posting every morning. The DON said he/she pulls it to make sure it is correct, and the Assistant Director of Nursing (ADON) was the one in charge, but he/she took it over when the ADON quit a month ago. The DON said he/she started as DON mid-February, and has been busy trying to get everything else done and did not know they were not accurate or being saved. During an interview on 07/17/24 at 2:39 P.M., the administrator said he/she did not know the daily nurse staff postings were not being completed correctly. He/She has only been administrator here for two months and he/she is working to get processes fixed and in place.	F 732		
F 880 SS=E	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.	F 880		

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F 880	Continued From page 38 §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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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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 review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants during perineal care, when staff failed to use Enhanced Barrier Precautions ((EBP), an infection control method that involves wearing gowns and gloves during high-contact resident care activities) for one resident (Resident #19) and perform appropriate hand hygiene, and glove changes during care for two residents (Resident #35 and #47) of 23 sampled residents. Staff failed to ensure the first step of the two-step purified protein derivative (PPD) (skin test for Tuberculosis (TB)) was administered and read prior to the hire date, in accordance with their policy for seven employees (Certified nursing assistant (CNA) P, Dietary Aide (DA) Q, Certified Medication Technician (CMT) J, Maintenance

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F 880	Continued From page 40 Director, Laundry Aide S, Director of Nursing (DON), and Housekeeper V). The facility census was 48. 1. Review of the facility policy titled, "Enhanced Barrier Precautions to Infection Control Guidance", dated March 2024, showed; -The purpose is to prevent broader transmission of Multidrug Resistant Organisms (MDRO), and to help protect patients with chronic wounds and indwelling devices; -EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed; -Residents with an indwelling medical device, including urinary catheter, should be on EBP; -EBP should be used with high-contact resident care activities such as providing hygiene and caring for or using an indwelling medical device. -Required equipment is gown and gloves to be donned prior to care 2. Review of Resident #19's Quarterly Minimum Data Set (MDS), dated 07/02/24, showed staff assessed the resident had an indwelling urinary catheter. Review of the resident's care plan, dated 07/09/24, showed staff assessed resident as follows: -Indwelling urinary catheter due to Benign Prostatic Hyperplasia ((BPH) enlargement of the prostate gland) and neurogenic bladder; -Perform catheter care every shift; -Empty catheter bag every shift and as needed. Review of the resident's medical record showed	F 880		

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the resident had been treated for a urinary tract infection (UTI) from 04/20/24-04/20/24, 06/10/24-06/18/24, and 06/23/24-06/27/24.

Observation on 07/14/24 at 9:48 A.M., showed Certified Nursing Aide (CNA) E entered the resident's room, performed hand hygiene, applied clean gloves and provided catheter care. CNA E did not wear a gown during catheter care for the resident.

During an interview on 07/15/24 at 9:52 A.M., CNA E said he/she did not know about EBP. The CNA said he/she did not know what the signs on the door or the cart outside the door was for. The CNA said he/she knew the resident was on precautions but forgot what it means.

During an interview on 07/17/24 at 9:48 A.M., the MDS Coordinator said EBP is for anyone who has a catheter, open wound with infection from a drug resistant organism, tracheostomy, or anytime staff could come in contact with bodily fluids. The MDS coordinator said EBP means staff must wear a gown and gloves when providing care. The MDS Coordinator said a gown and gloves should be worn when providing catheter care. If EBP are not followed this could lead to a staff member being exposed to bodily fluids and increased risk of infection to the resident.

During an interview on 07/17/24 at 10:02 A.M., the Director of Nursing (DON) said EBP is another level of infection control and prevention for residents with open wounds, tracheostomies, or catheters. The DON said staff should wear a gown and gloves every time they enter these residents' rooms. The DON said if staff are not following EBP this could lead to the spread of

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F 880	Continued From page 42 infections. 3. Observation on 07/17/24 at 8:30 A.M., showed CNA M and CNA F entered Resident #35's room, performed hand hygiene, and applied gloves. CNA F removed the resident's soiled brief, and reached in his/her pocket, grabbed trash bags, removed one trash bag, and placed the rest of the trash bags back in to his/her pocket. CNA F continued to wear the same soiled gloves and wiped the resident's front perineal area. CNA F removed his/her soiled gloves and applied clean gloves without performing hand hygiene between glove changes. CNA F and CNA M moved the resident toward CNA M. CNA F wiped the resident's backside. CNA F continued to wear the same soiled gloves, applied barrier cream and placed a clean brief on the resident. During an interview on 07/17/24 at 8:45 A.M., CNA F said hand hygiene should be performed with all gloves changes. The CNA said he/she knew he/she should have washed his/her hands more. The CNA said there is no access to hand sanitizer in the resident rooms and soap and water hand hygiene should be performed. During an interview on 07/17/24 at 8:45 A.M., CNA M said hand hygiene should be performed when moving from dirty to clean tasks, so multiple times during care. The CNA said hand sanitizer should be kept in their pockets for performing hand hygiene during care. 4. Observation on 07/15/24 at 1:28 P.M., showed CNA E and CNA F entered Resident #47's room, applied gloves, and did not perform hand	F 880		

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hygiene. CNA E and CNA F transferred the resident with the hydraulic lift from his/her recliner to the bed. CNA F removed the resident's soiled brief and provided perineal care. With the same soiled gloves, CNA F handed the resident's barrier cream and wipes to CNA E and moved the resident toward CNA F. CNA F wiped the residents' backside. CNA E and CNA F removed their soiled gloves, applied clean gloves and did not perform hand hygiene. CNA E applied barrier cream to the resident and wiped the excess cream off their glove on to the clean brief and put the brief on the resident. With the same soiled gloves, CNA F and CNA E transferred the resident back to his/her chair.

During an interview on 07/15/24 at 1:36 P.M., CNA E said hand hygiene should be done before and after care and with all gloves changes to prevent cross contamination and infection. The CNA said a clean wipe should be used for each area during perineal care. The CNA did not say why he/she did not use a clean portion of the wipe with each swipe. The CNA said incontinence care should be performed at the beginning of your shift and at least once before the end of your shift.

During an interview on 07/15/24 at 1:27 P.M., CNA F said a clean wipe should be used for each area during perineal care.

During an interview on 07/17/24 at 9:48 A.M., the MDS coordinator said gloves should be changed and hand hygiene should be completed when moving from a dirty to clean task The MDS Coordinator said during perineal the resident should be wiped with a clean wipe or clean area of the wipe every time, and if not there is an

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F 880	Continued From page 44 increased risk of infection to the resident. During an interview on 07/17/24 at 10:02 A.M., the DON said staff should perform hand hygiene with all gloves changes, and should change their gloves when soiled or when moving from dirty to clean tasks. The DON said staff can use hand sanitizer for hand hygiene when their hands are not visibly soiled, and staff have access to small bottles they can keep in their pocket, as well as on the carts and in the hallways. 5. Review of the facility's, "Tuberculosis Control" policy, undated, showed once the decision has been made to employ an individual, the individual will be asked for documentation of a prior PPD. If the employee does not have documentation of a prior PPD, the first step PPD will be administered by the nursing department, documented on the Employee's Immunization record, and must be read prior to or no later than start date. 6. Review of CNA P's employee file showed: -Hire date of 07/10/24; -First step PPD on 07/11/24 and read on 07/13/24 -Review showed the employee file did not contain a documented PPD prior to the employee's start date. 7. Review of DA Q's employee file showed: -Hire date of 06/11/24; -First step PPD on 06/26/24 and read on 06/28/24; -Review showed the employee file did not contain a documented PPD prior to the employee's start date.	F 880		

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F 880	Continued From page 45 8. Review of CMT J's employee file showed: -Hire date of 05/30/24; -First step PPD on 05/30/24 and read on 06/01/24; -Review showed the employee file did not contain a documented PPD prior to the employee's start date. 9. Review of the Maintenance Director's employee file showed: -Hire date of 02/19/24; -First step PPD on 02/19/24 and read on 02/21/24; -Review showed the employee file did not contain a documented PPD prior to the employee's start date. 10. Review of Laundry Aide S's employee file showed: -Hire date of 01/22/24; -First step PPD on 05/07/24 and read on 05/10/24; -Review showed the employee file did not contain a documented PPD prior to the employee's start date. 11. Review of the DON 's employee file showed: -Hire date of 01/20/24; -First step PPD on 01/20/24 and read on 01/22/24; -Review showed the employee file did not contain a documented PPD prior to the employee's start date.	F 880		

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F 880	Continued From page 46 12. Review of Housekeeper V's employee file showed: -Hire date of 04/18/24; -First step PPD on 04/18/24 and read on 04/21/24; -Review showed the employee file did not contain a documented PPD prior to the employee's start date. During an interview on 07/16/24 at 3:29 P.M., the DON said the Assistant Director of Nursing (ADON) who no longer works at the facility, did the TB screening for staff. The DON said staff's first TB test should be read before the staff starts, otherwise that defeats the purpose of doing the TB. The DON said he/she is also the Infection Preventionist and it is his/her expectation the TB be read before the staff can even start. The DON said the listed hire date is the actual day the staff started working at the facility. During an interview on 07/17/24 at 11:07 A.M., the administrator said staff's first step of TB screening should be done during the hiring process. The administrator said the first step of the TB screening for staff, should be administered and read prior to the staff starting. The administrator said the DON is now responsible, but the ADON was responsible for the TB screening, until the ADON quit three weeks ago. The administrator said the staff's hire date is the date they started working at the facility and the staff should have had the 1st step TB read before the hire date.	F 880		

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A3001	19 CSR 30-85.032(2) Substantially Constructed/Maintained The building shall be substantially constructed and shall be maintained in good repair. New facilities shall comply with the requirements in accordance with the provisions found in 19 CSR 30-85.012. Existing licensed facilities shall meet and maintain the facility's physical plant in accordance with the construction standards in effect at the time of initial licensing, unless there is a specific rule governing the subject cited in this section or in 19 CSR 30-85.022, except that those facilities licensed between 1957 and 1965 shall not increase the capacity of any room or the total capacity of the facility without meeting new construction requirements. Existing licensed facilities with plans approved after April 8, 1972 and prior to January 1, 1999, shall comply as Existing Health Care Occupancies with NFPA 101, 2000 edition. Facilities whose physical plant requirement plans are approved on or after January 1, 1999, shall comply as New Health Care Occupancies with NFPA 101, 2000 edition. II/III This regulation is not met as evidenced by: Class III Refer to F584	A3001		
A4003	19 CSR 30-85.042(3) Operator/Administrator Responsibilities The operator shall be responsible to assure compliance with all applicable laws and rules. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator ' s responsibilities shall include the	A4003		

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A4003	Continued From page 1 oversight of residents to assure that they receive appropriate nursing and medical care. II/III This regulation is not met as evidenced by: Class III Based on interview and record review, facility staff failed to check the Employee Disqualification List (EDL) (a list of individuals who have been determined to have abused or neglected a resident or misappropriated funds or property belonging to a resident) on a quarterly basis for five (Maintenance Director, Laundry Aide S, Director of Nursing (DON), Certified Nurse Aide (CNA) R and Minimum Data Set (MDS), a federal assessment used to assess a resident, Coordinator) out of 10 sampled employees. The facility census was 48. 1. Review of the facilities policy titled "Abuse, Back Ground Check Policy", undated, showed in addition to pre-employment EDL Checks, nursing homes must also check each quarterly EDL update to assure that no one employed in any capacity has been added to the EDL since the initial EDL check. Quarterly checks should be completed in January, April, July and October. 2. Review of the Maintenance Director's employee file showed: -Hire date of 02/19/24; -EDL check completed on 02/19/24. The employee's file did not contain quarterly checks of the EDL. 3. Review of Laundry Aide S's employee file showed:	A4003		

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A4003	Continued From page 2 -Hire date of 01/22/24; -EDL check completed on 01/17/24. The employee's file did not contain quarterly checks of the EDL. 4. Review of DON employee file showed: -Hire date of 01/20/24; -EDL check completed on 01/17/24. The employee's file did not contain quarterly checks of the EDL. 5. Review of CNA R's employee file showed: -Hire date of 07/15/23; -EDL check completed on 07/03/23. The employee's file did not contain quarterly checks of the EDL. 6. Review of MDS Coordinator employee file showed: -Hire date of 07/07/23; -EDL check completed on 06/26/23. The employee's file did not contain quarterly checks of the EDL. During an interview on 07/17/24 at 10:41 A.M., the Business Office Manager (BOM) said he/she runs EDL checks on employees annually. The BOM said he/she can not find the EDL ran on employees in 2023. The BOM said he/she forgot. During an interview on 07/17/24 at 11:07 A.M., the administrator BOM does EDL checks and he/she should be doing them quarterly. The	A4003		

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A4003	Continued From page 3 administrator said he/she does not know why the BOM thinks he/she is supposed to do EDL checks annually.	A4003		
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II Refer to F880	A4031		
A4033	19 CSR 30-85.042(29) Employee Hours Documented Facilities shall maintain written documentation on the premises showing actual hours worked by each employee. III This regulation is not met as evidenced by: Class III Refer to F732	A4033		
A4040	19 CSR 30-85.042(35)(B) SNF RN-Day Shift, LPN/RN eve/nights	A4040		

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A4040	Continued From page 4 Licensed Nursing Requirements; Skilled Nursing Facility. (B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II This regulation is not met as evidenced by: Class II Refer to F727	A4040		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Refer to F689	A4074		
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	A4086		

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A4086	Continued From page 5 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		
A4119	19 CSR 30-85.042(105) Records Required for Transfer In the event the resident is transferred from the facility, the resident shall be accompanied by a copy of the medical history, transfer forms which include the physical exam report, nursing summary, and report of orders physicians prescribed. II/III This regulation is not met as evidenced by: Class III Refer to F625	A4119		
A6039	19 CSR 30-87.020(39) Inspect/Rodent Control Effective measures intended to minimize the presence of rodents, flies, cockroaches and other insects on the premises shall be utilized. The premises shall be kept in such condition as to prevent the harborage or feeding of insects or rodents. II/III This regulation is not met as evidenced by: Class III	A6039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JAMES LIVING CENTER	**415 SIDNEY STREET, SAINT JAMES, MO 65559**

(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
A6039	Continued From page 6 Please refer to F584	A6039		

PLAN OF CORRECTION

Provider/Supplier Name:	St. James Living Center
Street Address, City, Zip:	415 Sidney Street St. James, MO 65559
Date of Survey:	07/17/2024

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/ A3001/ A6039	The facility will ensure to provide a comfortable and home-like environment that is free from pests. Administrator/Designee conducted an all staff in-serviced on 08/26/2024 on how to report environmental concerns. Maintenance Director/Designee will correct any leaking components of the water system located in front of the nurse's station between the memory care unit and 400 and paint the wall to correct the stain on the wall behind and above the trash can by 08/30/2024 Maintenance Director/Designee will correct resident rooms 403 and 405 by replacing the toilet seat, removing any unused bed pans/devices from bathroom by 08/30/2024 Maintenance Director/Designee will correct the shared bathroom by scheduling for bathroom and the inside of the door to room 405 to be painted by 08/30/2024 Maintenance Director/Designee will correct room 103 flooring by scheduling to have flooring replaced in room by 08/30/2024. Maintenance Director/Designee will correct room 407 gouged flooring by scheduling to have flooring replaced by 08/30/2024 The maintenance director/designee will audit on a monthly basis to ensure ongoing compliance. Maintenance Director/Designee will correct room 206 by fixing drywall and paint behind the headboard of bed B, the hanging drywall debris from wall, electric outlet and on floor will be scheduled to be fixed and painted by 08/30/2024 Maintenance Director/Designee will correct room 104 by fixing the AC to contain the correct parts to cover the AC and AC line. Toilet seat and hand sanitizer pump will be replaced by 08/30/2024. Maintenance Director/Designee will correct room 409 by replacing trim on wall in front of cabinet by the window by 08/30/2023 Bathroom and resident room door to resident room 409 will be scheduled to be painted by 08/30/2024. Maintenance Director/Designee will correct room 204 by scheduling painting for bathroom door and resident room door and frame by 08/30/2024. Maintenance Director/Designee will correct room 203 by fixing or replacing tiles in shower as well as plumbing on shower handles by 08/30/2024. Maintenance Director/Designee will schedule to have sections of missing paint and drywall by the beds in resident rooms 303,	08/30/2024 - Ongoing

	304, 309, 406, and in the 300-hall conference room corrected by 08/30/2024. Maintenance Director/Designee will correct the cover base (a trim piece used in the transition space between the wall and floor) in resident rooms 308, 404, 506, and 509 by 08/30/2024. Maintenance Director/Designee will correct the 400-hall shower room by fixing the hole in the shower wall and scrubbing and re-caulking between the shower wall and floor by 08/30/2024. Maintenance Director/Designee will schedule to correct window operation in rooms by fixing or replacing windows in rooms 101, 102, 103, 105, 106, 107, 109, 202, 203, 205, 208, 210, 403, 404, 405, 407, 408, 409, 410, 501, 502, 503, 504, 506, 507, 508, and 509 by 08/30/2024. Maintenance Director/Designee will correct flies in facility by having fly bait sprayed monthly to mitigate flies Maintenance Director/Designee will conduct room inspections on all rooms no later than 08/30/2024 and record all findings and present findings to the Administrator. Maintenance Director/Designee will conduct 2 room inspections weekly x4 weeks then monthly x2 months then quarterly to ensure ongoing compliance. Administrator/Designee will audit inspections and report any concerns to the QAPI committee.	
F625/ A4119	The facility will ensure to provide written information to the resident or the resident's representative of bed hold policy prior to transfer. Administrator/Designee will provide an all staff in-serviced on 08/26/2024 on Discharge/Transfer of a Resident Policy Residents 2,8, and 19 have received a bed hold policy. Resident 41 has expired. Social Service Director/Designee will audit transfer of residents weekly x 4 weeks and then monthly x2 months and then quarterly to ensure compliance with Discharge/Transfer of a Resident Policy Social Service Director/Designee will provide all audits to the Administrator and report any concerns to the QAPI Committee	08/30/2024 - Ongoing
F637	The facility will ensure to complete significant change and status assessment MDS. DON/Designee will in-service MDS Coordinator on completion of Significant Change MDS on 08/26/2024. Significant change MDS completed for resident #2 and #8. Resident 41 has expired.	08/30/2024 - Ongoing

	DON/Designee will monitor 2 MDS Assessments weekly x4 weeks and then monthly x2 months and then quarterly to ensure that significant MDS are completed when necessary and will follow up with QAPI to ensure ongoing compliance. DON/Designee will provide completed audits to the Administrator and report any concerns to the QAPI committee.	
F641	The facility will ensure to document and complete an accurate MDS. DON/Designee will in-service MDS Coordinator on accurate MDS completion on 08/26/2024. MDS Coordinator will correct assessments for resident #8, #34, and #16. DON/Designee will audit 2 MDS for accuracy weekly x4 weeks and monthly x2 months and then quarterly to ensure ongoing compliance. DON/Designee will provide completed audits to the Administrator and report any concerns to the QAPI committee.	08/30/2024 - Ongoing
F657	The facility will ensure the comprehensive care plans are updated. DON/Designee will in-service MDS Coordinator on updating comprehensive care plans on 08/26/2024 MDS Coordinator will update comprehensive care for residents #2, #8, #34, #36 and resident #45. Resident #41 has expired. DON/Designee will audit 2 care plans weekly x4 weeks monthly x2 months and then quarterly to ensure ongoing compliance. DON/Designee will provide evidence of completed audits to the Administrator and report any concerns to the QAPI committee.	08/30/2024 - Ongoing
F689/A4074	The facility will ensure to provide safe hydraulic lift transfers DON/Designee will conduct a nursing staff in-service on 08/26/2024 on Hydraulic Lift Policy and cover steps based on manufacturer recommendation. This education will specifically cover the expanding of the base on transfer. DON/Designee will audit 2 Hoyer transfers weekly x4 weeks then monthly x2 months and then quarterly to ensure ongoing compliance. DON/Designee will provide completed audits to the Administrator and report any concerns to the QAPI committee.	08/30/2024 - Ongoing
F727/ A4040	The facility will ensure to provide the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. Administrator/Designee will educate DON through in-service on the requirement to provide the services of a registered nurse at least 8 consecutive hours per day 7 days per week on 08/24/2024.	08/30/2024 - Ongoing

	Administrator/Designee will audit dailies weekly x4 weeks and monthly x2 months to ensure that it contains the services of a registered nurse at least 8 hours per day 7 days per week. Administrator/Designee will conduct audits and report any concerns to the QAPI Committee.	
F732/ A4033	The facility will ensure that they post the required nurse staffing information to include the total number of staff and the actual hours worked by a licensed and unlicensed nursing staff directly responsible for resident care per shift and daily. DON/Designee will educate nurses by an in-service that they post the required nurse staffing information to include the total number of staff and the actual hours worked by a licensed and unlicensed nursing staff directly responsible for resident care per shift and daily on 08/26/2024. DON/Designee will audit posted nurse staffing postings weekly x4 weeks and monthly x2 months. DON/Designee will provide evidence of audits completed to the Administrator and report any concerns to the QAPI Committee.	08/30/2024 - Ongoing
F880/A403/ A4086	The facility will ensure to use appropriate infection control procedures during peri-care and ensure to use enhanced barrier precautions during care and perform appropriate hand hygiene and glove changing. The staff will ensure the first step of the two-step PPD is administered and read prior to hire date. DON/Designee will educate all department heads through in-serviced on 08/26/2024 on two-step PPD and being read prior to hire date. DON/Designee will educate all nursing staff through in-service on 08/26/2024, on appropriate infection control procedures during peri-care and utilization of enhanced barrier precautions during care and perform appropriate hand hygiene and glove changing. DON/Designee will audit 2 peri-care weekly x4 weeks then monthly x2 months DON/Designee will make 2 observations on enhanced barrier precautions weekly x4 weeks and monthly x2 months. DON/Designee will audit all staff to ensure proper PPD has been completed by 08/30/2024. Administrator/Designee will ensure future new hires have an up-to-date TB test by inspecting/auditing bi-monthly x3 months. DON/Designee will provide evidence of audits and observations to the Administrator and will report any concerns to the QAPI committee.	08/30/2024 - Ongoing

A4003	The facility will ensure to check the EDL on a quarterly basis. Business Office Manager/Designee in-serviced by Administrator/Designee on 08/07/2024 on quarterly EDL checks. All EDLs are up to date as of 07/17/2024. Administrator/Designee will audit quarterly to ensure EDLs are completed. Administrator/Designee will conduct audits and report any concerns to the QAPI committee x3 Months.	08/30/2024 - Ongoing

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.