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VALLEY VIEW HEALTH & REHABILITATION	1600 EAST ROLLINS ST MOBERLY, MO 65270

(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 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Pakuni — TITLE: Administrator — (X6) DATE: 3/12/25

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

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure three residents (Resident #10, #9, and #13), in a review of 13 sampled residents, were treated with dignity and respect. Certified Medication Technician (CMT) F was rude and rough during care for one resident, (Resident #10) and the resident said it hurt his/her feelings and made him/her feel angry. CMT F was rough and forceful with Resident #9's care and the resident said it made him/her feel like he/she wasn't worth anything. Resident #13 reported CMT F was condescending and liked to show his/her authority; the resident said it made him/her so angry he/she wanted to punch CMT F in the face. The facility census was 76. Review of the facility's policy Resident Rights, revised December 2016, showed all employees should treat all residents with kindness, respect, and dignity. Review of the facility's policy Conduct and Behavior, revised May 2019, showed examples of conduct and behavior that were considered inappropriate and therefore prohibited included failure to treat all residents with kindness, respect and dignity, being discourteous to residents or any behavior that was deemed offensive or unsafe 1. Review of Resident #10's Care Plan, dated 11/12/24, showed the following: -The resident had a self-care deficit related to impaired balance and limited mobility; -Encourage resident to participate in the fullest	F 550		

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extent possible with each interaction;
-Encourage the resident to use the call bell for assistance;
-The resident needs prompt response to each call for assistance;
-The resident required partial to moderate assistance with personal hygiene, toileting, transfers, bathing, bed mobility, and dressing.

Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 1/14/25, showed the following:
-Moderate cognitive impairment;
-Upper extremity impairment on one side of the body;
-The resident required supervision or touching assistance moving from a lying position to sitting on the side of the bed;
-The resident required substantial to maximum assistance with toileting hygiene, showering and lower body dressing;
-The resident required partial to moderate assistance with personal hygiene, moving from sitting to standing position, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer and walking 10 feet;
-Mobility devices of walker and wheelchair;
-Diagnoses included cancer, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), arthritis and depression.

During an interview on 2/20/25 at 2:45 P.M. the resident said the following:
-Certified Medication Technician (CMT) F was very rude during care;
-Last week when he/she turned on his/her call

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F 550	Continued From page 3	F 550		

light, CMT F said four staff had just been in his/her room and said he/she (the resident) should have asked the other staff instead of turning on the call light again;
-CMT F was rough when he/she pulled the resident up in bed and made comments that he/she would push the resident through the wall when the resident complained about him/her being rough with care;
-CMT F hurt the resident's feelings and made the resident angry. CMT F acted like he/she was the "boss";
-The resident was afraid to report CMT F because he/she could retaliate against him/her.

2. Review of Resident #9's annual MDS assessment, dated 11/17/24, showed the following:
-The resident was cognitively intact;
-The resident was dependent on staff for toilet hygiene and lower body dressing and with transfers;
-The resident required substantial to maximal assistance with personal hygiene and bathing;
-Partial to moderate assistance needed with upper body dressing;
-Always incontinent of bowel and bladder;
-Diagnoses included multiple sclerosis (a chronic disease where the body's immune system attacks the protective coating around nerves in the brain and spinal cord, causing damage that disrupts signals and can lead to muscle weakness, vision problems and difficulty walking).

Review of the resident's Care Plan, revised 2/20/25 showed the following:
-The resident had an activities of daily living (ADL) performance deficit related to multiple sclerosis;

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F 550	Continued From page 4 -Allow sufficient time for dressing and undressing; -The resident had limited physical mobility related to ataxia (impaired balance or coordination) and multiple sclerosis; -The resident was dependent on a manual wheelchair for locomotion; -The resident refused showers at times. Caregivers to provide opportunity for positive interaction and attention; -Explain all procedures to the resident before starting and allow the resident time to adjust to the changes; -Approach and speak in a calm manner. During an interview on 2/25/25 at 10:18 A.M. the resident said the following: -CMT F was rough and forceful with care; -CMT F wanted to do everything his/her way and if the resident complained about it, CMT F said you just need to "fucking" get used to it; -This made the resident feel like he/she was not worth anything; -He/She just let it go, because it could get worse if he/she reported CMT F. 3. Review of Resident #13's Care Plan, dated 11/20/24, showed the following: -The resident had an activities of daily living (ADL) self-care performance deficit related to a stroke with hemiplegia (weakness on one side of the body); -The resident required extensive assistance with dressing; -The resident required limited assistance with transfers, bed mobility and toilet use; -The resident was independent with personal hygiene with setup assistance; -Encourage the resident to participate to fullest extent possible with each interaction;	F 550		

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F 550	Continued From page 5 -Encourage the resident to use his/her call bell for assistance; -The resident had impaired cognitive function/dementia or impaired thought processes; -With communication, identify yourself with each interaction, reduce any distractions, the resident understands simple directive sentences. Provide the resident with necessary cues and stop and return if agitated. Review of the resident's quarterly MDS, dated 1/5/25, showed the following: -Moderate cognitive impairment; -Functional limitation in range of motion affecting one side of the body; -The resident required partial to moderate assistance with toileting hygiene, bathing, personal hygiene, upper body dressing and chair/bed-to-chair transfer and the ability to come to a standing position from a sitting position; -The resident required substantial/maximal assistance with lower body dressing; -Mobility device used was a wheelchair; -Diagnoses included a stroke, aphasia (a language disorder that affects how you communicate), hemiplegia and depression. During an interview on 2/24/25 at 8:40 A.M. the resident said the following: -CMT F was rude and talked down to him/her; -CMT F was condescending and liked to show his/her authority; -The resident said "CMT F made him/her so angry he/she wanted to punch CMT F in the face!" During an interview on 2/24/25 at 10:00 A.M. Certified Nurse Assistant (CNA) C said the following:	F 550		

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F 550	Continued From page 6 -Many of the residents said CMT F was rough, hateful, and rude during care; -CMT F said things like, get up yourself, I'm not doing it for you, or you can do it yourself; -CMT F's tone was harsh, and it upset the residents; -He/She had reported the residents' complaints to different charge nurses, but nothing was ever done. During an interview on 2/24/25 at 1:45 P.M. the Director of Nursing (DON) said the following: -CMT F didn't have a gentle approach; -He had received a couple of complaints regarding CMT F in the past couple of years and one recently about his/her tone; -All residents should be treated with dignity and respect. During an interview on 2/24/25 at 3:30 P.M. the Administrator said the following: -CMT F was too gruff and had been written up before for not providing good customer service to one of the residents; -She would expect staff to treat all residents with dignity and respect.	F 550		
F 677 SS=D	MO248667 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	F 677		

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review, the facility failed to ensure staff provided assistance with Activities of Daily Living (ADLs) for two residents (Resident #1 and #7) in a review of 13 sampled residents, to maintain proper grooming to include nail care and personal hygiene. The facility census was 76.

Review of the facility's policy Activities of Daily Living (ADL), Supporting, revised March 2018, showed the following:
-Resident's will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs;
-Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal and oral hygiene;
-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care);
-If a resident with cognitive impairment or dementia resists care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining the care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.

Review of the facility policy titled, Fingernail/Toenail Care, dated February 2018, showed the following:
-Nail care includes daily cleaning and regular trimming;
-If the resident refuses nail care, document the reason why and the intervention taken.

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F 677	Continued From page 8 1. Review of Resident #1's Care Plan, last revised 2/24/25, showed the following: -The resident had an ADL self-care performance deficit related to impaired mobility; -The resident refused showers and nail care. The resident had been educated on the risks of refusing care and the importance of proper hygiene; -The resident will refuse hand hygiene and had been educated on the risks and benefits; -If possible, negotiate a time for ADLs so that the resident participates in the decision-making process; -If the resident resists ADLs, reassure resident, leave, and return five to 10 minutes later and try again; -Provide consistency in care to promote comfort in ADLs; -Provide resident with opportunities for choice during care provision. -Check nail length and trim and clean on bath day and as necessary; -The resident required extensive assistance with bathing/showering; -Provide a sponge bath when a full bath or shower cannot be tolerated; -The resident will hoard feces in his/her clothing. If reasonable, discuss the resident's behavior. Explain and reinforce why the behavior was inappropriate or unacceptable to the resident; -The resident had impaired cognitive function/dementia or impaired thought process. Cue, reorient and supervise as needed. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility	F 677		

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staff, dated 1/10/25, showed the following:
-The resident was cognitively intact;
-No rejection of care exhibited;
-Functional limitation in range of motion (ROM) impairment on both sides of lower extremities;
-Partial/moderate assistance needed with showering/bathing;
-Independent with upper and lower body dressing, personal hygiene and toileting;
-Occasionally incontinent of urine and frequently incontinent of bowel;
-Received Hospice care:

Review of the resident's shower sheets requested for the past 30 days showed the following:
-The resident received a shower on 1/22/25, 1/29/25, and 1/31/25;
-The resident received a shower on 2/5/25, 2/7/25, 2/12/25, and 2/19/25;
-There was no documentation that nail care was offered or provided on days staff provided showers.

Observation on 2/20/25 at 10:00 A.M. in the resident's room showed the following:
-The resident sat in his/her electric wheelchair;
-A strong odor of urine and feces was noted in the room;
-The resident's hands were dirty with brown debris and there was also brown debris under the resident's fingernails. The resident's fingernails were long and uneven;
-The resident's shirt was soiled with brown debris along the bottom of the shirt;
-There was a white hand towel soiled with brown debris by his/her feet on the foot rest of his/her electric wheelchair.

Observation on 2/20/25 at 2:06 P.M. in the

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outside smoking area showed the following:
-The resident had dark brown debris under his/her nails and the nails remained long and uneven;
-The resident's hooded jacket had brown debris along the bottom of the jacket.

Review of the resident's shower sheets showed the resident received a shower on 2/21/25. There was no documentation staff offered or provided nail care.

Observation on 2/25/25 at 10:15 A.M. in the resident's room showed the following:
-The resident sat in his/her wheelchair, brown debris was noted under his/her fingernails. The resident's nails remained long and uneven;
-The resident had an odor of urine and feces;
-The back of the resident's hooded jacket had brown debris along the bottom.

During an interview on 2/20/25 at 10:18 A.M. the resident said he/she refused showers at times and that was his/her right.

During an interview on 2/24/25 at 10:00 A.M. Certified Nurse Assistant (CNA) C said the following:
-The resident often had feces under his/her fingernails. Staff could only educate him/her if he/she refused; there was nothing else that could be done;
-The resident often refused showers;
-The resident's room had feces everywhere and needed to be cleaned daily.

During an interview on 2/20/25 at 11:30 A.M. Certified Medication Technician (CMT) D said the following:

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-The resident often had feces on his/hands, under his/her fingernails and on his/her clothes. The resident refused to shower and clean up;
-There was not much that could be done. Staff couldn't force the resident to shower.

2. Review of Resident #7's Care Plan, revised 11/15/24, showed the following:
-The resident had an ADL performance self care deficit related to Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors);
-Check nail length and trim and clean on bath day and as necessary;
-The resident had a communication problem related to deafness, anticipate, and meet needs.

Review of the resident's annual MDS dated 11/24/24 showed the following:
-The resident had moderate cognitive impairment;
-No rejection of care exhibited;
-The resident required substantial to maximum assistance with bathing;
-The resident required partial to moderate assistance with personal hygiene;
-Diagnoses included Parkinson's disease.

Observation on 2/25/25 at 3:25 P.M. in the resident's room showed the resident's nails were approximately 1/4 inch long, uneven, with brown crusted debris under the nails.

During an interview on 2/25/25 at 3:30 P.M. the Assistant Director of Nursing (ADON) said Resident #7 probably refused to have his/her nails trimmed, he/she often refused care.

During an interview on 2/24/25 at Director of

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F 677	Continued From page 12 Nursing (DON) said the following: -Resident #1 often had diarrhea and was fixated on his/her bowels; the physician had addressed this multiple times by adjusting laxatives; -Staff tried to assess the resident and offer a shower, but he/she often refused; -Resident #7 would allow only certain staff to trim his/her nails. He was not aware the resident's nails were that long. During an interview on 2/20/25 at 4:30 P.M. the Administrator said the following: -Many of the resident's complained about Resident #1's odor, because the resident didn't shower routinely and was often dirty; -Resident #1 refused to wash the dirty sweatshirt he/she wore, he/she seldom ever took it off so it was very dirty; -The resident often had fecal matter under his/her nails and would refuse to shower or clean up; -She would expect each resident to have a shower at least two times a week or per their preference. She would expect nails to be trimmed on shower days or as needed; -Staff should make multiple attempts to provide a shower or a partial bath if nothing else.	F 677		
F 689 SS=D	MO249168 MO248667 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	F 689		

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§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 interview and record review, the facility failed to provide protective oversight to ensure one resident (Resident #1), did not obtain a lighter and cigarettes within the facility on multiple occasions. The resident was also observed smoking in his/her room wearing oxygen and admitted to staff he/she was smoking in the facility. Staff educated the resident not to smoke in the building and on the smoking policy. There was no documentation any other interventions were put in place or the resident's smoking assessment was updated until 2/19/25. On 2/20/25 during the night, the resident was observed smoking and admitted to smoking in the facility on more than one occasion and was found with two lighters and a half pack of cigarettes. The facility census was 76.

Review of the facility's policy titled, Smoking Policy, dated 10/2/24, showed the following:
-When the resident requested to smoke, the interdisciplinary team (IDT) will assess the resident's capabilities and deficits to determine appropriate supervision and assistance. Smoking will only be allowed in designated areas at designated times in the facility that are not near flammable substances or where oxygen is in use. Residents, resident representatives, and visitors will be informed of the facility smoking policy;
-The objective of this policy is to complete an assessment when a resident requests to smoke, determine the level supervision, assistance and individualized approaches required for safety. In

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addition, the smoking policy outlines the designated areas, notices, education, and requirements for smoking on the facility property to ensure precautions are taken for resident's individual safety as well as the safety of others in the facility;
-Smoking will only be permitted in marked designated areas ONLY. Smoking is prohibited in all other areas;
-No residents with oxygen are permitted in the designated smoke areas;
-Any resident choosing to smoke will be assessed by a member of the IDT utilizing the Smoking Evaluation Assessment. The assessment will be completed upon admission, annually, with change of condition and as needed. Individualized approaches and directions for safety and assistance will be documented in the resident's plan of care and communicated to direct care staff. Documentation will detail situations when the resident is not allowed to smoke;
-Education about the policy will be provided to the resident/resident representative;
-Residents who can sign out per responsible party, may ask for their smoking materials after signing out and must leave the property to smoke at will. The residents must return smoking materials to nurse ' s station upon returning to the facility;
-Failure to comply or act in accordance with facilities smoking policy can result in the loss of smoking privileges due to severe possibility of harm and/or damages that may be caused from non-compliance;
-First violation will result in a 2-day suspension of smoking privileges;
-Second violation of our smoking policy will result in permanent revocation of smoking privileges and the resident will be offered smoking

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F 689	Continued From page 15 cessation products and education; -Continued non-compliance will result in a 30-day discharge from the facility; -All residents who smoke need to be supervised by a facility staff member or personal family member at designated smoke areas; -Smoke breaks are in the designated areas; -Smoke breaks are limited to one cigarette per resident; -All cigarettes will be extinguished in the appropriate receptacles; -Residents are not permitted to have smoking materials on their possession or in their room. All smoking materials such as lighters, matches and cigarettes are to be kept in the designated cabinet and passed out by the designated staff member; -The facility may conduct room searches for smoking materials, during which time the resident and or representative may be present; -Absolutely no smoking inside the facility. Violation of this rule may result in discharge. 1. Review of the Resident #1's Care Plan, initiated on 1/16/23 showed the following: -Educate the resident on smoking risks and hazards. Encourage the resident to participate in a smoking cessation program; -If the resident wears oxygen ensure the resident does not take the tank or tubing with him/her to smoke; -Educate the resident on the risks of smoking around/near oxygen; -Educate the resident on smoking with a compromised lung function; -Educate the resident on smoking times, rules and safe smoking practices; -Notify the Social Service Director (SSD)/Administrator if it is suspected the resident	F 689		

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had violated the facility smoking policy;
-Observe clothing for cigarette burns.

Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment required to be completed by facility staff, dated 1/10/25, showed the following:
-Admitted to the facility 1/3/23;
-The resident was cognitively intact;
-No behavioral symptoms exhibited;
-Functional limitation in range of motion in lower extremities, impairment on both sides;
-Independent with chair/bed-to-chair- transfer, toilet transfers;
-The resident used a motorized scooter independently, can wheel at least 150 feet once in the scooter;
-Diagnoses included arthritis, chronic pain syndrome (persistent pain that lasts for weeks to years), adult failure to thrive (a condition that commonly affects the elderly, especially those with multiple chronic medical conditions), unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (an emotional and behavioral issue with the onset being as a child or adolescent. Symptoms can include anger and aggression towards others or self, impulsivity, difficulty handling frustration, refusing to follow rules) and cognitive communication disorder (trouble reasoning and making decisions while communicating and sometimes have trouble responding in an appropriate or a socially acceptable manner).

Review of the resident's Physician Order Sheets (POS) dated February 2025, showed an order for oxygen to titrate to keep oxygen saturation above 90% (the measure of how well the body is

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F 689	Continued From page 17 delivering oxygen to tissues and organs in the body, a normal oxygen saturation level is between 95% to 100 %)) and as needed for dyspnea (shortness of breath). Review of the resident's smoking assessment dated 10/10/24 showed the following: -The resident was a smoker; -The resident had no visual or cognitive deficit and no dexterity problems; -The resident was an independent smoker and could light his/her own cigarettes; -The facility will store the resident's cigarettes and lighter; -The resident was to utilize an apron when smoking. Review of the resident's Nurse's Note, dated 2/7/25 at 11:20 P.M.,. showed the following: -The resident asked the Certified Nurse Assistants (CNAs) to let him/her out to smoke, they were busy with bed check and said they would as soon as they were finished. The resident went to charge nurse requesting to go out and was told the same thing; -After a few minutes a CNA from Unit 2 came down and let the resident outside. The resident was outside for five minutes and then came back inside. The resident immediately came out of his/her room and asked to go outside to smoke again. Staff told the resident they would let him/her out as soon as possible; -Unit 1 aide let the resident out after a few minutes The resident was outside for less then five minutes and came back in and went to his/her room. In less then five minutes the resident came out again requesting to go out and smoke. Staff told the resident they would let him/her out as soon as possible;	F 689		

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F 689	Continued From page 18 -The resident went to the dining room to wait for aides to let him/her outside. The aides went to the dining room and there was a strong cigarette smoke odor. The resident denied smoking but there was a partially smoked cigarette by his/her feet. The resident said the cigarette was not his/her's, but no other residents smoke this type of cigarette, only this resident; -On call was notified and social services. The resident was educated to not smoke in the building and on the smoking policy. The resident verbalized an understanding. Review of the resident's record showed his/her Care Plan was not updated to show staff smelled a strong cigarette odor or noted a partially smoked cigarette by the resident's feet or any new interventions for supervision. There was no evidence staff updated the resident's smoking assessment. Review of the resident's Nurse's Note, dated 2/11/25 at 9:26 A.M., showed the following: -The resident said staff were not quick enough to let him/her out at night to smoke and that was why he/she sometimes propped (the resident would leave the door propped open to the outside smoke area off the dining room after he/she smoked so he/she could come and go as he/she wanted) the door open. The resident said he/she had to smoke to be able to have a bowel movement; -Staff educated the resident on not propping the doors as it was a potential danger to other residents. The resident agreed to attempt to be patient so staff could let him/her through locked doors at night to smoke. Review of the resident's record showed no	F 689		

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update to the resident's Care Plan to show the resident admitted to propping the facility door open to smoke on occasion or any new interventions for increased supervision and no evidence the resident's smoking assessment was updated.

Review of the resident's Nurse's Note, dated 2/13/25 at 4:09 P.M., showed the following:
-The nurse along with the Director of Nursing (DON), Social Service Director, Housekeeping Supervisor, and the Administrator were requested to come to the resident's room. The resident requested staff look for missing money in his/her room;
-Upon going through the resident's room, staff found half smoked cigarettes, multiple piles of opened boxes of cigarettes, some half empty, and some that had been opened but had no cigarettes removed.

Review of the resident's Care Plan showed it was not updated to show staff found the resident with half smoked cigarettes in his/her room along with multiple boxes of cigarettes or any new interventions for increased supervision.

Review of the resident's social service note dated 2/18/25 at 11:32 P.M. showed the following:
-An aide was walking down the hall and smelled smoke;
-The aide knocked on the resident's door and the resident answered the door;
- Staff asked the resident if he/she was smoking as smoke was coming out the room;
- Charge nurse notified and staff educated the resident on the smoking policy.

Review of the resident's Care Plan showed it was

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not updated to show staff smelled smoke and observed smoke coming out of the resident's room or any new interventions for increased supervision.

Review of the resident's smoking assessment showed it was not updated after the resident was found with cigarettes

Review of the resident's Nurse's Note, dated 2/19/25 at 12:30 A.M., showed the following:
-The charge nurse and aide went to the resident's room to administer medications. The resident's door was closed;
-Upon entering the resident's room, it smelled strongly of smoke and the room was hazy from smoke;
-Staff questioned the resident about smoking and he/she denied it. Staff educated the resident on the smoking policy and the dangers of smoking around oxygen.

Review of the resident's Care Plan showed it was not updated to show that the resident's room smelled strongly of smoke and the room was hazy from smoke. There were no new interventions for increased supervision and no evidence the smoking assessment was updated at the time of the incident on 2/19/25 at 12:30 A.M.

Review of the resident's Progress Note, dated 2/19/25 at 12:40 A.M., showed the following:
-Aides went down the hall to answer a call light. The resident's door was closed but the hallway was smokey and there was a strong odor of cigarettes;
-Aides attempted to open the door, however the resident was in front of the door in his/her

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F 689	Continued From page 21 wheelchair; -Aides opened the door about six inches and were able to see the resident put his/her cigarette out on his/her wheelchair. The resident admitted he/she was smoking in his/her room; -The resident gave the aide around ten cigarette butts and two lighters. Staff left the resident's room and he/she followed them in his/her wheelchair. Aides reported the situation to charge nurse; -Staff educated the resident on the smoking policy and dangers of smoking around oxygen. The Social Service Director notified the on-call Administrator. Review of the resident's Nurse's Note, dated 2/19/25 at 5:34 A.M., showed the following: -The resident said he/she could not have a bowel movement unless he/she smoked. Offered medications for constipation and the resident refused; -The resident said he/she only had diarrhea and needed to smoke every time he/she had the urge to have a bowel movement. Review of the resident's Nurse's Note, dated 2/19/25 at 6:48 A.M., showed the following: -The resident was at the nursing station demanding to go out and smoke; -Staff told the resident he/she could not go out to smoke until supervised smoke time and that the facility was following the current smoking policy. Review of the resident's Nurse's Note, dated 2/19/25 at 7:24 A.M., showed the following: -The resident was going out to smoke break and asked for a pack of cigarettes; -The Social Service Director observed the resident had a hidden pack in his/her pocket. The	F 689		

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resident had been redirected several times and staff had no success redirecting him/her;
-The resident continued to argue with staff about why he/she was smoking in the facility.

Review of the resident's medical record showed there was no documentation to show the Administrator was notified of the resident being found with cigarettes in his/her pocket and continuing to argue about smoking in the facility.

Review of the resident's Nurse's Note, dated 2/19/25 at 8:39 A.M., completed by the Social Service Director showed the following:
-The resident was made a supervised smoker due to the resident hunched over and asleep numerous times with his/her electric wheelchair in drive several times through the night and because of smoking in the facility;
-The resident had been educated on the risks of smoking in the facility and had signed a new smoking policy that came out at the beginning of the year;
-The resident was supposed to have a smoking apron which he/she did not wear properly. The resident was educated on the risks of not wearing the apron properly;
-Staff completed a new smoking assessment due to the resident falling asleep in his/her electric wheelchair and smoking in the facility.

Review of the resident's Smoking Assessment, dated 2/19/25, showed the following:
-The resident was a smoker;
-The resident had no visual or cognitive deficit;
-The resident had a dexterity problem;
-The resident was to be a supervised smoker and could light his/her own cigarettes;
-The facility was to store the resident's cigarettes

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F 689	Continued From page 23 and lighter; -The resident was to utilize an apron when smoking. Review of the resident's Nurse's Note, dated 2/19/25 at 9:39 A.M., showed the following: -The resident was called to an Interdisciplinary Team (IDT) meeting to discuss the resident being caught in his/her room smoking; -The Administrator asked the resident if he/she was smoking in his/her room and the resident said "yes, yes", he/she had been smoking in his/her room, he/she needed to have a bowel movement and couldn't wait and was at his/her wits end; -The resident was offered a nicotine patch and he/she declined. The Administrator explained that the resident would be supervised because he/she had been caught multiple times smoking inside the facility. Review of the resident's Care Plan, last revised on 2/20/25, showed on 2/19/25 the resident required supervised smoking. Review of the resident's Nurse's Note, dated 2/20/25 at 12:55 A.M., showed the following: -The resident went to the dining room and the aides reported a strong smell of cigarette smoke coming from the dining room; -The resident went back to his/her room and admitted to the Social Service Director he/she was smoking in the dining room; -The resident gave the SSD two lighters and a half of a pack of cigarettes. The resident said he/she could not have a bowel movement without a cigarette; -The resident was educated on the smoking policy and the Administrator on call was notified.	F 689		

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F 689	Continued From page 24 Review of the resident's Care Plan showed no updated interventions of increased supervision/monitoring of the resident while in the facility after the resident was found with two lighters and a half of a pack of cigarettes and admitted to smoking in the dining room of the facility. Review of the resident's Nurse's Note, dated 2/20/25 at 2:40 A.M., showed the following: -The SSD was called down to Unit 1 due to smelling cigarette smoke in the dining room while the resident was coming out of the dining room; -The resident denied smoking at first, but later admitted he/she had been smoking due to not being able to have a bowel movement; -Staff educated the resident on the risks of smoking in the building and the smoking policy for the facility. Review of the resident's care plan showed no evidence the care plan was updated with any new interventions of increased supervision/monitoring of the resident while in the facility after smelling cigarette smoke while the resident was in the dining room and the resident admitted to smoking in the dining room of the facility. Review of the resident's Nurse's Note, dated 2/20/25 at 8:57 A.M., showed the following: -The Social Service Director called the nurse down the resident's room around 7:40 A.M., after the resident was caught smoking in his/her room; -Staff questioned the resident if he/she had any other smoking materials and the resident denied. The resident emptied his/her pockets; -Staff educated the resident on the smoking policy and dangers of smoking in his/her room	F 689		

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F 689	Continued From page 25 especially with oxygen in his/her room; -The resident denied having oxygen on. Observation on 2/20/25 at 2:06 P.M., during the resident's smoke break outside the facility in the designated smoke area showed over 20 cigarette butts scattered on the ground. During an interview on 2/20/25 at 10:00 A.M. the resident said the following: -Staff took all his/her cigarettes out of his/her room around two hours ago because he/she was found smoking in his/her room; -He/She stored cigarettes in his/her room in his/her safe; -Smoking helped the resident relax and have a bowel movement. He/She had to smoke to be able to have a bowel movement; -He/She didn't smoke with his/her oxygen on. During an interview on 2/25/25 at 1:00 P.M. Certified Nurse Aide (CNA) D said the following: -He/She caught the resident smoking in his/her room recently. CNA D could not recall the exact date but it was when he/she was working on the evening shift; -He/She was across the hall and smelled smoke. The resident was in his/her room wearing his/her oxygen with it turned on, smoking a cigarette; -He/She turned the oxygen off and reported it to the charge nurse; -All residents are now supervised during smoking times. Staff hand out one cigarette to each resident and the staff were to hold the lighter and light each resident's cigarette; -The residents were to give the cigarette butts to staff and they would throw them away in the receptacle.	F 689		

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F 689	Continued From page 26 During an interview on 2/20/25 at 2:00 P.M. and 2/25/25 at 10:22 A.M. the Social Services Director said the following: -He/She worked a split shift and worked at the facility at night, he/she was also a CNA; -There were a lot of places in the facility the resident had been found smoking in the past month and a half. The resident said he/she had to smoke to have bowel movement; -The resident's family brought cigarettes into the resident, and the resident hid cigarettes in his/her room; -Staff found cigarette packs all over his/her room and cigarette butts everywhere. The resident had 32 open packs of cigarettes in his/her room; -On 2/19/25, the resident changed to a supervised smoker. The SSD was normally always up and down the halls of the facility at night checking on the residents, but there was nothing specific put in place regarding supervision of the resident on 2/19/25 or 2/20/25 while he/she was in the facility; -On 2/20/25 staff found the resident smoking in his/her room; -Since the resident was now a supervised smoker, his/her cigarettes were accounted for, the issue with smoking inside had been addressed; -Staff didn't complete any room searches or provide increased supervision when the resident was inside the facility. Review of the resident's Care Plan, revised on 2/24/25, showed the following: -The resident will keep multiple packs of tobacco on his/her person in his/her room and will accuse staff of stealing them; -The resident had been educated on the proper storing of tobacco and refused to abide by the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265536	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTH & REHABILITATION	1600 EAST ROLLINS ST MOBERLY, MO 65270

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F 689	Continued From page 27 facility rules; -The resident will refuse to wear his/her smoking apron and had been educated on the risks and benefits and the importance of wearing the apron to avoid burns. During an interview on 2/24/25 at 1:45 P.M. the DON said the following: -In December of 2024, the facility put in place a strict policy regarding smoking and all residents had to be supervised with specific smoke times; -Prior to this resident coming to the facility he/she had been homeless for a long period. The resident would probably pick up cigarette butts; -The resident never denied smoking in his/her room. The facility had an IDT meeting regarding smoking on 2/20/25 and also had a meeting prior to that regarding the resident smoking in the facility; -There were no problems with the resident smoking in the facility until the new policy was put in place. The resident was independent prior to that; -The facility had never had problems with residents smoking in the facility prior to the new policy being implemented. During an interview on 2/24/25 at 3:30 P.M. the Administrator said the following: -Staff found a large amount of cigarettes in the resident's safe the day he/she reported some missing money on 2/13/25. Staff were searching for the money and found all of the cigarettes. Those items were brought up to front office; -On 2/18/25, the facility had a group meeting with all the residents that smoked, reviewed the smoking policy and had each resident who smoked sign the policy after it was reviewed; -Facility staff notified her by phone the resident	F 689		

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	265536	A. BUILDING _____ B. WING _____	C 02/25/2025

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VALLEY VIEW HEALTH & REHABILITATION	**1600 EAST ROLLINS ST MOBERLY, MO 65270**

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F 689	Continued From page 28 was smoking inside the facility once around 1:00 A.M. to 2:00 A.M. the morning of 2/20/25; -The other times staff thought the resident was possibly smoking, but wasn't sure as the resident may have a strong odor of smoke and it could have been because the resident just came back inside from smoking outside; -He/She would have expected to be notified of any incident of the resident suspected of smoking or found smoking inside the facility; -She instructed staff to do 15 minute checks on the resident after he/she was found smoking inside his/her room, he/she did not instruct staff to document the checks; -She hadn't decided if the resident would continue on 15 minute checks; -Staff searched the resident's room on 2/24/25 for any smoking contraband after the resident's family left and nothing was found; -She would expect staff to place all cigarette butts in the appropriate receptacles. MO249513	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13167	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTH & REHABILITATION	1600 EAST ROLLINS ST MOBERLY, MO 65270

(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
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		
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		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III	A4077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13167	A. BUILDING: _____ B. WING _____	C 02/25/2025

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A4077	Continued From page 1 This regulation is not met as evidenced by: Class II Refer to F677	A4077		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II Refer to F550	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Valley View Health and Rehabilitation
Street Address, City, Zip:	1600 East Rollins Moberly, MO 65270
Date of Survey:	02.25.25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. This submission of the POC does not constitute an admission on the part of Valley View Health and Rehabilitation ("the facility") as to the accuracy of the surveyor or findings, nor the conclusions drawn there from. The facility's submission of the POC does not constitute an admission on the part of the facility that the findings cited are accurate, or the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction.	
F550	The facility will take additional measures to ensure the facility follows all state and federal guidelines for resident rights/exercise of rights. **Corrections will include:** 1. Residents #10 and #9 have been discharged. Resident #13 has been treated with dignity and respect and a trauma assessment was completed. All residents have been treated with dignity and respect. **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows.** All residents have the potential to be affected. **The measures that will be put into place or systemic changes made to ensure the alleged deficient practice will not occur are as follows:** 1. Staff will be in-serviced on customer service and reporting with a 100% posttest. 2. Backgrounds for employees will be reran. 3. Filling out grievances and where they are located will be discussed in March at resident council. Resident #13	03.03.25

	was educated on grievances and who to turn into and where they are located. 4. Weekly IDT meetings with Resident #13 to discuss any concerns. 5. A clinoconex message will be sent out to resident's responsible parties on who to report a concern and where grievance forms are located. 6. CMT F was educated on customer service, dignity, and respect. Employee sat through training program on these topics with Administrator and Human Resources. 7. An audit/interview will be completed DON/ ADON/ IP/ Wound Nurse/ MDS nurse on five residents three times a week M- F for 3 months to ensure that all residents are being treated with dignity and respect. **The facility will monitor corrective actions to ensure that alleged deficient practice will not recur as follows:** 1. DON/ ADON/ IP/ Wound Nurse/ MDS nurse will report any issues with dignity and respect to the Administrator and QAPI. 2. An audit/interview will be completed by DON/ ADON/ IP/ Wound Nurse/ MDS nurse on five people three times a week M-F for 3 months to ensure all residents are being treated with dignity and respect. 3. The QAPI committee will meet for 3 months or until compliance is met. The QAPI committee will review outcomes and make recommendations as needed.	
F677	The facility will take additional measures to ensure the facility follows all state and federal guidelines for nail care/hygiene provided for dependent residents. **Corrections will include:** 1. Resident #1 had a shower and was provided nail care and allowed staff to trim nails on both hands minus index finger on left hand. Resident #7 had a shower and was provided nail care. All dependent residents have been given nail care. **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows.** All residents have the potential to be affected. **The measures that will be put into place or systemic changes made to ensure the alleged deficient practice will not occur as follows:** 1. Nursing staff will be in-serviced on nail care/hygiene provided for dependent residents by DON/ ADON/ IP/ Wound Nurse/ MDS nurse 2. Nursing staff will be required to complete a nail care competency. 3. Staff will be in-serviced on Kardex which alerts staff to dependent residents for nail care.	03.03.25

	4. Staff will monitor Resident #1 and offer assistance for personal hygiene and alert charge nurse of refusals of care. 5. An audit will be completed by DON/ ADON/ IP/ Wound Nurse/ MDS nurse on five people three times a week M-F for 3 months to ensure proper nail care for dependent residents. **The facility will monitor corrective actions to ensure the alleged deficient practice will not recur as follows:** 1. DON/ ADON/ IP/ Wound Nurse/ MDS nurse will report any issues with nail care for dependent residents to the Administrator and QAPI. 2. An audit will be completed by Nursing Administration on five people three times a week M-F for 3 months to ensure proper nail care for dependent residents. 3. The QAPI committee will meet for 3 months or until compliance is met. The QAPI committee will review outcomes and recommendations as needed.	
F689	The facility will take additional measures to ensure the facility follows all state and federal guidelines for free of accident Hazards/ Supervision/ Devices. **Corrections will include:** 1. Resident #1 smoking assessment and care plan have been updated to reflect residents' status. **The facility will identify other residents having the potential to be affected by the same alleged deficient practices as follows:** All residents have the potential to be affected. **The measures that will be put into place or systemic changes made to ensure the alleged deficient practice will not occur are as follows:** 1. Staff will be in-serviced on the smoking policies for residents by DON/ ADON/ IP/ Wound Nurse/ MDS nurse. 2. Staff will be required to complete a smoking test with 100%. 3. Resident #1 family educated not to bring smoking items to resident, but they have to be turned into facility. 4. Residents #1 room checked three times weekly for 3 months for smoking materials 5. Staff has been in-serviced on the Kardex/ Smoking instruction sheet with alerts staff to special smoking instructions for residents. 6. All residents will have a smoking assessment completed on them. 7. DON/ ADON/ IP/ Wound Nurse/ MDS nurse will do an audit for 2 smoking times 3 times a week M- F for 3 months or until compliance is met.	03.03.25

	The facility will monitor corrective actions to ensure the alleged deficient practice will not recur as follows: 1. DON/ ADON/ IP/ Wound Nurse/ MDS nurse will report any issues with smoking to the Administrator and QAPI. 2. An audit will be completed by DON/ ADON/ IP/ Wound Nurse/ MDS nurse for 2 times 3 times a week M- F for 3 months to ensure residents are following the smoking policy. 3. The QAPI committee will meet for 3 months or until compliance is met. The QAPI committee will review outcomes and make recommendations as needed.	
A4074	Refer to F689	
A4075	Refer to F677	
A4077	Refer to F677	
A8030	Refer to F550	

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.