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	265472	A. BUILDING _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENT B TINNIN MANOR	220 EUEL POLK DRIVE ELLINGTON, MO 63638

(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 570 SS=D	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain the surety bond (a purchased bond for the security of residents' personal funds) for at least one and one-half times the average monthly balance of the residents' personal funds for the last 12 consecutive months from November 2023 through October 2024. The facility's census was 40. Review of the facility's policy titled, "Surety Bond," dated March 2021, showed: - A surety bond is an agreement between the facility, the insurance company, and the resident or the State acting on behalf of the resident, wherein the facility and the insurance company agree to compensate the resident for any loss of the resident's funds that the facility holds, accounts for, safeguards, and manages; - This facility holds a surety bond to guarantee the protection of the residents' funds managed by the facility on behalf of its residents; - All funds (including refundable deposits) entrusted to the facility for a resident are covered by the surety bond; - The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring from any failure by the facility; - Inquiries concerning the financial security of personal funds managed by the facility should be referred to the Administrator;	F 570		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 4/11/25

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 570	Continued From page 1 - The policy did not address how the surety bond would be calculated. Review of the Residents' Personal Funds Account for the last 12 consecutive months from March 2024 through February 2025 showed: - The facility's approved bond amount equaled $51,000.00; - The average monthly balance of the residents' personal funds equaled $38,481.13; - An average monthly balance of $38,481.13 rounded to the nearest thousand equaled $38,000.00 and at one and one-half times would equal the required bond amount of at least $57,000.00. During an interview on 03/19/25 at 10:30 A.M., the Administrator said she would expect the facility's bond to be sufficient to cover the residents' funds. The previous administration misappropriated money and therefore, the accounts were not reconciled and were incorrect.	F 570		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		

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F 582	Continued From page 2	F 582		

changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:

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Based on interview and record review, the facility failed to properly document notification and obtain a signature of the resident or legal representative for three residents (Residents #2, #36, and #51) out of three sampled residents on the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms prior to the facility discharging the resident from Medicare services. The census was 40.

Review of facility policy titled, "Medicare Advance Beneficiary and Medicare Non-Coverage Notices," revised September 2022, showed:
- If the director of admissions or benefits coordinator believes (upon admission or during a resident's stay) that Medicare Part A will not pay for an otherwise covered skilled service(s), the resident or representative is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s);
- SNF ABN is issued to the beneficiary before non-covered care items or services are furnished to the beneficiary;
- SNF ABN is issued to the beneficiary before items or services to the beneficiary are reduced;
- The facility must issue a NOMNC at least two days before the terminated covered care;
- The resident or representative is informed that they may choose to receive the skilled services that may not be paid for by Medicare and assume the financial responsibility.

1. Review of Resident #2's medical record showed:
- The resident was discharged from skilled services on 11/01/24, with remaining days in the benefit period and remained in the facility;

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- No documentation of the NOMNC and SNF ABN forms;
- The facility failed to issue the NOMNC and SNF ABN forms.

2. Review of Resident #36's medical record showed:
- The resident was discharged from skilled services on 11/01/24, with remaining days in the benefit period and remained in the facility;
- No documentation of the NOMNC and SNF ABN forms;
- The facility failed to issue the NOMNC and SNF ABN forms.

3. Review of Resident #51's medical record showed:
- The resident was discharged from skilled services on 11/01/24, with remaining days in the benefit period and discharged from the facility;
- The facility failed to notify the resident or the resident's representative of the change to the skilled services;
- No documentation of the NOMNC form;
- The facility failed to issue the NOMNC form.

During an interview on 03/19/25 at 10:05 A.M., the Administrator said she would expect the SNF ABN and NOMNC forms to be provided with the proper notifications conducted and the correct signatures in a timely manner.

During an interview on 03/19/25 at 10:19 A.M., the Social Service Designee (SSD) he/she will now be now responsible for the SNF ABN and NOMNC forms in the future. He/She would expect the forms to be completed, the resident's and or the resident resident's representative to be notified, and the signatures to be obtained in

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F 582	Continued From page 5 timely a manner.	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedure to complete Criminal Background Checks (CBC) for	F 607		

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four employees (Employees A, B, C, and D) and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused, neglected, and/or misappropriated funds or property from a resident) prior to the hire date for two employees (Employees A and B) out of five sampled employees . The facility census was 40.

Review of the facility's policy titled, "Background Screening Investigations," dated March 2019, showed:
- Background checks, reference checks, and criminal conviction checks on all potential direct access employees and contractors should be conducted. Background and criminal checks are initiated within two days of an offer of employment and completed prior to employment.

Review of the facility policy titled, "Hiring and Orientation," undated, showed:
- Pre-screening for employment may include license verification, criminal background check, pre-employment physical screening/questionnaire and drug testing.

Review of the facility policy titled, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," dated April 2021, showed:
- Develop and implement policies and protocols to prevent and identify the above;
- Conduct employee background checks.

The facility did not provide a policy in regards to checking the EDL.

1. Review of Employee A's personnel file showed:
- A hire date of 05/15/24;
- No documentation of a CBC completed prior to

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the hire date;
- No documentation of a EDL completed prior to the hire date;
- The facility failed to perform the CBC and EDL prior to the hire date.

2. Review of Employee B's personnel file showed:
- A hire date of 03/16/24;
- The employee's CBC completed after the hire date on 03/20/24;
- The employee's EDL completed after the hire date on 03/20/24;
- The employee's last EDL completed 05/03/24;
- The facility failed to perform the CBC and EDL prior to the hire date.

3. Review of Employee C's personnel file showed:
- A hire date of 01/21/25;
- The employee's CBC completed after the hire date on 01/23/25;
- The facility failed to perform the CBC prior to the hire date.

4. Review of Employee D's personnel file showed:
- A hire date of 07/05/23;
- No documentation of a CBC completed prior to the hire;
- The facility failed to perform the CBC prior to the hire date.

During an interview on 03/19/25 at 10:45 A.M., the Human Resources (HR) staff said CBC and EDL checks should be done prior to employment and the EDL checks should be done again quarterly. He/She just started in this position and was working to get everything in order.

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F 607	Continued From page 8 During an interview on 03/19/25 at 10:30 A.M., the Administrator said the CBC and EDL checks should be completed prior to employment and the EDL checked at least quarterly after employment.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		

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(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party for five residents (Residents #5, #9, #34, #36, and #45) out of five sampled residents. The facility census was 40.

Review of the facility's policy titled, "Transfer or Discharge," dated October 2022, showed:
- Transfer and discharge includes movement of a resident from a certified bed in the facility to a non-certified bed in another part of the facility, or to a non-certified bed outside the facility;
- When residents who are sent emergently to an acute care setting, these scenarios are

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considered facility-initiated transfers, not discharges, because the resident's return is generally expected;
- Resident who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility;
- Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident or an immediate transfer or discharge is required by the resident's urgent medical needs;
- Notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care ombudsman (a resident advocate) when practicable (example a monthly list of residents that includes all notice content requirement);

1. Review of Resident #5's medical record showed:
- The resident transferred to the hospital on 01/15/25;
- No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party.

2. Review of Resident #9's medical record showed:
- The resident transferred to the hospital on 01/23/25, 02/08/25, and 03/02/25;
- No documentation of the written notifications with the reasons for the hospital transfers provided to the resident and/or the responsible party.

3. Review of Resident #34's medical record showed:

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F 623	Continued From page 12 - The resident transferred to the hospital on 12/14/24 and 02/28/25; - No documentation of the written notifications with the reasons for the hospital transfers provided to the resident and/or the responsible party. 4. Review of Resident #36's medical record showed: - The resident transferred to the hospital on 01/30/25 and 02/02/25; - No documentation of the written notifications with the reasons for the hospital transfers provided to the resident and/or the responsible party. 5. Review of Resident #45's medical record showed: - The resident transferred to the hospital on 02/27/25; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or responsible the party. During an interview on 03/19/25 at 10:05 A.M., the Administrator said she would expect residents and/or the resident's representative to be given a written copy of the notice of the transfer or discharge.	F 623		
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- §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	F 625		

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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, the facility failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of the transfer to the hospital for six residents (Residents #2, #5, #9, #34, #36, and #45) out of six sampled residents. The facility's census was 40.

Review of the facility's policy titled, "Bed Holds and Returns," dated October 2022, showed:
- All residents/representatives are provided written information regarding the facility and state bed-hold policies, which addresses holding or reserving a resident's bed during periods of

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absence at least twice (included in the admission packet, and at the time of transfer, if an emergency, within 24 hours.)

1. Review of Resident #2's medical record showed:
- Admitted on 07/06/24;
- The resident transferred to the hospital on 02/22/25, and returned to the facility on 02/22/25;
- The resident transferred to the hospital on 03/12/25, and returned to the facility on 03/13/25;
- No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer.

2. Review of Resident #5's medical record showed:
- Admitted on 09/18/24;
- The resident transferred to the hospital on 01/15/25, and returned to the facility on 01/19/25;
- No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer.

3. Review of Resident #9's medical record showed:
- Admitted on 01/30/25;
- The resident transferred to the hospital on 01/23/25, and returned to the facility on 01/29/25;
- The resident transferred to the hospital on 02/08//25, and returned to the facility on 02/10/25;
- The resident transferred to the hospital on 03/02/25, and returned to the facility on 03/02/25;
- No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer.

4. Review of Resident #34's medical record showed:

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F 625	Continued From page 15 - Admitted on 07/18/23; - The resident transferred to the hospital on 12/14/24, and returned to the facility on 12/18/24; - The resident transferred to the hospital on 02/28/25, and returned to the facility on 02/28/25; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 5. Review of Resident #36's medical record showed: - Admitted on 09/03/24; - The resident transferred to the hospital on 01/30/25, and returned to the facility on 01/30/25; - The resident transferred to the hospital on 02/02/25, and returned to the facility on 02/08/25; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 6. Review of Resident #45's medical record showed: - Admitted on 09/26/24; - The resident transferred to the hospital on 01/30/25, and did not return; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. During an interview on 03/19/25 at 10:05 A.M., the Administrator said he/she would expect residents and/or the resident's representative to be informed in writing of the facility bed hold policy before a resident was transferred.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		

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F 637	Continued From page 16 §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, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) assessment within 14 days of admission to hospice services for one resident (Resident #4) out of one sampled resident. The facility census was 40. The facility did not provide a policy regarding the completion of significant change MDS assessments. 1. Review of Resident #4's medical record showed: - Admitted to hospice services on 02/28/25; - No significant change MDS dated on or after 02/28/25; - The facility failed to complete a significant change MDS within 14 days of the resident's admission to hospice. During an interview on 03/19/25 at 1:15 P.M., the Administrator said a significant change MDS	F 637		

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F 637	Continued From page 17 should be completed with a significant change, decline, admission to hospice, or an improvement. It should be done as soon as the staff became aware of it. During an interview on 03/19/25 at 1:23 P.M., the MDS Coordinator said the significant change MDS should be completed within 14 days of the change.	F 637		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #4) had a completed hospice (palliative care for the terminally ill with a life expectancy of six months or less) coordinated plan of care, received the needed care and services in accordance with professional standards of practice by not turning and repositioning, and to follow physician's orders for daily wound care treatments and a wound culture out of one sampled resident receiving hospice services, positioning due to impairment, and wound care and culture. The facility also failed to monitor a valproic acid (an anticonvulsant medication) level for one resident (Resident #3) out of one sampled	F 684		

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resident. The facility census was 40.

Review of the facility's policy titled, "Hospice Program," revised July 2017, showed:
- Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being;
- The coordinated care plan will reflect the resident's goals and wishes, as stated in his/her advance directives and during ongoing communication with the resident or representative, including palliative goals and objectives; palliative interventions; and medical treatment and diagnostic tests;
- The coordinated care plan shall be revised and updated as necessary to reflect the resident's current status including, but not limited to diagnosis, problem list; symptom management (pain, nausea, vomiting, etc.); bowel and bladder care; nutrition and hydration needs; oral health; skin integrity; spiritual, activity and psychosocial needs; and mobility; and positioning.

Review of the facility's policy titled, "Lab and Diagnostic Test Results - Clinical Protocol," revised November 2018, showed:
- The staff will process test requisitions and arrange for tests;
- When test results are reported to the facility, a nurse will first review the results. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility

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(supervisor, charge nurse, etc.) should follow or coordinate the procedure.

Review of the facility's policy titled, "Prevention of Pressure Ulcers," revised April 2020, showed:
- The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors;
- Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable;
- Reposition resident as indicated on the care plan;
- Clean promptly after episodes of incontinence;
- Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team.

The facility did not provide a policy regarding ordering labs for medication monitoring.

1. Review of Resident #3's March 2025 Physician Order Sheet (POS):
- Diagnosis of epilepsy (a seizure disorder);
- An order for Depakote (valproic acid) delayed release 125 milligram (mg) by mouth two times a day related to epilepsy, dated 06/17/24;
- An order for Depakote delayed release 500 mg by mouth two times a day related to epilepsy, dated 06/17/24;
- An order for Depakote delayed release 250 mg by mouth two times a day related to epilepsy, dated 06/17/24;
- No order for a valproic acid level.

Review of the resident's Medical Record showed:
- Valproic Acid Lab report, dated 01/03/24, with a

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valproic acid level of 81 micrograms per milliliter (ug/mL) (normal range of 50-100 ug/mL);
- No documentation of valproic acid lab values since 01/03/24.

Review of the resident's Care Plan, revised 01/15/25, showed:
- A focus of seizure disorder with a goal of the resident will maintain lab values within therapeutic range. Interventions included: monitor the resident's labs and report any sub therapeutic or toxic results to the physician.

During a phone interview on 03/19/25 at 9:01 A.M., the Nurse Practitioner said lab frequency for valproic acid levels vary based on when the medication was started. If the medication was just started, he/she would expect the level to be checked within one week to 10 days. If the resident was on the medication for a while and the level had been within the normal range, ideally the level should be checked every six months to one year. If the dose was changed, the level would be checked at that time, and again in one week to 10 days. He/She would expect to be notified by the facility of the need for a lab level to be drawn if one had not been completed in the last six months to one year.

2. Review of Resident #4's March 2025 POS showed:
- An admission date of 02/10/25;
- An order to admit to hospice, diagnoses of protein calorie malnutrition, dated 02/28/25;
- An order for two hour turn check. Left to right turns only per wound care, two times a day for wound care, dated 02/24/25;
- An order for a wound culture to the wound on the right leg to be picked up on the next lab date,

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dated 02/21/25;
- An order to cleanse the sacral wound with facility cleanser, apply Medihoney (a wound dressing) gel, cover with non-bordered foam (a type of dressing), and secure with tape daily, dated 02/12/25;
- An order to cleanse the right heel wound with facility cleanser, apply Medihoney gel, cover with non-bordered foam, wrap with Kerlix (sterile gauze), and secure with tape daily, dated 02/12/25;
- An order to cleanse the right great toe wound with facility cleanser, apply Medihoney gel, cover with non-bordered foam, wrap with Kerlix, and secure with tape daily, dated 02/12/25.

Review of residents admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), 02/18/25, showed:
- Moderate cognitive impairment;
- Partial/moderate assistance to roll left and right, sit to lying, and lying to sit on side of bed;
- Indwelling catheter;
- Always incontinent of bowel;
- At risk for pressure ulcer (damage to the skin and/or underlying tissue as a result of pressure);
- One stage 1 (intact skin with non-blanchable redness) or higher, two stage 3 (full thickness tissue loss) pressure ulcers present on admission, one unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (a type of non-viable tissue that accumulates in wounds) and/or eschar (dark, dead matter that is cast off from the surface of the skin) in the wound bed) pressure ulcer, present on admission;
- Other ulcers, wounds, and skin problems, infection of foot, and other open lesion(s) on the

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foot;
- Moisture associated skin damage (MASD);
- Skin and ulcer treatments, turning and reposition program, nutrition or hydration interventions, pressure ulcer care, application of non-surgical dressing other than to feet, application of ointments/medications other than to feet, applications of dressing to feet;
- Did not receive hospice services.

Review of resident's Care Plan, dated 02/20/25, showed:
- Osteomyelitis (an infection in a bone) of the right foot;
- Pressure ulcer with interventions to check every two hours and turned to the left and right side only. If drainage present, obtain an order for a wound culture and provide the wound care per the treatment order;
- Bowel incontinence related to immobility with interventions to check every two hours and assist with toileting as needed, provide bedpan/bedside commode, provide peri care after each incontinent episode;
- Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcers to the right heel and coccyx (a small triangular bone at the base of the spinal column). An unstageable wound to the third toe on the right foot related to disease process and immobility with interventions to administer treatments as ordered and monitor for effectiveness; check every two hours and turn left and right sides only; monitor dressing to ensure it is intact and adhering; report loose dressing to the treatment nurse; obtain and monitor lab/diagnostic work as ordered; report results to the physician and follow up as indicated; teach the resident/family the

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importance of changing positions for prevention of pressure ulcers; and encourage small frequent position changes;
- Foley catheter (a tube inserted into the bladder to drain urine) related to neurogenic bladder (condition that results in lack of bladder control due to a brain, spinal cord or nerve problem) with interventions to position the catheter bag and tubing below the level of the bladder and away from the entrance room door, change the catheter on the 17th of every month, and check tubing for kinks every two hours each shift;
- Did not address hospice or catheter care.

Review of the resident's Hospice Coordinated Plan of Care, dated 02/28/25, showed:
- Did not address wounds or wound care;
- Did not address Foley catheter care.

Review of the resident's Lab Wound Culture Report, dated 02/27/25, showed:
- Wound culture with the missing information of no date/time of the collection on the swab and no culture results.

During an interview on 03/19/25 at 1:36 P.M., LPN A said Resident #4's wound culture was sent on 02/26/25, but the lab rejected it due to it was missing the date and time information. He/She did not follow up to resend another wound culture sample.

Observations of the resident showed:
- On 03/16/25 from 12:02 P.M. - 2:59 P.M., the resident lay in bed on his/her back with the head of the bed elevated approximately 40 degrees; a wound dressing, dated 03/14/25, to the right great toe; undated dressing to the right heel with reddish/brown colored substance on the dressing

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and the fitted sheet under the right foot; both feet pressed against the footboard; Foley catheter bag hung on the bed frame away from the door with a privacy cover in place; and a waffle mattress overlay folded on the floor. The resident lay in the same position for two hours and 57 minutes;
- On 03/17/25 from 8:35 A.M. - 2:01 P.M., the resident lay in bed on his/her back with both feet pressed against the footboard. The resident lay in the same position for five hours and 26 minutes;
- On 03/18/25 at 8:33 A.M., and 11:05 A.M., the resident lay in bed on his/her back;
- On 03/19/25 at 10:15 A.M., the resident lay in bed on his/her back with a dressing to the right foot. dated 03/17/25;
- On 03/19/25 at 10:24 A.M., the resident lay in bed on his/her back with a dressing to the right foot, dated 03/17/25. The Director of Nursing (DON) observed the date on the wound dressing of 3/17/25.

Review of the resident's Wound Care Notes showed:
- On 02/17/25, wound #1 right great toe was a stage 3 pressure injury pressure ulcer, status not healed, with 0.8 centimeter (cm) x 1.6 cm, with an area of 1.28 square (sq.) cm (sq) with a moderate amount of serosanguineous (discharge that contains both blood and a clear yellow liquid known as blood serum drainage) drainage; wound # 2 right heel was a stage 3 pressure injury pressure ulcer, status not healed, 1.5 cm x 1.8 cm with an area of 2.7 sq cm and a volume of 0.27 cubic cm, with a scant amount of serosanguineous drainage; wound #3 coccyx was an unstageable pressure injury obscured full-thickness skin and tissue loss, status not healed with 5 cm x 6.5 cm and an area of 32.5 sq cm with moderate amount of serosanguineous

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drainage. Wound bed had 1-25% granulation (the appearance of the red, bumpy tissue in the wound bed as the wound heals), 76-100% slough (the yellow/white material in the wound bed);
- On 02/24/25, wound #1, status not healed, 0.5 cm x 0.4 cm with an area of 0.2 sq cm with a moderate amount of serosanguineous drainage, wound was improving; wound #2, status not healed, 1.5 cm x 1.6 cm x 0.1 cm with an area of 2.4 cm and a volume of 0.24 cubic cm with a scant amount of serosanguineous drainage, wound was improving; wound #3, status not healed, 6 cm x 9.5 cm with an area of 57 sq cm with a moderate amount of serosanguineous drainage, wound bed has 51-75% granulation, 26-50% slough, the wound was deteriorating;
- On 03/03/25, wound #1, status not healed, 0.5 cm x 0.7 cm with an area of 0.35 sq cm with a moderate amount of serosanguineous drainage, the wound was deteriorating; wound #2, status not healed, 1.8 cm x 0.7 cm x 0.1 cm with an area of 1.26 sq cm and a volume of 0.126 cubic cm with a scant amount of serosanguineous drainage, the wound was improving; wound #3, status not healed, 8 cm x 8 cm with an area of 64 sq cm with a moderate amount of serosanguineous drainage, wound bed had 51-75% granulation, 26-50% slough, the wound was improving;
- On 03/10/25, wound #1, status not healed, 0.5 cm x 0.6 cm with an area of 0.3 sq cm with a moderate amount of serosanguineous drainage, the wound was improving; wound #2, deep tissue pressure injury persistent non-blanchable deep red, maroon or purple discoloration, status not healed, 3.5 cm x 4 cm with an area of 14 sq cm with a scant amount of serosanguineous drainage, wound was improving; wound #3, status not healed, 7 cm x 12 cm with an area of

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84 sq cm with a moderate amount of serosanguineous drainage, wound bed had 76-100% granulation, 1-25% slough, the wound was deteriorating;
- On 03/17/25, wound #1, status not healed, 0.5 cm x 0.6 cm with an area of 0.3 sq cm with a moderate amount of serosanguineous drainage, there was no change in the wound progression; wound #2, deep tissue pressure injury persistent non-blanchable deep red, maroon or purple discoloration, status not healed, 3 cm x 5 cm with an area of 15 sq cm with a scant amount of serosanguineous drainage, wound was deteriorating; wound #3, status not healed, 13 cm x 12.3 cm with an area of 84 sq cm with a moderate amount of serosanguineous drainage, wound bed had 76-100% granulation, 1-25% slough, the wound was deteriorating;

During an interview on 03/16/25 at 2:05 P.M., Resident #4 said hospice came twice a week. Wound dressings were not changed daily, they were usually changed by the hospice nurse. Hospice changed them on Friday (03/14/25). He/She had wounds on his/her bottom, right heel, and right toe.

During an interview on 03/18/25 at 2:05 P.M., Licensed Practical Nurse (LPN) A said residents should be checked, and changed, and repositioned at least every two hours. Wound care should be completed per physician's order.

During an interview on 03/18/25 at 2:15 P.M., the DON said hospice was with the resident yesterday and should have changed the dressings. The dressings were to be changed at least daily. Hospice staff was not the only one's that did wound care for Resident #4.

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F 684	Continued From page 27 During an interview on 03/19/25 at 10:24 A.M., the DON said she observed the resident's wound dressing to the right foot, to see when it was last completed. The wound dressing was dated 03/17/25. She said the resident's Medication Administration Record (MAR) showed the dressing was changed on 03/18/25 and 03/19/25. During an interview on 03/19/25 at 1:10 P.M., the DON said the hospice coordinated plan of care should address wound and catheter care, which staff was going to do what, what equipment or care was required, and anything personal to the resident's situation. The facility's care plans should address hospice, wounds, catheters, and should be personalized for each resident. During an interview on 03/19/25 at 1:15 P.M., the Administrator said bed bound residents should be checked and repositioned every two hours and the policy was before and after meals and throughout night. Physician orders should be followed. Care plans should cover wounds, hospice, and oxygen. Hospice coordinated plan of care should cover that too.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to obtain an order for use of a continuous positive airway pressure machine (CPAP - a machine that uses mild air pressure to keep breathing airways open during sleep) and failed to follow physician's order for continuous oxygen for one resident (Resident #4) out of three sampled residents. The facility's census was 40.

Review of the facility's policy titled, "Oxygen Administrator," revised October 2002, showed:
- Verify that there is a physician's order.

The facility did not provide a policy regarding CPAP use.

1. Review of Resident #4's medical record showed:
- Admission date of 02/10/25;
- Diagnoses of protein calorie malnutrition and heart failure (heart doesn't pump blood like it should).

Review of the resident's Physician's Order Sheet (POS), dated March 2025, showed:
- An order for oxygen at 2 liters per minute via nasal cannula (a tube delivering oxygen to a person's nose) continuous, every shift for oxygen, dated 02/13/25;
- No order for a CPAP.

Review of the residents admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 02/18/25, showed:
- Oxygen not used;
- CPAP not used.

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Review of the resident's Care Plan, dated 02/20/25, showed:
- Resident had oxygen therapy related to ineffective gas exchange with interventions to change the resident's position every 2 hours to facilitate lung secretion movement and drainage. Resident to wear oxygen at 2 liters per minute via nasal cannula continuously;
- Did not address the use of a CPAP machine or the settings.

Observations of the resident showed:
- On 03/16/25 from 12:02 P.M. - 2:59 P.M. and on 03/17/25 from 8:35 A.M. to 2:01 P.M., the resident lay in bed on his/her back and not wearing the oxygen. The oxygen concentrator sat in the corner to the right of the bed with an undated nasal cannula draped over the top of the oxygen concentrator. A CPAP machine sat on the nightstand to the left of the bed with the mask draped over the nightstand;
- On 03/18/25 at 8:33 A.M., the resident lay in bed on his/her back, wearing the CPAP mask, and the CPAP machine on;
- On 03/18/25 at 11:05 A.M., the resident lay in bed on his/her back and not wearing the oxygen. The oxygen concentrator sat in the corner to the right of the bed with an undated nasal cannula in a bag on the concentrator. A CPAP machine sat on the nightstand to the left of the bed with the mask draped over the nightstand;
- On 03/18/25 at 1:41 P.M., the resident lay in bed and not wearing the oxygen. Certified Medication Technician (CMT) I checked the resident's oxygen saturation which was 88% on room air with the resident's breathing unlabored. CMT I reported to the resident's oxygen saturation to the nurse and the nurse checked the physician

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orders. The oxygen was placed on the resident via nasal cannula at 2 liters per minute. CMT I rechecked the residents oxygen saturation at 1:45 P.M., and it was 97% on the 2 liters of oxygen.

During an interview on 03/18/25 at 2:05 P.M., Licensed Practical Nurse (LPN) A said he/she would follow a physician's order for oxygen. If the order was for continuous oxygen, he/she would expect the oxygen to always be on the resident. The resident should be checked for wearing the oxygen at least once a shift, but should be looked at by staff when walking by rooms, going into rooms, and when providing care. Residents on oxygen should have oxygen saturation checked at least once a shift. Oxygen tubing should be dated and changed weekly, and stored on the machine in a bag when not in use. There should be an order for a CPAP.

During an interview on 03/18/25 at 2:15 P.M., the Director of Nursing (DON) said she would expect a physician's orders to be followed. If the order was for continuous oxygen, then oxygen should be on the resident continuously. The resident's oxygen should be monitored during rounds and oxygen saturation should be checked every shift, unless the order specified otherwise, or the resident was having an episode of shortness of breath. There should be a physician's order for CPAP use and the order should show the settings. Oxygen tubing should be changed once a week, and tubing should be dated. The CPAP should be filled with distilled water when needed, cleaned by the nurse, and the mask and tubing should be stored in a bag with the resident's name when not in use.

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F 695	Continued From page 31 During an interview on 03/19/25 at 1:15 P.M., the Administrator said physician's orders should be followed for oxygen use and should have an order for a CPAP.	F 695		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through	F 728		

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satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure four nurse aides (NAs) (NA B, NA D, NA F and NA G) out of four sampled NAs, completed a nurse aide training program within four months of his/her employment at the facility. The facility's census was 40.

Review of the facility's policy titled, "Nurse Aide Orientation," revised October 2017, showed:
- All newly hired nurse aides must attend an orientation program within their first five days of employment;
- The orientation program is not a part of the 75 hour training program and must be completed before the nurse aide begins the training course;
- The policy didn't address the time frame the NA must complete the nurse aide training.

1. Review of NA B's personnel file showed:
- A hire date of 03/16/24;
- NA B completed the nurse aide program, but did not test;
- The facility failed to ensure the completion of the program within four months of the hire date.

2. Review of NA D's personnel file showed:
- A hire date of 07/05/23;
- NA D completed the nurse aide program, but did not test;
- The facility failed to ensure the completion of the program within four months of the hire date.

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F 728	Continued From page 33 3. Review of NA F's personnel file showed: - A hire date of 10/01/24; - NA F completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. 4. Review of NA G's personnel file showed: - A hire date of 10/02/24; - NA F completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. During an interview on 03/19/25 at 11:18 A.M., NA G said he/she started working at the facility as a NA at the start of October 2024. He/She didn't start NA classes until January 2025. He/She finished the classes and was waiting to test. During an interview on 03/19/25 at 9:55 A.M., NA D said he/she had started working as a NA a few years ago. He/She didn't start NA classes until January, 2025. He/She finished the classes and was waiting to test. During an interview on 03/19/25 at 11:30 A.M., the Director of Nursing (DON) said NA B, NA D, NA F, and NA G were working in NA positions. During an interview on 03/19/25 at 12:10 P.M., the Administrator said she expected NAs to be certified within four months of hire. The facility had NAs ready to test and the previous administration didn't make that a priority.	F 728		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	F 865		

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F 865	Continued From page 34 §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be	F 865		

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ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and

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prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to implement a Quality Assurance and Performance Improvement Plan (QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved.) The facility census was 40.

Review of the facility's policy titled, "Quality Assurance and Performance Improvement Program," dated February 2020, showed:
- The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven

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F 865	Continued From page 37 QAPI program that is focused on indicators of the outcomes of care and quality of life for residents; - The owner and/or governing board of the facility is ultimately responsible for the QAPI program; - The QAPI plan is presented to the state survey agency annually during the recertification survey, and as requested during any other survey. Review showed the facility did not have a QAPI plan implemented containing how they will identify and correct their quality deficiencies, track and measure performance, and establish goals and thresholds for performance measurements. During an interview on 03/19/25 at 12:00 P.M., the Administrator said he just started in January 2025. The facility had the QAPI program shell and policy and procedures in place to follow. He did not have the program up and running yet.	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		

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§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems

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level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The facility census was 40.

Review of the facility's policy titled, "Quality Assurance and Performance Improvement Program," dated February 2020, showed:
- The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents;
- The owner and/or governing board of the facility is ultimately responsible for the QAPI program;

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F 867	Continued From page 41 - The QAPI plan is presented to the state survey agency annually during the recertification survey, and as requested during any other survey; The facility did not provide a policy for Performance Improvement Plans (PIPs). Review showed no documentation the facility maintained the minimum required documentation for a QAPI plan or PIPs. During an interview on 03/19/25 at 12:08 P.M., the Administrator said the QAA/QAPI program shell and policy and procedures were in place to follow. The program was not up and running yet. The facility did not have documentation of the QAPI program so no previous PIPs were in place. The Administrator started in January 2025. During an interview on 03/19/25 at 1:20 P.M., the Director of Nursing (DON) said she thought she saw a book with PIPs and but didn't know where it was located.	F 867		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868		

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§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:
(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.

§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to maintain quarterly Quality Assessment and Assurance/Quality Assurance and Improvement Program (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee meetings with the required members. The facility census was 40.

Review of the facility's policy titled, "Quality Assurance and Performance Improvement Program," dated February 2020, showed:

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F 868	Continued From page 43 - The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents; - The owner and/or governing board of the facility is ultimately responsible for the QAPI program; - The QAPI plan is presented to the state survey agency annually during the recertification survey, and as requested during any other survey; - The QAPI committee reports directly to the administrator; - The QAPI committee oversees implementation of the QAPI plan; - The committee meets monthly to review reports, evaluate data, and monitor QAPI - related activities and make adjustments to the plan; - Did not address who the required committee members should be. Review showed no documentation the facility maintained the minimum required quarterly QAA/QAPI meetings with the required members. During an interview on 03/19/25 at 12:08 P.M., the Administrator said the QAA/QAPI program shell and policy and procedures was in place to follow. The the program was not up and running yet. Therefore, these was no committee to meet until it was implemented. The Administrator started in January 2025.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify 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.

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F 880	Continued From page 45 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during catheter (a tube inserted into the bladder to drain urine) care for one resident (Resident #4) out of one sampled resident, wound care for three residents (Residents #4, #19, and #33) out of three sampled residents, and incontinent care for two residents (Resident #4 and #34) out of three sampled residents. The facility failed to ensure proper enhanced barrier precautions (EBP) were utilized for three residents (Residents #4, #19, and #33) and to have dedicated disposable supply items for two residents (Residents #4 and #34) out of three sampled residents on EBP. The facility also failed to correctly screen five residents (Residents #2, #4, #9, #25, and #34) for	F 880		

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tuberculosis (TB - an infectious disease characterized by the growth of nodules in the tissues, especially the lungs) out of five sampled residents required by state regulation 19 CSR 20-20.100 . The facility census was 61.

The facility did not provide an EBP policy.

Review of the facility's policy titled, "Catheter Care, Urinary," revised August 2022, showed:
- Wash and dry your hands thoroughly;
- If using bathing wipes, open the package;
- Place the wash basin or wipes on the bedside stand within easy reach.;
- Put on gloves;
- Use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward;
- Secure the catheter with a catheter securement device;
- Check the drainage tubing and bag to ensure the catheter is draining properly;
- Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly.

Review of the facility's policy titled "Wound Care," revision October 2010, showed:
- Use disposable cloth (paper towel is adequate) to establish a clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field;
- After completion of the wound care: use the clean field saturated with alcohol to wipe the overbed table; wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor

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blades, etc.); return the reusable supplies to resident's drawer in the treatment cart;
- Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart.

Review of the facility's policy titled, "Screening Residents for Tuberculosis," revised August 2019, showed:
- This facility shall screen all residents for TB infection and disease;
- The admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB;
- If a potential resident has been exposed to active TB or is at increased risk of TB infection, he/she will be screened for latent tuberculosis infection (LTBI) using tuberculin skin test (TST) or interferon gamma release assay (IGRA);
- Screening of new admissions or readmissions for TB infection and disease is in compliance with state regulations;
- The facility will conduct an annual risk assessment to determine the risk of exposure;
- Residents who have health conditions or take medications that predispose them to developing active TB disease, once infected, are tested regularly according to their exposure risk assessment.

1. Observation on 03/17/25 at 1:43 P.M., of Resident #4's catheter care showed:
- EBP signage on the door frame;
- Certified Nursing Assistant (CNA) H entered the resident's room, did not put on a gown, did not perform hand hygiene, and put on gloves;
- CNA H exited the room, did not remove gloves, did not perform hand hygiene, and retrieved

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wipes from Resident #34's room with EBP signage on the door frame;
- CNA H did not remove the gloves, did not perform hand hygiene, and re-entered the resident's room;
- CNA H did not remove the gloves, did not perform hand hygiene, and performed the resident's catheter care;
- CNA H removed the gloves, did not perform hand hygiene, and touched the resident's blanket;
- CNA H did not perform hand hygiene, exited the resident's room, took the trash to the dirty utility closet, walked to the medication room and touched the door knob, walked back to the resident room, and performed hand hygiene;
- CNA H failed to have dedicated disposable supplies for the resident on EBP.

During an interview on 03/17/25 at 1:50 P.M., CNA H said hands should be sanitized when entering a resident room, when leaving a room, and when going from dirty to clean care.

2. Observation on 03/17/25 at 1:51 P.M., of Resident #34's incontinent care showed:
- EBP signage on the door frame;
- CNA H entered the resident's room, put on gloves, did not perform hand hygiene, and did not put on a gown;
- CNA H exited the room, did not remove gloves, did not perform hand hygiene, and retrieved wipes from Resident #4's room with EBP signage on the door frame;
- CNA H did not remove the gloves, did not perform hand hygiene, and re-entered the resident's room;
- CNA H did not remove the gloves, did not perform hand hygiene, and performed the resident's incontinent care;

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F 880	Continued From page 49 - CNA H failed to have dedicated disposable supplies for the resident on EBP. 3. Observation on 03/17/25 at 2:01 P.M., of Resident #4's wound care treatment, incontinent care, and catheter care showed: - EBP signage on the door frame; - Licensed Practical Nurse (LPN) A entered the resident's room, did not put on a gown, did not perform hand hygiene, and put on gloves; - CNA G entered the room, did not put on a gown, did not perform hand hygiene, did not put on gloves, and exited the room; - CNA G did not put on a gown, did not perform hand hygiene, did not put on gloves, and entered Resident #34's room;34's room with EBP signage on the door frame; - CNA G retrieved a package of wipes, did not perform hand hygiene, and exited the room; - CNA G re-entered Resident #4's room, did not put on a gown, did not perform hand hygiene, and put on gloves; - LPN A performed the wound care treatment; - LPN A held the resident on his/her side and CNA G cleaned the resident's buttocks, removed the gloves, performed hand hygiene, and put on gloves; - LPN A changed gloves, performed hand hygiene, and rolled the resident to his/her back; - CNA G cleaned the resident's front peri area, changed gloves, performed hand hygiene, and wiped the catheter toward the insertion point during catheter care; - LPN A put a clean brief on the resident, pulled up the blanket, removed the gloves, and performed hand hygiene; - CNA G removed the gloves, did not perform hand hygiene, picked up the trash, took the trash down the hall to the dirty utility closet, and	F 880		

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performed hand hygiene.

During an interview on 03/19/25 at 11:15 A.M., LPN A said hands should be sanitized when walking into a resident room, leaving, in between care, when changing gloves, and when going from dirty to clean tasks. The catheter should be cleaned away from the insertion point. Supplies shouldn't be shared between residents.

During an interview on 03/19/25 at 12:00 P.M., CNA G said hands should be sanitized when walking into a resident room, leaving, in between care, when changing gloves, and when going from dirty to clean tasks. The catheter should be cleansed away from insertion point.

4. Observation on 03/18/25 at 2:43 P.M., of Resident #19's wound care showed:
- EBP signage on the door frame;
- The Director of Nursing (DON) and LPN A did not put on a gown and entered the resident's room with the wound care supplies;
- LPN A put the shared wound care supplies, which included a roll of tape and a bottle of wound cleanser, on the bed without a clean barrier;
- The DON and LPN A performed hand hygiene and put on gloves;
- LPN A performed the wound care treatment;
- LPN A removed the gloves and performed hand hygiene;
- LPN A picked up the roll of tape and the wound cleanser, did not cleanse them, and put them back into the treatment cart.

5. Observation on 03/18/25 at 2:49 P.M., of Resident #4's wound care treatments showed:
- EBP signage on the door frame;

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- LPN A and CNA H entered the resident's room and did not put on gowns;
- CNA H and LPN A performed hand hygiene and put on gloves;
- LPN A placed the wound care supplies, which included a container of Medihoney (a type of wound treatment); a roll of tape; and a bottle of wound cleanser, on the unsanitized bedside table and without a clean barrier;
- LPN A performed the wound care treatments;
- LPN A removed the gloves and performed hand hygiene;
- LPN A picked up the Medihoney container, the roll of tape, and the wound cleanser bottle, did not cleanse them, and put them back into the treatment cart.

6. Observation on 03/18/25 at 3:02 P.M., of Resident #33 wound care treatment showed:
- EPB signage on the door frame;
- LPN A did not put on a gown and entered the room;
- LPN A performed hand hygiene and put on gloves;
- LPN A placed the wound care supplies, which included a container of Medihoney; a roll of tape; and a bottle of wound cleanser, on the unsanitized bedside table and without a clean barrier;
- LPN A cleansed the wounds and sat the wound cleanser bottle on the floor;
- LPN A changed gloves, performed hand hygiene, and used the scissors that lay on the bed without a clean barrier to cut the PolyMem (a type of wound dressing), and placed the scissors back on the bed without a clean barrier;
- LPN A performed the wound care treatments;
- LPN A removed the gloves, performed hand hygiene, picked up the scissors from the bed

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without a clean barrier, and put them into his/her clothes pocket;
- LPN A picked up the Medihoney container, the roll of tape, and the wound cleanser bottle, did not cleanse them, and put them back into the treatment cart.

7. Review of Resident #2's medical record showed:
- Admit date of 07/06/24;
- TB first step TST, dated 08/20/24, with a result of 0 millimeters (mm) and no read date.

8. Review of Resident #4's medical record showed:
- Admit date of 02/10/25;
- No documentation of an admission TST or screening completed.

9. Review of Resident #9's medical record showed:
- Admit date of 12/15/22;
- No documentation of an annual TST or screening completed.

10. Review of Resident #25's medical record showed:
- Admission dated of 11/02/22;
- No documentation of an annual TST or screening completed.

11. Review of Resident #34's medical record showed:
- Admission dated of 07/18/23;
- No documentation of an annual TST or screening completed.

During an interview on 03/19/25 at 11:50 P.M., the DON said hands should be sanitized when

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F 880	Continued From page 53 entering a resident room, leaving, between care, when going from dirty to clean tasks, and between glove changes. Wound supplies should not be placed on a resident bed or bedside table, but on a clean area. Gloves should be changed between care and when going from dirty to clean tasks. Catheters should be cleaned away from the insertion point. A resident should receive a two step TB. One upon admission and the second three weeks later. A TST should be read within 72 hours of administration. EBP should be worn when providing care for a resident with wounds, catheters, and any other indwelling devices. She expected the staff to not share supplies between residents, especially when they were on EBP. During an interview on 03/19/25 at 12:15 P.M., the Administrator said he expected staff to follow policy and procedure regarding infection control, catheter care, administration of TB, and EBP.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an Infection Prevention and Control Program (IPCP) that included an	F 881		

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antibiotic stewardship program to include an infection surveillance program and antibiotic use protocols. The facility failed to identify an appropriate indication for use of an antibiotic for one resident (Resident #19) out of one sampled resident who was currently being treated with an antibiotic. This deficient practice had the potential to affect all residents in the facility. The facility census was 40.

Review of the facility's policy titled, "Antibiotic Stewardship," revised December 2016, showed:
- Antibiotics will be prescribed and administered to the residents under the guidance and the facility's Antibiotic Stewardship Program;
- The purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics in the residents.

Review of the Antibiotic Stewardship Program binder showed:
- Incomplete documentation related to the appropriate indication of antibiotic use;
- Did not include lab reports/findings.

Review of the facility's Matrix (a listing of all facility residents), dated 03/17/25, showed:
- Five residents currently received antibiotics.

1. Review of Resident #19's Physician Order Sheet, dated March 2025, showed:
- An order for doxycycline hyclate (an antibiotic medication) 100 milligram (mg) by mouth one time a day for wound infection for 10 days, start date of 3/12/25;
- An order for Flagyl (an antibiotic medication) 500 mg by mouth two times a day every 7 day(s) for diarrhea related to unspecified infectious disease 03/14/2025, start date of 03/07/25.

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Review of the resident's Nurse's Notes showed:
- On 03/10/25 at 10:00 A.M., the resident complained of increased pain and not feeling well overall. Requested to be sent to the emergency department for evaluation. Emergency Medical Services arrived at at the facility to transport the resident to the hospital;
- On 03/11/25 at 9:16 A.M., the resident continued to be monitored for antibiotic use related to loose fecal material. The resident had a general complaint of not feeling well;
- On 03/12/25 at 9:26 A.M., the resident continued to be monitored for antibiotic use related to loose fecal material and cellulitis (a skin infection). The resident had no signs and symptoms of adverse reaction and no complaints of pain or discomfort;
- On 03/12/25 at 9:39 P.M., the resident continued on an antibiotic for wound infection and no adverse reactions noted at this time;
- On 03/13/25 at 5:35 A.M., the resident continued to be monitored related to the antibiotic use. The wound was weeping (the release of fluids from the tissue) and an odor noted. The resident complained of not feeling well. Redness noted to the thigh and abdomen. Resident continued on Flagyl and doxycycline. The resident had no further complaint of loose fecal material.

During an interview on 03/18/25 at 2:50 P.M., the Director of Nursing (DON) said Resident #19 didn't have a stool culture for the Flagyl. The resident took Senna (stool softener) and started having diarrhea. They stopped the Senna and the diarrhea stopped. The Flagyl order came from the medical director for the diarrhea. The resident was started on doxycycline from the hospital for a wound infection on the leg. They

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F 881	Continued From page 56 did not have a would culture or the hospital records to show if one was completed. During an interview on 03/19/25 at 12:20 P.M., the Administrator said he would expect the facility to follow policy and procedures for an ICPC. Cultures and labs should be done as ordered and as expected with standard practice. Hospital records should be followed up on.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		

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§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to document pertinent education provided to the resident or the resident's representative regarding benefits, side effects, or warnings of the influenza (a viral respiratory infection) vaccine for four residents (Residents #2, #4, #25, and #34) and for the pneumococcal (an infectious lung disease) vaccine for three residents (Residents #4, #25, and #34) and administered the pneumococcal vaccine to one resident (Resident #2) who refused the vaccine out of five

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F 883	Continued From page 58 sampled residents. The facility's census was 40. Review of the facility's policy titled, "Influenza Vaccine," revised March 2022, showed: - All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza; - The facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or residents' legal representatives); - Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents, unless the vaccine is medically contraindicated or the resident has already been immunized; - Residents admitted between October 1st and March 31st shall be offered the vaccine five working days of the resident's admission to the facility; - Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record; - For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the resident's medical record; - A resident's refusal of the vaccine shall be documented on the informed consent for the influenza vaccine and placed in the resident's medical record; - Residents may obtain their influenza vaccines from their personal physicians. Documentation of	F 883		

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previous vaccinations should be provided to the facility.

Review of the facility's policy titled, "Pneumococcal Vaccine," revised March 2022, showed:
- All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections;
- Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated;
- Assessments of pneumococcal vaccination status are conducted within five working days of the resident's admission if not conducted prior to admission;
- Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record;
- Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination;
- For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record.

1. Review of Resident #2's medical record showed:
- Admission date of 07/06/24;

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- Influenza vaccination administered on 10/27/24;
- Refusal of the pneumoccoccal vaccine, dated 01/23/23;
- Prevnar 20 (pneumococcal vaccination), administered 01/26/23;
- No documentation the facility provided information, education, and received consent for the influenza vaccination;
- Facility provided the pneumococcal vaccination after the refusal for the pneumonia vaccine was given.

2. Review of Resident #4's medical record showed:
- Admission date of 02/10/25;
- No documentation the facility provided information and education for the influenza or pneumococcal vaccinations;
- No documentation of consent or refusal for the influenza or pneumococcal vaccinations;
- No documentation the influenza or the pneumococcal vaccinations were administered or refused.

3. Review of Resident #25's medical record showed:
- Admission date of 11/09/22;
- No documentation the facility provided information and education for the influenza or pneumococcal vaccinations in 2024 and 2025;
- No documentation of the consent or refusal for the influenza or pneumococcal vaccinations in 2024 and 2025;
- No documentation the influenza or the pneumococcal vaccinations were administered in 2024 and 2025.

4. Review of Resident #34's medical record showed:

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F 883	Continued From page 61 - Admission date of 07/18/23; - Influenza vaccination administered on 10/27/24; - No documentation the facility provided information and education for the influenza or pneumococcal vaccinations; - No documentation of consent or refusal for the influenza or pneumococcal vaccinations; - No documentation the pneumococcal vaccinations had been administered or refused. During an interview on 03/19/25 at 1:23 P.M., the Director of Nursing (DON) said vaccinations were offered on admission, annually, and when the facility provided them. The residents and/or resident's representatives received the risks, benefits, education, and consent forms to show acceptance or declination of the vaccinations.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;	F 887		

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F 887	Continued From page 62 (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 887		

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failed to ensure the COVID-19 (an infectious disease caused by a virus that could cause some people to become seriously ill and require medical attention) vaccination was offered, administered, or refused by the resident and/or resident's representative for three residents (Residents #2, #4 and #34) out of five sampled residents. The facility's census was 40.

Review of the facility's policy titled, "Coronavirus Disease (COVID-19) - Vaccination of Residents," revised May 2023, showed:
- Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated;
- COVID-19 vaccine education, documentation, and reporting are overseen by the infection preventionist (IP) and coordinated by his or her designee;
- Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risk, and potential side effects associated with the vaccine;
- Information is provided to the resident in a format and language that is understood by the resident or representative;
- Residents must sign a consent to vaccinate form prior to receiving the vaccine;
- A vaccine administration record is provided to the resident and a copy is filed in the resident record;
- The resident's medical record includes documentation that indicates, at a minimum, the following: the resident or resident representative was provided education regarding the benefits and potential risk associated with COVID-19 vaccine, including the samples of the educational materials used, the date the education took place, and the name of the individual who received the

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education; signed consent; and each dose of COVID-19 vaccine that was administered to the resident;
- If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination, or refusal, appropriate documentation is made in the residents record.

1. Review of Resident #2's medical record showed:
- Admission date of 07/06/24;
- Diagnoses of metabolic encephalopathy (an alteration of brain function resulting from other internal organ failure), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), hypertension (high blood pressure), major depressive disorder (MDD - long-term loss of pleasure or interest in life), panic disorder (repeated, unexpected panic attacks and worry constantly about when the next one might happen), anxiety disorder (persistent worry and fear about everyday situations), and hearing loss;
- No documentation the COVID-19 vaccination education was provided;
- No documentation the COVID-19 vaccination was administered or refused.

2. Review of Resident #4's medical record showed:
- Admission date of 02/10/25;
- Diagnoses of hematogenous osteomyelitis (a type of bone infection), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and

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dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning);
- No documentation the COVID-19 vaccination education was provided;
- No documentation the COVID-19 vaccination was administered or refused.

3. Review of Resident #34's medical record showed:
- Admission date of 07/18/23;
- Diagnoses of Alzheimer's disease (progressive mental deterioration), cerebral infarction (a stroke), atrial fibrillation (heart beats out of rhythm), and hypertension;
- No documentation the COVID-19 vaccination education was provided;
- No documentation the COVID-19 vaccination was administered or refused.

During an interview on 03/19/25 at 1:23 P.M., the Director of Nursing (DON) said the COVID-19 vaccinations were offered on admission, annually, and/or when the facility provided them. The residents and/or the resident's representatives received the risk and benefits and education and consent forms to show to accept or decline the vaccination.

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08027	A. BUILDING: _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENT B TINNIN MANOR	220 EUEL POLK DRIVE ELLINGTON, MO 63638

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4017	19 CSR 30-85.042(17) Criminal Background Check Request Effective August 28, 1997, each facility shall, not later than two (2) working days of the date an applicant for a position to have contact with residents is hired, request a criminal background check, as provided in sections 43.530, 43.540 and 610.120, RSMo. Each facility must maintain in its record documents verifying that the background checks were requested and the nature of the response received for each such request. The facility must ensure that any applicant who discloses prior to the check of his/her criminal records that he/she has been convicted of, plead guilty or nolo contendere to, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, will not be allowed to work in contact with patients or residents until and unless a check of the applicant ' s criminal record shows that no such conviction occurred. II/III This regulation is not met as evidenced by: Class III Refer to F607.	A4017		
A4023	19 CSR 30-85.042(21)(A) NA Training Complete In 4 mos All nursing assistants shall successfully complete the entire basic course (including passing the final examination) of the nursing assistant training program and be certified within four (4) months of employment. II/III This regulation is not met as evidenced by:	A4023		

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A4023	Continued From page 1 Class III Refer to F728.	A4023		
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 F684 and F695.	A4075		
A4078	19 CSR 30-85.042(69) Reposition Every 2 hr/Maintain Body Alignment Residents who are physically or mentally incapable, or both, of changing their own positions shall have their positions changed at least every two (2) hours and shall be provided supportive devices to maintain good body alignment. I/II This regulation is not met as evidenced by: Class II Refer to F684.	A4078		
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 2 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		
A8008	19 CSR 30-88.010(8) Informed Services/Charges - Alz Disclosure Prior to or at the time of admission and during his or her stay in the facility, each resident and/or his or her next of kin, legally authorized representative or designee shall be fully informed, in writing, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or federal or state programs. Information shall include procedures to be followed by the facility in cases of medical emergency, including transfer agreements and costs. All residents who receive treatment in an Alzheimer's special care program or unit and their next of kin, legally authorized representatives or designees shall be given a copy of the Alzheimer's Special Care Services Disclosure Form at the time of admission. Residents also shall be informed of services outside the facility which may reasonably be made available to the resident and of any reasonable estimate of any foreseeable costs connected with those services. II/III This regulation is not met as evidenced by:	A8008		

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A8008	Continued From page 3 Class III Refer to F582 and F625.	A8008		
A8018	19 CSR 30-88.010(18) Emergency Discharges In emergency discharge situations the facility shall submit to the resident and his or her next of kin, legally authorized representative or designee a written notice of discharge. The written notice of discharge shall be given as soon as practicable and advise the resident of the right to request an expedited hearing. In the event that there is no next of kin, legally authorized representative or designee known to the facility, the facility shall send a copy of the notice to the appropriate regional coordinator of the Missouri State Ombudsman's office. II/III This regulation is not met as evidenced by: Class III Refer to F623.	A8018		
A9023	19 CSR 30-88.020(14) Resident Fund Bond Requirements The bond required by section 198.096, RSMo, for operators holding personal funds of residents shall be in a form approved by the department and shall provide that residents who allege that they have been wrongfully deprived of moneys held in trust may bring an action for recovery directly against the surety. The bond shall be in an amount equal to at least one and one-half (1 1/2) times the average monthly balance of the residents ' personal funds, including residents ' petty cash, or the average total of the monthly balances for the preceding twelve (12) months.	A9023		

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A9023	Continued From page 4 The average monthly balance(s) or the average total of the monthly balance(s) shall be rounded to the nearest one thousand dollars ($1,000). One (1) bond may be used to cover the residents ' funds in more than one (1) facility operated by the same operator, if the facility is a multilicensed facility on the same premises. If not on the same premises, then one (1) bond may be used if the bond specifies the amount of coverage provided for each individual facility and the coverage for each facility is a minimum of one thousand dollars ($1,000). II/III This regulation is not met as evidenced by: Class III Refer to F570	A9023		

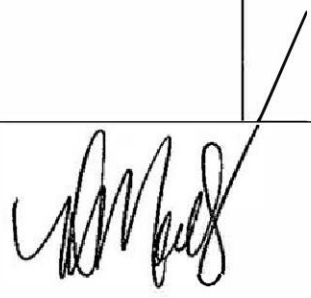
PLAN OF CORRECTION

Provider/Supplier Name:	BRENT B TINNIN MANOR
Street Address, City, Zip:	220 EUEL POLK DRIVE ELLINGTON, MO 63638
Date of Survey:	03/19/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265472

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 is submitted as required under the State Law. The submission of this plan does not constitute an admission on the part of **Brent B Tinnin Manor** as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding any of the deficiencies cited are correctly applied. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil action or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility. Any changes to the facility policies and procedures should be considered to be subsequent remedial measures as that employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction with completion dates as our written credible allegation of compliance.	

F 570	**Surety Bond-Security of Personal Funds** **CFR(s): 483.10(f)(10)(vi)** The facility will maintain the surety bond (a purchased bond for the security of residents' personal funds) for at least one and one-half times the average monthly balance, to ensure protection of the residents' personal funds for the last 12 consecutive months from April 2024 through March 2025. On 3/20/2025, the facility Administrator educated the facility Bookkeeper regarding Resident Bond Fund Requirements. The Resident Trust Fund balance was decreased to meet the surety bond requirement of $ 51,000. To monitor compliance, the Administrator or designee will review the surety bond monthly for 6 months and document findings for Morning QA Meetings, then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 6 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025



F 582	**Medicaid/Medicare Coverage/Liability Notice** **CFR(s): 483.10(g)(17)(18)(i)-(v)** The facility will properly document notification and obtain a signature of the resident or legal representative for Residents #2, #36, and #51, and all other residents of the facility, on the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms prior to the facility discharging the resident from Medicare services. On 3/20/2025, the Social Service Designee (SSD) was educated by the Administrator regarding accurately and fully completing the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN). The forms to include the reason why Medicare might not pay and the estimated cost to the resident and obtain the signature of the resident or legal representative. The SSD will log each resident that is assessed to end Medicare coverage to ensure the proper notification is submitted (NOMNC and SNFABN) with the correct information. To monitor compliance, the Admin. or designee will review the NOMNC and SNFABN log each week for 6 weeks in Morning QA Meetings, then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025

F 607	**Develop/Implement Abuse/Neglect Policies** **CFR(s): 483.12(b)(1)(5)(ii)(iii)** The facility will follow our policy and procedure to complete Criminal Background Checks (CBC) for Employees A, B, C, and D, and all other potentially hired employees, and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused, neglected, and/or misappropriated funds or property from a resident) prior to the hire date for Employees A and B, and all other employees, going forward. On 3/25/2025, the Administrator educated the Business Office Manager and all other department managers regarding their policy and procedure to complete Criminal Background Checks (CBC) and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused, neglected, and/or misappropriated funds or property from a resident) prior to the hire date. On 4/11/24, the Business Office Manager completed CBC and EDL checks for Employees A, B, C, and D and for all other employees that were found to not have them completed. To maintain compliance the Business Office Manager will utilize a tracking log to ensure CBC and EDL checks are completed for all newly hired employees prior to their date of hire. To monitor compliance, the Admin. or designee will review the New Hire log weekly for 6 weeks in Morning QA Meetings, then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025

F 623	**Notice Requirements Before Transfer/Discharge** **CFR(s): 483.15(c)(3)-(6)(8)** The facility will provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party for Residents #5, # 9, #34, #36, and #45 and all other residents going forward. On 3/25/2025 and dates thereafter, the DON educated the licensed staff regarding to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party for all residents at time of discharge. On 3/25/25, the Notice of Transfer forms were placed in a folder accessible to nursing staff to complete and submit to residents upon discharge. Once the form is completed, a copy will be submitted to SSD to mail to the resident's responsible party and/or place in the resident's medical record. To monitor compliance, SSD will utilize a tracking log to ensure a Notice of Transfer is completed and submitted to the resident and/or responsible party as time of discharge. To monitor compliance, the Admin./DON or designee will review the Notice of Transfer log daily during weekdays, for 6 weeks in Morning QA Meetings, then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025

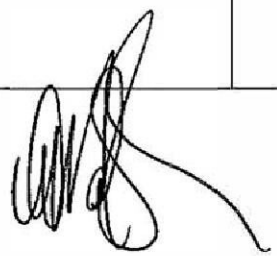


F 625	**Notice of Bed Hold Policy Before/Upon Trnsfr** **CFR(s): 483.15(d)(1)(2)** The facility will provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of the transfer to the hospital for Residents #2, #5, #9, #34, #36, and #45 and all other residents going forward. On 3/25/2025, the DON educated the licensed staff regarding to provide a written copy of the Bed hold to the resident and/or the resident's responsible party for all residents at time of discharge. On 3/25/25, the Bed Hold forms were placed in a folder accessible to nursing staff to complete and submit to residents upon discharge. Once the form is completed, a copy will be submitted to SSD to mail to the resident's responsible party and/or place in the resident's medical record. To monitor compliance, SSD will utilize a tracking log to ensure a Bed Hold is completed and submitted to the resident and/or responsible party as time of discharge. To monitor compliance, the Admin. or designee will review the Bed Hold log weekly for 6 weeks in Morning QA Meetings, then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025

F 637	**Comprehensive Assessment After Signifcant Chg** **CFR(s): 483.20(b)(2)(ii)** The facility will complete a significant change Minimum Data Set (MDS) assessment within 14 days of admission to hospice services for Resident #4, and all resident's who require a significant change MDS assessment. On /2025, the MDS Coordinator was educated by the Administrator and DON regarding completing a significant change Minimum Data Set (MDS) assessment within 14 days of admission to hospice services for Resident #4, and all residents who require a significant change MDS assessment. The Director of Nursing (DON) will meet with the MDS coordinator, daily (Monday- Friday) for 4 weeks followed by weekly for 4 weeks then monthly for 4 months, to ensure all significant change MDS' are completed timely (within 14 days of admission to hospice services). Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025

F 684	**Quality of Care** **CFR(s): 483.25** The facility will ensure Resident #4 has a completed hospice (palliative care for the terminally ill with a life expectancy of six months or less) coordinated plan of care, received the needed care and services in accordance with professional standards of practice by turning and repositioning, and to follow physician's orders for daily wound care treatments and a wound culture. The facility will monitor a valproic acid (an anticonvulsant medication) level for Resident #3 as ordered by the physician. On 4/2/2025, the Regional Consultant educated the DON and the MDS Coordinator regarding completing a hospice coordinated plan of care, to receive the needed care and services in accordance with professional standards of practice by turning and repositioning before and after meals and throughout night, and to follow physician's orders for daily wound care treatments and a wound culture. On 4/10/2025, the Education Coordinator, DON, and MDS Coordinator educated the nursing staff regarding completion of hospice coordinated care plans, turning and repositioning Resident #3 and all other residents of the facility, and to follow physician's orders for daily wound care treatments and to obtain wound cultures as physician prescribed. To monitor compliance, the DON and MDS Coordinator will review residents' needs hospice care and care planning needs in daily clinical meetings. The DON/designee will monitor to ensure residents receiving hospice services receives a coordinated plan of care, received the needed care and services in accordance with professional standards of practice by turning and repositioning, and to follow physician's orders for daily wound care treatments and a wound culture, weekly for 4 weeks then monthly thereafter in monthly QAPI meetings. To monitor compliance, the DON and/or designee will make rounds 3-5 times per week for 4 wk; then weekly thereafter to monitor appropriate dressing changes and turning and repositioning of all residents who cannot	5/2/2025

F 695	**Respiratory/Tracheostomy Care and Suctioning** **CFR(s): 483.25(i)** The facility will obtain an order for use of a continuous positive airway pressure machine (CPAP - a machine that uses mild air pressure to keep breathing airways open during sleep) and will follow physician's order for continuous oxygen for Resident #4 and all other residents of the facility with oxygen orders On 03/25/25, the DON educated the facility nurses regarding obtaining physician orders for use of a continuous positive airway pressure machine (CPAP - a machine that uses mild air pressure to keep breathing airways open during sleep) and to follow physician's order for continuous oxygen for Resident #4 and all other residents of the facility with oxygen orders. On 03/18/25, the order for CPAP settings were clarified and obtained by nursing staff then implemented as ordered. To monitor compliance DON and/or designee will make rounds 3-5 times per week for 2wk; then weekly thereafter to monitor appropriate residents with oxygen are receiving it as ordered by the physician. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	5/2/2025



	perform this task independently. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	



F 728	**Facility Hiring and Use of Nurse Aide** **CFR(s): 483.35(d)(1)-(3)** The facility will ensure four nurse aides (NAs) (NA B, NA D, NA F and NA G) complete a nurse aide training program within four months of his/her employment at the facility. NAs are currently enrolled in CNA classes will complete their training no later than 120 days after their hire date. On 3/20/24, the DON/Staff Coordinator were educated by the Administrator, regarding nurse aides completing their training no later than 120 days from their hire date or no longer provide direct resident care. DON and/or designee will monitor nurse aides in training hire date and class schedule to ensure they are completed by 120 days post hire date. For Quality Assurance: This process will be reviewed monthly at the QAPI meeting x 3 months and randomly thereafter until the committee deems it no longer necessary. Concerns identified will be addressed through education/re-education. Noncompliance issues will be addressed in the monthly QAPI with the administrator.	5/2/2025
F 865	**QAPI Prgm/Plan, Disclosure/Good Faith Attmpt** **CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)** The facility will implement a Quality Assurance and Performance Improvement Plan (QAPI).	5/2/2025



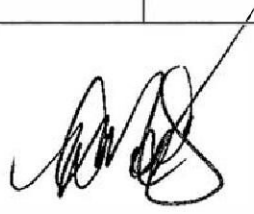
	On 3/20/25, the Regional Consultant educated the Administrator and DON regarding implementing the QAPI with their new leadership team, containing how they will identify and correct their quality deficiencies, track and measure performance, and establish goals and thresholds for performance measurements. The Administrator will be responsible to ensure the facility will develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents. To monitor compliance, the Administrator or designee will be present, review QAPI minutes an document findings monthly for 3 months then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	
F867	**QAPI/QAA Improvement Activities** **CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)** The facility will ensure the Quality Assessment and Assurance/Quality Assurance Performance Improvement	5/2/2025

	(QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. On 3/20/2025, the Regional Consultant educated the Administrator and DON regarding Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. The Administrator will be responsible to ensure the facility will develop, implement, and maintain an ongoing, facility-wide, Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI - services are maintained at acceptable levels of performance and continually improved) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. To monitor compliance, the Administrator or designee will be present, review the facility-identified Performance Improvement Plan (PIP) and document findings monthly for 3 months then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	
F868	**QAA Committee** **CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)** The facility will maintain a quarterly Quality Assessment and Assurance/Quality Assurance and	5/2/2025

	Improvement Program (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee meetings with the required members. On 3/20/2025, the Administrator and DON were educated regarding quarterly Quality Assessment and Assurance/Quality Assurance and Improvement Program (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee meetings and who the QAPI committee members shall be in attendance. The Administrator will be responsible to ensure the facility holds Quality Assessment and Assurance/Quality Assurance and Improvement Program (QAA/QAPI meetings at least quarterly with the following committee members present: The director of nursing services; The Medical Director or his/her designee; at least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and the infection preventionist. To monitor compliance, the Administrator or designee will review the attendance of members, including the signature page of the meeting minute document, during the QAPI meetings monthly for 3 months then randomly thereafter and will correct practices as needed. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	
F880	**Infection Prevention & Control** **CFR(s): 483.80(a)(1)(2)(4)(e)(f)** The facility will maintain proper infection control practices	5/2/2025

	during catheter care for Resident #4, wound care Residents #4, #19, and #33, and incontinent care for Resident #4 and #34 and all other residents of the facility if applicable. The facility will ensure proper enhanced barrier precautions (EBP) are utilized for Residents #4, #19, and #33 and all others identified to require such precautions and to have dedicated disposable supply items for Residents #4 and #34 on EBP. The facility will correctly screen Residents #2, #4, #9, #25, and #34 for tuberculosis required by state regulation. On 4/10/2025, the Staff Educator/Administrator /DON/ designee educated all staff on facility p/p for EBP On 4/8/2025, the DON/Infection Preventionist (IP) or designee will monitor/review residents to determine who qualifies for EBP, ensure proper signage, and PPE is utilized. To monitor compliance the DON/IP will make facility rounds 3-5 times per week for 4 weeks; then 3 times per week thereafter to ensure PPE is correctly worn for residents requiring EBP. To monitor compliance the Adm/DON/IP or designee will continue to monitor EBP in daily, clinical, weekly risk, and monthly QAPI. This will be an ongoing process until CMS updates and/or changes EBP guidelines Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	
F 881	**Antibiotic Stewardship Program** **CFR(s): 483.80(a)(3)** The facility will maintain an Infection Prevention and	5/2/2025

	Control Program (IPCP) that included an antibiotic stewardship program to include an infection surveillance program and antibiotic use protocols. The facility will identify an appropriate indication for use of an antibiotic for Resident #19 and all other residents of the facility requiring antibiotic usage. On 3/25/25 and thereafter, the DON and/or Infection Preventionist educated all nursing staff regarding maintaining an IPCP, including an antibiotic stewardship program that monitors infection surveillance and antibiotic use protocols. The facility identified an appropriate indication for the use of antibiotics for Resident # 19 and will continue to do so, for all residents going forward. DON/Designee will monitor (using audit form) lab orders, dates obtained, results obtained daily in clinical meetings to ensure orders are followed and our ABX Stewardship program is effective. The DON/IP/designee will document all infections, types, antibiotics, and where in facility, on facility layout map each month to track facility infections, every week. To ensure compliance, the DON will review ABX Stewardship tracking weekly for 4 weeks, and thereafter. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	
F 883	**Influenza and Pneumococcal Immunizations** **CFR(s): 483.80(d)(1)(2)** The facility will document pertinent education provided to the resident or the resident's representative	5/2/2025



	vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record. On 3/25/25 and dates thereafter, facility staff was educated regarding documenting accurate immunization status, provide information, and education to each resident or the resident's representative of the influenza vaccine (a vaccine used to protect against influenza (a viral respiratory infection)), pneumococcal vaccines (a vaccine used to protect against pneumonia bacteria). To monitor compliance, the DON/MDS Coordinator/Infection Preventionist or designee will review newly admitted residents' medical records to establish vaccination status, provide education, administer vaccinations as indicated, and ensure vaccinations are documented. To monitor compliance, the DON/MDS coordinator/IP/designee will review all resident vaccination status monthly to ensure residents (responsible party) are offered and educated regarding the influenza and pneumococcal vaccinations and are administered as indicated with appropriate documentation. The facility will document accurate immunization status, provide information, and education to each resident or the resident's representative of the influenza vaccine, between October 1st and March 31st of each year. For pneumococcal vaccines, prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA	

	regarding benefits, side effects, or warnings of the influenza vaccine for Residents #2, #4, #25, and #34, and for all other facility residents, and for the pneumococcal vaccine for Residents #4, #25, and #34 and will NOT administer the pneumococcal/flu vaccine to any resident who refuses the vaccine. On 3/20/25 and dates thereafter, the DON, MDS Coordinator, and IP were educated by the Administrator regarding documenting pertinent education provided to the resident or the resident's representative regarding benefits, side effects, or warnings of the influenza vaccine for all residents of the facility, and for the pneumococcal vaccine for all residents of the facility and will NOT administer the pneumococcal/flu vaccine to any resident who refuses the vaccine. -Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents, unless the vaccine is medically contraindicated, or the resident has already been immunized. - Residents admitted between October 1st and March 31st shall be offered the vaccine five working days of the resident's admission to the facility. - Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the residents/employee's medical record -Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. - Before receiving a pneumococcal vaccine, the resident or legal representative will receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the residents' medical record. - Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. - For each resident who receives the vaccine, the date of	

	Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	
F887	**COVID-19 Immunization** **CFR(s): 483.80(d)(3)(i)-(vii)** The facility will ensure the COVID-19 vaccination is	5/2/2025

	offered, administered, or refused by the resident and/or resident's representative for Residents #2, #4 and #34. On 3/20/25, the DON, MDS Coordinator, and IP were educated by the Administrator regarding ensuring the COVID-19 vaccination is offered, administered, or refused by the resident and/or resident's representative for all residents of the facility. -Each resident will be offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident is fully vaccinated. - COVID-19 vaccine education, documentation, and reporting will be overseen by the infection preventionist (IP) and coordinated by his or her designee. - Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risk, and potential side effects associated with the vaccine. - Information is provided to the resident in a format and language that is understood by the resident or representative. - Residents must sign a consent to vaccinate form prior to receiving the vaccine. - A vaccine administration record will provided to the resident, and a copy is filed in the resident record. - The resident's medical record includes documentation that indicates, at a minimum, the following: the resident or resident representative was provided education regarding the benefits and potential risk associated with COVID-19 vaccine, including the samples of the educational materials used, the date the education took place, and the name of the individual who received the education; signed consent; and each dose of COVID-19 vaccine that was administered to the resident. - If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination, or refusal, appropriate documentation is made in the resident's record. To monitor compliance, the DON/MDS Coordinator/Infection Preventionist or designee will review newly admitted residents' medical records to establish vaccination status, provide education, administer vaccinations as indicated, and ensure vaccination is documented. To monitor compliance, the DON/MDS	

	Coordinator/IP/designee will review all resident vaccination status monthly to ensure residents (responsible party) are offered and educated regarding the COVID-19 vaccination and are administered as indicated with appropriate documentation. The facility will document accurate immunization status, provide information, and education to each resident or the resident's representative of the COVID-19 vaccine prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	

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



PLAN OF CORRECTION

Provider/Supplier Name:	**BRENT B TINNIN MANOR**
Street Address, City, Zip:	**220 EUEL POLK DRIVE** **ELLINGTON, MO 63638**
Date of Survey:	**3/19/25**

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 is submitted as required under the State Law. The submission of this plan does not constitute an admission on the part of Brent B. Tinnin as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding any of the deficiencies cited are correctly applied. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil action or criminal action against the facility or any employee, agent, officer, director, or shareholder of the facility. Any changes to the facility policies and procedures should be considered to be subsequent remedial measures as those employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction with completion dates as our written credible allegation of compliance.	
A4017	19 CSR 30-85.042(17) Criminal Background Check Request Class III Refer to F607.	5/2/2025
A4023	19 CSR 30-85.042(21)(A) NA Training Complete In 4 mos Class III Refer to F728.	5/2/2025

A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Class II Refer to F684 and F695.	5/2/2025
A4078	19 CSR 30-85.042(69) Reposition Every 2 hr/Maintain Body Alignment Class II Refer to F684.	5/2/2025
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Class II Refer to F880	5/2/2025
A8008	19 CSR 30-88.010(8) Informed Services/Charges - Alz Disclosure Class III Refer to F582 and F625.	5/2/2025
A8018	19 CSR 30-88.010(18) Emergency Discharges Class III Refer to F623.	5/2/2025
A9023	19 CSR 30-88.020(14) Resident Fund Bond Requirements Class III Refer to F570	5/2/2025

The Administrator signing and dating the first page of the CMS-2567/5tate Form is indicating their approval of the plan of correction being submitted on this form.

