STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265431	A. BUILDING _____ B. WING _____	C 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN LAKE MANOR INC	600 EAST 7TH ST LOWRY CITY, MO 64763

(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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an environment as free from accident hazards as possible for all residents when medications when one resident (Resident #1) had an almost full bottle of medication in his/her room, on the memory care unit, unsecured and unattended by authorized personnel. The facility had a census of 70. Review of a facility policy titled "Storage of Medication," dated April 2019, showed the following: -The facility stored all drugs and biologicals in a safe, secure, and orderly manner; -Drugs and biologicals used in the facility were stored in locked compartments under proper temperature, light, and humidity controls; -Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received; -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; -Hazardous drugs shall be clearly marked as such and shall be stored separately from other	F 689		

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

Tim Corbin | 11/27/2024

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 689	Continued From page 1	F 689		

medications;
-Only persons authorized to prepare and administer medications have access to locked medications;
-Access to controlled medications is limited to authorized personnel. Personnel access to controlled medications is recorded.

Review of a facility policy titled "Administering Medications," dated April 2019, showed the following:

-Medications are administered in a safe and timely manner and as prescribed;
-Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so;
-The Director of Nursing Services supervises and directs all personnel who administer medication and/or have related functions;
-Residents may self-administer their own medications only if the Attending Physician, in conjunction with the interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

Review of the prescribing information for Brukinsa (zanubrutinib - prescription drug used to treat certain types of blood cancers in adults), dated June 2024, showed the following:

-It is a prescription medicine used to treat adults with chronic lymphocytic leukemia (CLL - type of cancer that causes the bone marrow to produce too many lymphocytes, or white blood cells);
-Recommended dosage of 160 milligram (mg) orally twice daily or 320 mg orally once daily. Patient to swallow whole with water and with or without food;

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F 689	Continued From page 2	F 689		

-Advise patients not to open, break, or chew capsules;
-Side effects can include fatal and serious hemorrhage (bleeding) in patients with hematological malignancies (blood cancers) treated with Brukinsa; fatal and serious infections (including bacterial, viral, or fungal infections) and opportunistic infections in patients with hematological malignancies;
-Store the medication in the original, labeled container at room temperature and in a dry location;
-Keep containers out of reach of children and pets;
-If a caregiver prepares the dose, they should consider wearing gloves or pour the pills directly from their container into the cap, a small cup, or directly into the patient hand. They should avoid touching the pills. They should always wash their hands before and after giving the medication.

1. Review of Resident #1's face sheet (a brief information sheet about the resident), showed the following:

-Admission date of 09/19/24;
-Self-responsible;
-Diagnoses included osteomyelitis (serious bone infection that causes inflammation and swelling of the bone tissue) of vertebra thoracic region, chronic lymphocytic leukemia of B-Cell type (type of white blood cell that makes antibodies) not having achieved remission, and cognitive social or emotional deficit following other cerebrovascular disease (conditions that affect blood flow to your brain).

Review of the resident's admission Minimum Data Set (MDS - a federally mandated

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F 689	Continued From page 3	F 689		

comprehensive assessment instrument completed by facility staff), dated 09/26/24, showed the following:

-Cognitively intact;
-Staff supervision for oral hygiene, toileting hygiene, personal hygiene, and transfers;
-Partial to moderate assistance of staff for showering and dressing.

Review of the resident's care plan, dated 09/20/24, showed the following:

-The resident had an alteration in hematological (refers to blood) status related to lymphocytic leukemia;
-Staff would give medications as ordered and monitor for side effects and effectiveness;
-Staff would provide medications as ordered and assist to follow up appointments as needed;
-Resident was on antibiotic therapy (IV - into the vein) related to osteomyelitis;
-Staff should administer antibiotic as ordered by physician.

Review of the resident's physician orders, current as of 11/06/24, showed the following:

-An order, dated 09/20/24, for Sodium Chloride solution 0.9% (solution containing sodium chloride (salt) in water for injection intended for IV administration), use 10 milliliter (ml) intravenously every six hours for flush, flush before and after antibiotic.
-An order, dated 10/01/24, for Brukinsa (zanubrutinib) oral 80 milligram (mg), give two capsules by mouth twice daily for cancer.

Observation on 11/06/24, at 9:20 A.M., showed

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F 689	Continued From page 4 the following: -The resident's room was located in the secured care unit (SCU - intentionally designed space that helps people with dementia live in a safe environment); -The room door was closed and not secured with no information on the door; -The resident was not in the room; -The room was cluttered with papers on the floor; -The sink counter contained a unsecured box of medication with a pharmacy prescription label. The medication was bottle was for Brukinsa 80 mg capsule; -Licensed Practical Nurse (LPN) B did not know where the resident was. He/she knew the resident had taken a shower and then thought he/she went to his/her room. Observation and interview on 11/06/24, at 9:28 A.M., showed the following: -Two residents were ambulating up and down the hall; -Resident #3 was confused and asked if he/she could go down the hall. LPN B advised he/she could go down the hall, but not out the end door. The resident ambulated down the hall; -LPN B spoke with shower aide in hall and determined Resident #1 went to a doctor's appointment with his/her family; -LPN B said that Resident #1 was admitted after back surgery and wanted a private room, that was why he/she was located on the secured care unit. He/she did not have a diagnosis of dementia. Observation and interview on 11/06/24 showed the following:	F 689		

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F 689	Continued From page 5 -At 10:45 A.M., Resident #1 was not in his/her room. The door was closed and there was no lock on the door. The room connected to an empty resident room through the shared bathroom. On the counter in the room, next to the sink, was a nearly full bottle of Brukinsa 80 mg caplets with a pharmacy labeled dated 10/01/24. The bottle read take one tablet four times per day, quantity 120 tablets. There was also approximately 50 empty sodium chloride solution 10 ml syringes on the counter in a clear plastic bag and two full unopened 10 ml syringes; -At 10:50 A.M., two residents (Resident #5 and #6) were ambulating up and down hall past the room; -At 10:55 A.M., two residents were observed in a resident room three doors down from Resident #1's room. One resident was resting under the covers in the bed and the second resident was standing and touching the curtains in the room; -At 10:55 A.M., LPN B said that Resident #3 did not belong in the room and then noted that Resident #4, that was in the bed, also did not belong in the room. Staff re-directed both residents out of the room. The room belonged to Resident #2 and he/she was seated in a wheelchair in the common area propelled by staff; -LPN B said that generally Resident #1 stayed in his/her room; -Resident #3 frequently wandered in and out of rooms; -Many of the residents will open a closed door and peek in, but then close the door and not go in; -Many of the residents will wander into a room if the door was open; -When passing morning medications, he/she did not see the bottle of medication in the room;	F 689		

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F 689	Continued From page 6 -He/she was going to talk to the Administrator about the medication at bedside but had not done that yet; -A resident would require a physician's order to have medications at bedside; -If one of the wandering residents got the medication he/she was unsure what the possible side effects could be. During an interview on 11/06/24, at 11:10 A.M., the Director of Nursing (DON) said Resident #1 wanted a private room and no rooms were available other than in the SCU. The resident was always in his/her room unless out for an appointment. The residents on the SCU did tend to wander and open doors. Resident #1 was difficult and wanted to do things his/her way. The bottle of pills should not have been in the room. The resident wanted to keep the empty sodium chloride vials to use on his/her farm. There was no known risk for the empty syringes to other residents. There was concern for risk of chemo drug being possibly accessible to the other residents. During an interview on 11/06/24, at 11:20 A.M., the Administrator said the following: -Any resident should have an order and have an evaluation to determine if it was safe to have medications at bedside; -There was a potential risk to all other residents with medication left in a resident room; -Resident #1 had not been diagnosed with dementia. He/she was in the SCU by choice for a private room.	F 689		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2)	F 841		

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F 841	Continued From page 7 §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to employee a medical director who was actively involved in the implementation of care policies and assisted with coordination of medical care when the facility had not entered into a contract with the medical director and ensured he/she was aware of his/her medical director responsibilities and when when the facility failed to ensure the medical director participated and was involved in completing/updated the facility assessment and attended the Quality Assessment and Assurance (QAA) Committee meeting. The facility census was 70. Review of the facility policy titled "Medical Director," dated July 2016, showed the following: -Physician services shall be under the supervision of the Medical Director; -The Medical Director is a licensed physician in this state and is responsible for ensuring adequate and appropriate physician services; reviewing practitioner credentials and overseeing physicians and those who perform physician-delegated tasks; reviewing physician performance and provide feedback to try to improve performance; overseeing and helping develop and implement care-related policies and	F 841		

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practices; participating in efforts to improve quality of care and services; serving as the liaison with the community; and serving as a source of education, training, and information;
-The Medical Director functions also included, but were not limited to acting as a liaison between administration and attending physicians; acting as a consultant to the director of nursing services in matters related to resident care services; helping assure that residents receive adequate services appropriate to meet their needs; helping assure that the resident care plan accurately reflects the medical regimen; participating in staff meetings concerning infection prevention and control, quality assurance and performance improvement, antibiotic stewardship, pharmaceutical services, resident care policies, etc.; assisting with employee health issues and concerns; and assuring that physician services comply with current rules, regulations, and guidelines concerning long-term care.

Review of the facility policy titled "Quality Assurance and Performance Improvement (QAPI) Committee," dated July 2016, showed the following:

-This facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI program;
-The primary goals of the QAPI Committee were to establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; promote the consistent use of facility systems and processes during provision of care and services; help identify actual and potential negative outcomes relative to resident care and resolve them

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F 841	Continued From page 9 appropriately; support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problems; help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members; -The committee has the full authority to oversee the implementation of the QAPI Program, including, but not limited to establishing performance and outcome indicators for quality of care and services delivered in the facility; choosing and implementing tools that best capture and measure data about the chosen indicators; appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility; and communicating the information gathered and their interpretation to the owner/governing board; The Committee Chairperson, Administrator, Director of Nursing Services, Medical Director, Dietary Representative, Pharmacy Representative, Social Services Representative, Activities Representative. Environmental Services Representative, Infection Control Representative, Rehabilitative/Restorative Services Representative, Staff Development Representative, Safety Representative, and Medical Records Representative will service on the committee: -The committee with meet monthly at an	F 841		

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appointed time;
-Special meetings may be called by the coordinator as needed to address issues that cannot be help until the next regularly scheduled meeting.

1. During an interview on 11/06/24, at 12:45 P.M., Physician A said the following

-He/she had not signed a written contract to be the Medical Director;
-He/she agreed to be the Medical Director on 07/01/24;
-He/she had not done much yet, as he/she was new;
-There had not been any meetings yet for him/her to attend, including QAPI meetings.

During an interview on 11/06/24, at 11:10 A.M., the Director of Nursing said the following:

-Physician A was the new Medical Director;
-The Medical Director had not yet attended a QAPI committee meeting;
-He/she was unsure of the date that he/she started as the Medical Director and thought it had been about two months.

During an interview on 11/06/24, at 11:20 A.M., the Administrator said the following:

-Physician A had not signed a formal contract to be the Medical Director;
-Physician A and the Administrator shook hands on the Medical Director agreement;
-Physician A agreed to be the Medical Director on 07/01/24;
-The Medical Director had not yet attended a QAPI committee meeting.

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Missouri Department of Health and Senior Services

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A4012	19 CSR 30-85.042(12) Supervising Physician A supervising physician shall be available to assist the facility in coordinating the overall program of medical care offered in the facility. II This regulation is not met as evidenced by: 1. Please refer to F841. MO00244644	A4012		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II 1. Pleaes refer to F689.	A4074		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Tim Corbin Adl — (X6) DATE: 11/27/2024

PLAN OF CORRECTION

Provider/Supplier Name:	Truman Lake Manor
Street Address, City, Zip:	600 East 7th street Lowry City, MO 64763
Date of Survey:	11/6/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction is submitted as required under state and federal law. The submission of this Plan of Correction does not constitute an admission on the part of __Truman Lake Manor_ as to the accuracy of the surveyors' findings nor the conclusions drawn there from. The Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings are accurate, that the findings constitute a deficiency, or 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 or criminal action against the Facility or any employee, agent, officer, director or shareholder of the Facility. This will also serve as our credible letter of allegation.	12/10/2024
F689	**Corrections for Cited examples**: Resident #1 has been discharged tc **The facility will identify other situations having the potential to be affected by the same issue.:** **A.** All residents will be at risk for the deficient practice.	Completed by 12/10/2024

	The measures that will be put into place or systemic changes made to ensure that the deficient practice will not reoccur as follows: **A. Facility will audit for any medications that are unsecured in resident rooms.** **B. Residents wishing to have any medications at bedside will be assessed by the DON or designee for safety.** **C. Any medications at bedside will be audited by the DON for safety.** **D. No medications at bedside will be allowed on the Dementia Unit.** **The facility will monitor the corrective action to ensure that the deficient practice will not recure as follows:** **A. All current staff will be in-serviced before 12/10/2025 and annually on medications at beside by the DON or designee.** **B. All new staff will be in serviced upon hire by the DON or designee.** **C. DON or designee will audit monthly for compliance and report at least quarterly to the QAPI committee for tracking and trending.** **To be completed by 12/10/2024**	
F841	**Correction for cited examples:** A. Dr. Mark Snell was hired August 1, 2024 **The measures that will be put into place or systemic changes made to ensure that the deficient practice will not reoccur as follows:** A. Official contracts will be signed with Dr. B. Dr. will attend QAPI meetings at least quarterly and fulfill all the needs of a medical director for Truman Lake Manor. **The facility will monitor the corrective action to ensure that the deficient practice will not recure as follows:** A. Administrator will monitor QAPI attendance to ensure that the medical director attends at least quarterly. To be completed by 12/10/2024	12/10/2024
A4012	Refer to F841	12/10/2024
A4074	Refer to F689	12/10/2024

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.

Tim Carl Ad 11/27/2024