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	265798	A. BUILDING _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MANOR	783 WEBER ROAD FARMINGTON, MO 63640

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for one resident (Resident #36) out of 20 sampled residents. The facility's census was 96. Review of the facility policy, "Certifying Accuracy of Resident Assessment," revised November 2019, showed: - Any health care professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident that is relevant to the professional's qualifications and knowledge; - Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment; - The information captured on the assessment reflects the status of the resident during the observation (lookback) period for that assessment. Different items on the MDS may have different observation periods; - The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse; - Inquiries concerning the signing of the MDS	F 641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rhonda Parker MHA LNHA | TITLE: Administrator | (X6) DATE: 7/12/24

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

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for one resident (Resident #36) out of 20 sampled residents. The facility's census was 96. Review of the facility policy, "Certifying Accuracy of Resident Assessment," revised November 2019, showed: - Any health care professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident that is relevant to the professional's qualifications and knowledge; - Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment; - The information captured on the assessment reflects the status of the resident during the observation (lookback) period for that assessment. Different items on the MDS may have different observation periods; - The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse;	F 641		8/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		07/12/2024

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 641	Continued From page 1 - Inquiries concerning the signing of the MDS should be referred to the assessment coordinator, director of nursing services, or to the administrator; - Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action. 1. Review of Resident #36's medical record showed: - Diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other import mental functions), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood.); - Resident discharged from hospice services on 04/09/23. Review of the resident's annual MDS, dated 03/04/24, showed: - Hospice care; - The facility did not code the resident's MDS accurately. Review of the resident's quarterly MDS, dated 06/04/24, showed: - Hospice care; - The facility did not code the resident's MDS accurately. During an interview on 06/20/24 at 10:25 A.M., LPN F said the resident was on hospice services at one time but started doing better so hospice services were discontinued.	F 641		

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F 641	Continued From page 2 During an interview on 06/21/24 at 12:00 P.M., the Administrator and DON said they would expect the MDS to accurately reflect the resident's status.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician's orders for one resident (Resident #48) outside of the sample. The facility census was 96. Review of the facility policy titled, "Medication and Treatment Orders", last revised 2016, showed: - Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state; - Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record; - Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis; - All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order;	F 658		8/4/24

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F 658	Continued From page 3 - The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used; - The staff and practitioner shall use only approved abbreviations and symbols when ordering and/or charting medications; - Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, and the date and the time of the order; - Verbal orders must be signed by the prescriber at his or her next visit; - Orders for medications must include: a. name and strength of the drug; b. number of doses, start and stop date, and/or specific duration of therapy; c. dosage and frequency of administration; d. route of administration; e. clinical condition or symptoms for which the medication is prescribed; f. any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). - Only authorized personnel shall call in orders for prescribed medications to the pharmacy. - Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. Review of Resident #48's medical record showed: - Admission date of 05/29/18; - Diagnoses of Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), traumatic subdural hemorrhage with	F 658		

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F 658	Continued From page 4	F 658		

loss of consciousness, (head injury, such as a blow to the head or a fall that develops when tiny veins that are located between the membranes covering the brain leak blood after an injury to the head), dysphagia (swallowing difficulties), hyperlipidemia (an elevated level of lipids like cholesterol and triglycerides in the blood), major depressive disorder, recurrent, severe with psychotic symptoms (disorder in which a person has depression along with loss of touch with reality (psychosis);
- An order dated 05/14/24 for Tramadol HCl oral tablet 50 mg, give 1 tablet by mouth in the morning for back pain.

Review of Resident #48's Medication Administration Record (MAR), dated May 2024, showed the resident did not receive the medication from 05/14/24 through 06/20/24.

During an interview on 06/20/24 at 9:00 A.M., Certified Medication Technician (CMT) J said the Tramadol has not been delivered from pharmacy and unsure of the reason. CMT J said he/she would expect all medications prescribed to be available and given.

During an interview on 06/20/24 at 9:10 A.M., Licensed Practical Nurse (LPN) F said he/she would expect all prescribed medications to be delivered from the pharmacy and given to residents. LPN F would expect nurses and CMTs to notify the pharmacy, physician's office, and supervisor, if medications were not delivered and available for residents.

During an interview on 06/21/24 at 12:00 P.M., the Administrator and Director of Nursing said

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F 658	Continued From page 5 they would expect all prescribed medications to be ordered and delivered from the pharmacy to be available to residents as physician ordered.	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility staff failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase their ROM and/or prevent a further decrease in their ROM. The facility staff failed to perform restorative services as ordered for two residents (Resident #7 and #30) out of two sampled residents. The facility census was 96. 1. Review of Resident #7's medical record	F 688		8/4/24

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F 688	Continued From page 6	F 688		

showed:
- Diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other import mental functions), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), other bilateral secondary osteoarthritis of first carpametacarpal joint (breakdown of cartilage in the joint.)

Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 05/10/24, showed:
- Moderately impaired cognition;
- Dependent with activities of daily living (ADLs) and self care;
- Impairment on one side of lower extremities;
- Restorative Nursing Program for active (when an outside force, such as another person, causes movement of a joint) range of motion.

Review of the resident's care plan, dated 05/13/24, showed:
- Dependent on staff for toileting and transferring;
- At risk for falls due to gait and balance problems.

Review of the resident's Physician's Order Sheet (POS), dated 05/31/24, showed an order for Restorative Nursing Services to be provided 1-5 days a week, dated 05/07/24.

Review of the resident's restorative nursing documentation showed no documentation that restorative therapy occurred.

2. Review of Resident #30's medical record showed:

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F 688	Continued From page 7 - Diagnoses of congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), hyperlipidemia, and chronic kidney disease, stage 4 (loss of kidney function). Review of the resident's Physician's Order Sheet (POS), dated 06/19/24, showed an order for Restorative Nursing Services to be provided 1-5 days a week, dated 05/07/24. Review of the resident's restorative nursing documentation showed restorative therapy occurred on 05/09/24, 05/24/24, 05/31/24, and 06/21/24. During an interview on 06/21/24 at 9:36 A.M., Restorative Aide H said Resident #7 isn't on his list of residents he/she sees for restorative. He/She hasn't done any documentation on Resident #7. During an interview on 06/21/24 at 10:22 A.M., Restorative Aide H said they normally will have residents complete twelve weeks of restorative services and then therapy will re-evaluate and determine if they if they need to stay on services. They normally complete their notes for each resident in the electronic medical record at the end of each week. When they first started doing restorative therapy, they were not good about completing the notes, but they are doing better about it now and try to get them put in at the end of each week.	F 688		

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F 688	Continued From page 8 During an interview on 06/21/24 at 12:00 P.M., the Administrator and Director of Nursing (DON) said they would expect restorative services to be completed as ordered and appropriate documentation to be completed regarding the services.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Registered Dietician's (RD) recommendations for weight loss were provided to the physician which affected one resident (Resident #7) out of 20 sampled residents. The facility census was 96.	F 692		8/4/24

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F 692	Continued From page 9	F 692		

Review of the facility policy, "Weight Assessment and Intervention," revised March 2022, showed:
- Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing;
- The threshold for significant unplanned and undesired weight loss will be based on the following criteria: One month - 5% weight loss is significant; greater than 5% is severe. Three months - 7.5% weight loss is significant; greater than 7.5% is severe; Six months - 10% weight loss is significant; greater than 10% is severe.

Review of the facility policy, "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol," revised September 2017, showed the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.

1. Review of Resident #7's medical record showed:
- An admission date of 05/26/22;
- Diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), gastroesophageal reflux disease (GERD - a digestive disease in which stomach acid or bile irritates the food pipe lining), and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues);
- At risk of malnutrition, per the Mini Nutrition Evaluation, dated 02/09/24.

Review of the resident's weights showed:

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F 692	Continued From page 10 - On 12/11/23, the resident weighed 207.4 pounds (#); - On 01/09/24, the resident weighed 206.4#; - On 02/05/24, the resident weighed 207.0#; - On 03/05/24, the resident weighed 194.0#; - On 04/04/24, the resident weighed 187.6#; - On 05/06/24, the resident weighed 175.9#; - On 05/24/24, the resident weighed 193.8#; - On 06/03/24, the resident weighed 181.2#; - On 06/7/24, the resident weighed 181.0#; - On 06/14/24, the resident weighed 177.3#, which is a 14.51% loss over six months. Review of the resident's care plan, revised on 05/16/24, showed: - Resident has an activities of daily living (ADL) self-care performance and mobility deficit related to Alzheimer's and requires supervision/touching assist of one staff with eating; - Cue, reorient, and supervise as needed; - Dietary consult for nutritional regimen and ongoing monitoring; - Resident has a nutritional problem and has had a recent weight loss and is on an appetite stimulant and supplement; - Administer medications as ordered. Monitor/Document for side effects and effectiveness; - Provide and serve diet as ordered; - Provide and serve supplements as ordered; - RD to evaluate and make diet change recommendations as needed; - Weights to be monitored monthly and as needed/ordered. Review of the RD note, dated 03/12/24, showed: - Resident continues to receive a regular diet for meals, eats independently in the dining room	F 692		

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after meal set up.
- Current weight 194#, reflecting 6.3% loss in 30 days.
- Will request re-weigh to ensure accuracy. Will continue to monitor and follow as needed.

Review of the RD note, dated 04/09/24, showed:
- Weight: 187.6# indicative of 3.3% loss past month and 9.1% loss past three months;
- Resident receives a regular diet and eats meals usually in the dining room, though has refused at times;
- Staff have placed resident at the assist table for encouragement, but has not been responding well to this per staff. Resident has changed from taking food from other resident at times to no longer doing this and refusing to eat at times. Resident will not respond to assistance efforts either;
- Cognition is altered such that he/she will smile or laugh at times, but then does not follow through with eating, etc. No skin breakdown, though redness to groin and buttocks noted 04/03/24;
- Cause for weight loss evaluated due to variable intake related to decline in mental status. Continued rapid loss not desired. To support stability, recommend 1) Assure kcal drinks offered every meal and encouraged. 2) Offer high kcal snacks between meals 3) Monitor meal intake for 30 days. Will notify nursing of recommendations. RD to follow as needed.

Review of the resident's May 2024 physician orders showed:
- Regular diet, regular consistency, dated 07/28/22;
- Weight check and record weekly every day shift

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every Friday for weight loss, dated 05/17/24;
- Two Cal (a calorie and protein dense nutrition supplement) (90 milliliters) two times a day with meals, dated 05/15/24;
- Megestrol Acetate Suspension 400 milligrams (mg)/10 milliliters (mL), give 5 mL by mouth one time a day for anorexia, dated 04/12/24;
- No order for Assure kcal drinks every meal;
- No order to offer high kcal snacks between meals;
- No order to monitor meal intake for 30 days.

Review of the resident's "Nutrition - Amount Eaten" task showed no documentation of the resident's meal intake per dietician recommendation.

Observations of the resident showed:
- On 06/18/24 at 1:18 P.M., the resident fed self a few bites with spoon, set spoon down and moved the plate away. Staff approached and fed the resident a bite of dessert and then walked away to assist another resident. After a few minutes, the resident ate another bite of dessert. Resident very slow to feed self and was still feeding self at 1:56 P.M. At 2:09 P.M., resident had eaten approximately 25%. No observation of Assure kcal drinks per dietician recommendation;
- On 06/19/24 from 1:05 P.M. to 1:28 P.M., the resident ate independently and ate approximately 25%. No observation of Assure kcal drink per dietician recommendation;
- On 06/20/24 from 1:36 P.M. to 1:56 P.M., the resident fed self slowly and ate almost 100%. No observation of Assure kcal drink per dietician recommendation.

During an interview on 06/20/24 at 2:54 P.M., the

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F 692	Continued From page 13 Director of Nursing (DON) said they have a new dietician and she comes every couple weeks. She will typically focus on new admissions and hospitalizations or if someone has had a significant weight loss. The RD will send an email to the DON and Administrator and they give it to the unit managers, who put recommendations in as orders. If someone has a low intake, they try them in the assisted dining room. Monthly weights have been inconsistent in the past with some of the CNA's weighing, so now the unit managers do the weights. If they are off, they will weigh again and/or find out why the resident has a weight loss or gain. They try to do a weekly risk meeting where they discuss residents with weight loss. The DON would expect the dietician to see a resident with weight loss at least monthly. During an interview on 06/21/24 at 10:00 A.M., the Director of Nursing said staff should have been recording the resident's intake in the chart per the dietician's recommendation, but the task is not showing up in the medical record for them to chart. He will go reactivate that so they can begin charting. During an interview on 06/21/24 at 12:00 P.M., the Administrator and Director of Nursing said they would expect the dietician recommendations to be relayed to the physician for appropriate orders to be completed and they would expect residents with weight loss to be seen monthly by the dietician.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		8/4/24

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The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide documentation of ongoing assessments, monitoring, and communication between the facility and the dialysis (the process for removal of waste and excess fluid from the blood due to kidney failure) center for one resident (Resident #33) out of one sampled resident receiving dialysis. The facility census was 96.

Review of the facility's policy titled, "Hemodialysis Catheters-Access and Care of," dated 02/2023, showed:
Care of the AVF's and AVGs:
- Do not use access arm to take blood pressure;
- Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals;
- Check patency of the site at regular intervals. Palpate the site to feel the "thrill,"or use a stethoscope to hear the "whoosh" or "bruit" of blood flow through the access;
- The nurse should document in the resident's medical record every shift as follows: location of catheter, condition of dressing, If dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given, observations post dialysis.

Review of the Dialysis Critical Element Pathway Form CMS 20071, dated 5/2017, provided by the

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Director of Nursing (DON), showed:
- Physician Orders: dialysis access care, dialysis schedule, individualized dialysis prescription such as number of treatments per week; length of treatment time, type of dialyzer, fluid restrictions, target weight, blood pressure monitoring;
- Care Plan: Has staff evaluated the resident's response to dialysis and developed/revised the care plan in collaboration with the dialysis facility:
- Monitoring vital signs, weights nutritional, and fluid needs or any restrictions, lab results, and who to notify with concerns;
- Specific type and location of dialysis services, transportation arrangements, and the interventions and goals based upon the type of dialysis;
- For hemodialysis (HD), which arm to use for blood pressure;
- Who to contact such as the attending practitioner, nephrologist, and dialysis staff, for dialysis related emergencies, concerns or complications;
- Monitoring for risk factors and managing complications such as hemorrhage, access site infection, hypotension, and to whom to report concerns;
- Approach to administering medications before, during, or after dialysis according to the practitioner's orders.

Review of Resident #33's Physician's Order Sheet (POS), dated 06/01/24-06/30/24, showed:
- Admitted to the facility on 03/05/24 and readmitted on 04/28/24;
- Diagnosis of end stage renal disease (chronic irreversible kidney failure), congestive heart failure (heart is unable to push enough blood into

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circulation), diabetes mellitus type II (body is unable to control the amount of sugar in the blood), and chronic respiratory failure (lungs cannot get enough oxygen in the blood or eliminate carbon dioxide from the blood);
- 2000 cc Fluid Restriction over 24 hours;
- No documentation of dialysis days, times or transportation;
- No documentation of dialysis Facility with demographics;
- No orders to assess and monitor the dialysis access site;
- No orders to assess and monitor the resident before and after a dialysis treatment.

Review of the resident's medical record, dated 04/28/24 through 06/21/24, showed:
- No documentation of the resident's condition being assessed and monitored before and after dialysis treatments;
- No documentation of the resident's dialysis access site being assessed and monitored from 04/28/24-06/21/24;
- No documentation of any communication between the facility and the dialysis staff.

Review of the resident's Medication Administration Record (MAR) and the Treatment Administration Record (TAR), dated 4/28/24 through 06/21/24, showed:
- No documentation of the resident's condition being assessed and monitored before and after dialysis treatments;
- 2000 ml fluid restriction not documented in the electronic medical record or monitored each shift and totaled daily;
- No documentation of pre or post dialysis weights or vital signs;

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F 698	Continued From page 17 - No documentation of the resident's dialysis access site being assessed and monitored daily or before and after dialysis treatments. Record review of the resident's care plan, dated 3/18/24, showed: - Potential for fluid deficit related to presence of foot infection, goes to dialysis 3x week, he/she is on fluid restriction; - No interventions for the assessment and monitoring of the resident before and after dialysis; - No monitoring of fluid limits or amounts per shift or per day. Record review of the resident's progress notes, dated 03/05/24 to 06/20/24, showed: - No documentation of ongoing assessments and/or monitoring of the resident's condition; - No documentation of assessment or monitoring resident before or after dialysis on Monday, Wednesday, and Friday. During an interview on 06/18/24 at 1:30 P.M., Licensed Practical Nurse (LPN) G said the facility does not have dialysis communication sheets. Dialysis calls us or the nurses call them if we have questions. The resident has early morning dialysis, so he/she does not take medication prior to dialysis. The resident comes back from dialysis and immediately lays down. LPN G said he/she looks at the pressure dressing and checks bruit and thrill, but doesn't usually record it. During an interview on 06/20/24 at 11:20 A.M., the DON said dialysis is mentioned in the fluid dehydration care plan and there was an order	F 698		

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F 698	Continued From page 18 under other 3/8/24 for dialysis (no documentation required). During an interview on 06/20/24 at 11:20 A.M., the Minimum Data Set (MDS - a mandatory assessment completed by the facility) Coordinator said dialysis is mentioned in the fluid dehydration care plan. During an interview on 06/21/24 at 12:00 P.M., the Administrator and DON said they would expect staff to assess a resident before and after dialysis. They would expect the resident to have a care plan for dialysis and would expect a resident with fluid restriction to be monitored for fluid intake.	F 698		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		8/4/24

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F 812	Continued From page 19 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These practices had the potential to affect all residents who are served food from the kitchen. The facility census was 96. Review of the facility policy, "Refrigerators and Freezers," revised November 2022, showed: - Refrigerators and/or freezers are maintained in good working condition. Refrigerators keep foods at or below 41° F and freezers keep frozen foods frozen solid; - Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures; - Monthly tracking sheets include time, refrigerator temperature, temperature of PHF/TCS food, initials, and "action taken." The last column will be completed only if temperatures are not acceptable; - Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening; - The supervisor takes immediate action if temperatures are out of range. Actions necessary to correct the temperatures are recorded on the tracking sheet, including the repair personnel and/or department contacted; - Information regarding acceptable storage periods for perishable foods are kept in the supervisor's office. A condensed version is posted by each refrigerator and freezer for reference;	F 812		

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F 812	Continued From page 20 - All food is appropriately dated to ensure proper rotation by expiration dates. "Received" dates (dates of delivery) are marked on cases and on individual items removed from cases for storage. "Use by" dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and "use by" dates are indicated once food is opened; - Foods kept in the refrigerator/freezer are stored according to the Food Receiving and Storage policy; - Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past "use by" or expiration dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes on packaging; - Supervisors inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. Maintenance schedules per manufacturer guidelines are scheduled and followed; - Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary. 1. Observation on 06/18/24 at 11:40 A.M. of the walk-in refrigerator showed: - Numerous items in plastic storage bags, some of which were opened, that were not labeled or dated; - An opened energy drink sat on the top right shelf. Dietary Staff I took a drink from the can and then put it back on the shelf.	F 812		

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F 812	Continued From page 21 2. Observation on 06/18/24 at 11:40 A.M. of the walk-in freezer showed: - Ice build up on the inside of the door; - A pie sat on the top right self, uncovered and not labeled or dated; 3. Observation on 06/18/24 at 11:40 A.M. and 06/19/24 at 12:54 P.M., of the dry food storage room showed: - A bottle of opened lemon juice which said refrigerate after opening; - Open bags of shake mix in an opened and undated plastic storage bag; - An opened, undated bag of muffin mix; - Instant pudding/pie filling in a sealed plastic storage bag with no date or label; - Large opened bag of cheesecake mix, not dated; - Two large, unopened jars of French dressing sat on the floor of the storage area; - A 25 pound opened bag of catfish breading with a delivery date of 8/22/23. No best or used by date; - An opened box of pasta, not dated; - A 25 pound bag of opened biscuit mix not dated, with a delivery date of 10/27/23. No best by or use by date; - An opened bag of dry milk with scoop inside, not sealed or dated. 4. Observation on 06/18/24 at 11:40 A.M. and on 06/19/24 at 12:45 P.M. of the kitchen showed: - Debris on the shelves and counters throughout the kitchen; - Debris on the floors throughout the kitchen; - A buildup of a brown substance in the fryer; - Debris on the front and back of the fryer, around	F 812		

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the knobs and down the sides of the fryer;
- Carbon buildup on the convection oven and stove;
- A black substance buildup on the stove;
- A black substance buildup on skillets, pots, and cooking sheets.

Review of the temperature logs indicated daily temperatures were not being taken for the following:
- Food cooking temperatures;
- Steam table temperatures;
- Walk-in freezer;
- Walk in refrigerator;
- Double door refrigerator;
- Water;
- Dishwasher - High temp sanitizing;
- Dishwasher PPM sanitizer.

During an interview on 06/19/24 at 12:45 P.M. the Dietary Manager (DM) said the cook is responsible for completing the temp logs for the refrigerators, freezer, and steam table. He/she said anyone can check the water and dishwasher temps.

During an interview on 06/21/24 at 9:26 A.M., the DM said he/she would expect food to be stored off the floor, opened packages wrapped or put into appropriate storage containers and to be labeled and dated. The DM said he/she would expect kitchen equipment, cookware and bakeware to be free from grease, debris and carbon buildup. The DM said he/she would expect temperature logs to be kept for the freezer, refrigerator, steamtable, dishwasher, and water. He/she said staff are not supposed to keep their personal drinks in the walk-in

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F 812	Continued From page 23 refrigerator, because they have an employee break room where they are to be kept. During an interview on 06/21/24 at 12:00 P.M., the Administrator and DON said they would expect food to be stored off the floor, opened packages wrapped or put into appropriate storage containers and to be labeled and dated. They said they would expect kitchen equipment, cookware and bakeware to be free from grease, debris and carbon buildup. They said they would expect temperature logs to be maintained for the freezer, refrigerator, steamtable, dishwasher, and water. They said they would expect staff to keep their personal drinks out of the kitchen and in the employee break room.	F 812		
F 868 SS=C	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. §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	F 868		8/4/24

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(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 Assurance and Improvement Program (QAPI) committee meetings with the required members. The facility census was 96.

The policies provided by the facility did not address who is required to attend QAPI meetings.

1. Review of the QAPI sign in sheets, provided by the Administrator, showed the Medical Director did not attend any meetings from August 2023 through May 2024.

During an interview on 06/21/24 at 10:10 A.M., the Administrator said QAPI meetings are held monthly and the previous month is reviewed. The Medical Director has not attended QAPI meetings in quite some time, but she would

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F 868	Continued From page 25 expect him to.	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 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		8/4/24

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F 880	Continued From page 26 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain proper infection control practices while providing care for two residents (Resident #1 and #36) out of 20 sampled residents and failed to provide	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265798	A. BUILDING _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MANOR	783 WEBER ROAD FARMINGTON, MO 63640

(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 880	Continued From page 27	F 880		

appropriate documentation of tuberculosis (TB-an infectious bacterial disease that affects the lungs) testing for five residents (Resident #12, #24, #28, #30 and #76) out of five sampled residents. The facility census was 96.

Review of the facility's policy, "Personal Protective Equipment-Using Gloves", last revised September 2010, showed:
- Use gloves when touching excretions, secretions, blood, body fluids, or non-intact skin;
- To prevent spread of infection;
- To protect hands from potentially infectious material;
- Wash hands after removing gloves.

Review of the facility's policy, "Screening Residents for Tuberculosis", last revised August 2019, showed:
- The facility shall screen all residents for tuberculosis infection and disease;
- Individuals identified with active TB shall be isolated from other residents and ancillary staff and transported to an appropriate care facility as soon as possible;
- The admitting nurse will screen referrals for admission and readmission;
- Signs and symptoms of TB include cough, loss of appetite, fatigue, weight loss, night sweats, bloody sputum, fever and chest pain;
- Did not address exact measures in testing for TB.

1. Observation of Resident #1 on 06/18/24 at 12:50 P.M. showed:
- Certified Nursing Assistant (CNA) C and CNA D provided perineal care for the resident;
- CNA D cleaned the resident while CNA C

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F 880	Continued From page 28	F 880		

positioned the resident on his/her side;
- Resident repositioned to back. CNA D cleaned the front perineal area and did not change gloves;
- With the same gloves, CNA D placed a brief on the resident;
- With the same gloves, CNA D touched the mechanical lift pad, controls and hand bars to transfer the resident with the assistance of CNA C;
- CNA C and CNA D removed gloves, but did not wash or sanitize hands before leaving the room.

During an interview on 06/20/24 at 9:05 A.M., the Director of Nursing (DON) said he/she would expect staff to use proper infection control practices while giving peri care.

During an interview on 06/20/24 at 9:09 A.M., Licensed Practical Nurse (LPN) E said he/she would expect staff to use proper infection control practices while giving peri care.

2. Observation for Resident #36 on 06/21/24 at 9:00 A.M. showed:
- CNA A and CNA B provided perineal care for the resident;
- CNA B cleaned the resident while CNA A positioned the Resident on his/her side;
- The resident had a bowel movement during care. CNA B did not change gloves after cleaning;
- Resident repositioned to back. CNA A cleaned the front perineal area and did not change gloves;
- With the same gloves, CNA B touched sheets and pulled them over the resident;
- With the same gloves, CNA B touched the door

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F 880	Continued From page 29	F 880		

knob to push chair out of the room before removing gloves and washing hands;
- With the same gloves, CNA A touched the resident's call light and clean sheets before removing gloves and washing hands.

During an interview on 06/21/24 at 9:16 A.M., CNA A and CNA B said gloves should have been changed between dirty and clean and before they touched resident's sheets, call lights, door knobs and other items.

3. Review of Resident #12's medical record showed:
- Admitted on 04/02/20;
- A first step TB test given on 9/05/23, with no date for a reading of 0 millimeters (mm);
- A second step given on 9/19/23, with no date for a reading of 0 mm.

4. Review of Resident #24's medical record showed:
- Admitted on 07/07/22;
- A first step TB test given on 5/21/24, with no date for a reading of 0 mm;
- A second step given on 06/07/24, with no date for a reading of 0 mm.

5. Review of Resident #28's medical records showed;
- Admitted on 07/21/23;
- A first step TB test administered on 8/24/23, with no date for a reading of 0 mm;
- A second step given on 9/07/23, with no date for a reading of 0 mm.

6. Review of Resident #30's medical record showed:

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F 880	Continued From page 30 - Admitted on 10/25/21; - A one time readmission screen given on 4/03/24, with no date for a reading of 0 mm. 7. Review of Resident #76's medical record showed: - Admitted on 07/02/22; - A yearly screen, dated 10/14/23, with no documentation of signs or symptoms. During an interview on 06/20/24 at 09:45 A.M., the DON said he would expect the signs and symptoms to be marked yes or no. During an interview on 06/20/24 at 11:55 A.M., the DON said they have contacted the electronic medical record company and they will be having the read date of the PPD(s) added to the system. During an interview on 06/21/24 at 12:00 P.M., the Administrator and DON said they would expect staff to change gloves, once contaminated, before touching a clean surface or resident and TB results should have correct read dates.	F 880		

Missouri Department of Health and Senior Services

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	13887A	A. BUILDING: _____ B. WING _____	C 06/21/2024

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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 F658 and F698.	A4075		
A4081	19 CSR 30-85.042(72) Restorative Nursing, Res Out of Bed Facilities shall provide each resident, according to his/her needs, with restorative nursing to encourage independence, activity and self-help to maintain strength and mobility. Each resident shall be out of bed as desired unless medically contraindicated. II This regulation is not met as evidenced by: Class II Refer to F688.	A4081		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as	A4086		

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A4086	Continued From page 1 amended. I/II This regulation is not met as evidenced by: Class II Refer to F880.	A4086		
A5001	19 CSR 30-85.052(1) Nutritional Needs Met, Assess Res, Inform Dr Each resident shall be served nutritious food, properly prepared and appropriately seasoned, taking into consideration resident food preferences, to provide an adequate diet in accordance with the physician ' s order and as recommended by the National Research Council. Nutritional needs of residents shall be met and shall be based on the individual ' s circumstances, medical condition and goals of treatment as determined and justified by the physician. A qualified professional, such as a dietitian or registered nurse, shall regularly assess these needs and shall keep the physician informed of the nutritional status of the resident. I/II This regulation is not met as evidenced by: Class II Refer to F692.	A5001		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects,	A7015		

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A7015	Continued From page 2 rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III Refer to F812.	A7015		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Refer to F812.	A7067		

PLAN OF CORRECTION

Provider/Supplier Name:	Community Manor
Street Address, City, Zip:	783 Weber Road, Farmington, MO 63640
Date of Survey:	6/21/2024

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
F 641	• The facility will document accurate minimum data sets (MDS_a federally mandated assessment completed by facility staff) for all residents. • 4/18/24, prior to 6/21/24 survey, resident #36's annual MDS assessment dated 3/4/24 was modified and submitted to remove hospice care to accurately reflect the residents status. • resident #36's quarterly MDS dated 6/4/24 was modified and submitted on 7/3/24 to remove hospice care to accurately reflect the residents status • A facility wide audit of accurately documenting hospice care on the mds assessments completed by the DON on 7/9/2024. • MDS coordinator educated on F 641 Accuracy of Assessments CFR(s): 483.20(g) on 7/9/2024 by the DON. • DON or designee will audit 1 random MDS for accuracy to ensure compliance with F 641 CFR(s): 483.20(g) weekly x4 then monthly until substantial compliance is met. • Don or designee will report audit findings to QAPI committee until substantial compliance is met. • on 7/8/24 F641 was added to QAPI agenda until substantial compliance is met.	8/4/24

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F 658	• The facility will follow physician orders by ensuring ordered medications are given as prescribed. • An audit was completed on 6/20/24 of resident #48's orders. • Pcp notified by pharmacy on 5/28/24 nad 6/16/24 that resident #48 tramadol order required a signed script before the controlled substance could be delivered to the facility. • 6/21/24 ADON notified PCP the tramadol order from 5/14/24 still requires a signed script before pharmacy can deliver it. PCP gave direction to re-enter order as a new order so the PCP could utilize escript. 6/22/24 tramadol med card delivered from pharmacy and physicians order initiated. • Facility staff requested tramadol to be filled by the pharmacy on 5/13/24, 5/28/24, 6/10/24, 6/12/24, and 6/16/24. • 7/3/24 PCP educated by DON on sending scripts for controlled substances to pharmacy timely and educated on controlled substances not being able to be initiated until script is sent to the pharmacy. • Facility wide audit was completed on 7/9/24 of current residents with active controlled medication orders to ensure compliance with F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) & A4075 • Medication administering staff were educated on F658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) & A4075 on 6/21/24 by DON and Unit manager staff to include notification of PCP when med is not available to get clarifying direction. • Don or designee will Audit two random residents Administration records vs physician orders weekly x4 then monthly until substantial compliance is met to ensure compliance with F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) & A4075 • Don or designee will report audit findings to QAPI committee until substantial compliance is met. • On 7/8/24 F 658 & A4075 was added to QAPI agenda until substantial compliance is met.	8/4/24

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F688	• The facility staff will ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase their ROM and/or prevent a further decrease in their ROM. • The facility staff will provide restorative services as ordered for all residents. • On 7/8/24 restorative nursing staff ensured restorative services were provided per physicians order for resident #7 and appropriate documentation completed for resident #7 • On 7/8/24 restorative nursing staff ensured restorative services were provided per physicians order for resident #30 and appropriate documentation completed for resident #30 • On 7/12/24 a facility wide audit was completed of residents with orders for restorative services to ensure services were completed appropriately to maintain compliance with F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) & A4081 • Restorative nursing staff educated on F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) & A4081 to include documenting provided services on 7/12/24. • DON or designee will audit two random residents with current orders for restorative for F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) & A4081 weekly x4 then monthly until substantial compliance is met. • Don or designee will report audit findings to QAPI committee until substantial compliance is met. • On 7/8/24 F688 & A4081 was added to QAPI agenda until significant compliance is met.	8/4/24

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F692	• The facility will ensure the registered dieticians (RD) recommendations for weight loss are provided to the physician for all residents. • On 6/20/24 Consumption % recording was added to documentation for resident #7. • 7/10/24 Resident #7 PCP notified of last 6 months (1/1/24-6/20/24) of weights and dietician recommendations by DON. • 7/10/24 order for assure Kcal drinks every meal obtained from PCP and transcribed . care plan updated to reflect this. • 7/10/24 order to offer high kcal snacks between meals obtained from PCP and transcribed. Care plan updated to reflect this. • 7/10/24 order to monitor meal intake for 30 days obtained from PCP and transcribed. Care plan updated to reflect this. • 7/10/24 facility wide audit completed by Don and designees on last 6 months of weights and dietician recommendations reported to PCP with dietician recommendations being followed. All concerns corrected. • Consumption % recording was added to all current residents with documented weight loss of 5% or greater in one month, 7.5% in 3 months, or 10% in 6 months on 6/20/24 • All nursing staff educated on F 692 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) & A5001 to include communication dietician recommendations with PCP and following recommendations on 7/19/24 • Don or designee will audit 3 random resident's medical records to ensure registered dieticians (RD) recommendations for weight loss were provided to the physician with followup completed weekly x4 and then monthly until substantial compliance is met. • Don or designee will report audit findings to QAPI committee until substantial compliance is met. • On 7/8/24 F692 & A5001 was added to QAPI agenda until substantial compliance is met.	8/4/24

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Provider/Supplier Name:	Community Manor
Street Address, City, Zip:	783 Weber Rd Farmington, MO 63640
Date of Survey:	6/21/2024

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F 698	• The facility will provide documentation of ongoing assessments, monitoring, and communication between the facility and the dialysis center for all residents receiving dialysis services. • Dialysis Communication tool was initiated on 6/20/24 to comply with F 698 Dialysis CFR(s): 483.25(l) & A4075 • Documentation of dialysis days, times, transportation, dialysis facility, demographics added to resident #33 electronic medical record on 7/10/24 • 7/10/24 orders obtained and transcribed to resident #33's electronic medical record to 1. 2000ml fluid restriction updated to include documentation each shift and totaled daily 2. Assess and monitor dialysis access site daily and before and after dialysis treatments. 3. Assess and monitor resident before and after dialysis treatment (weight, vital signs, signs and symptoms of infections or bleeding, access site.) • 7/10/24 resident #33 care plan updated to include documentation and orders added to residents medical record. • Nursing staff and MDS coordinator educated on F 698 Dialysis CFR(s): 483.25(l) & A4075 to ensure future compliance on 7/19/24 by the DON. • DON or designee will audit residents receiving dialysis for documentation of ongoing assessments, monitoring, and communication between the facility and dialysis center weekly x4 and then monthly until substantial compliance is met. • Don or designee will report audit findings to QAPI committee until substantial compliance is met. • On 7/8/24 F698 & A4075 was added to QAPI agenda until substantial compliance is met.	08/04/24

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F812	Community Manor will store and distribute food under sanitary Conditions, decreasing the risk of cross-contamination and food-borne illness to keep all residents safe and healthy. On 06/21/2024 all opened, unlabeled and undated food items located in the walk-in refrigerator, walk-in freezer and dry food storage room were removed and disposed of. Dietary Staff were educated on the proper food receiving and storage procedures. Food items inappropriately stored on the dry storage floor were relocated and properly stored on a shelf. Staff food and beverages were removed from the walk-in refrigerator and all staff were educated on proper storage areas for staff food and beverages. On 07/09/2024 the ice build-up on the walk-in freezer door was removed. On 07/09/2024 Kitchen Staff were educated on keeping the freezer door properly closed to prevent condensation and refreezing. On 06/22/2024 Kitchen staff cleaned debris from the shelves and counters throughout the kitchen and cleaned debris from the floors throughout the kitchen. On 07/10/2024 the buildup of brown substance in the fryer and debris, on the front, back, around the knobs, and down the sides of the fryer was removed. On 07/10/2024 the carbon buildup was removed from the convection oven. On 07/10/2024 the black substance buildup was removed from the stove. On 07/10/2024 the black substance buildup was removed from skillets, post and cooking sheets. On 07/10/2024 All Kitchen Staff were educated on completion of daily assigned cleaning tasks/checklists to ensure cleanliness of the food preparation and storage areas. On 07/10/2024 All Kitchen Staff were educated on completion of temperature logs, food cooking temp logs, steam table temp logs, walk in freezer temps, walk in refrigerator logs, double door refrigerator temps, water temps, dishwasher high temp sanitizing, dishwasher ppm sanitizer.	08/04/2024

F812 continued.	Beginning on 07/10/2024 The Dietary Manager or representative will audit each of the following; daily for four weeks and then weekly until substantial compliance is reached to ensure the following remain corrected. 1. Opened food items are dated, labeled, and covered. 2. Each temperature log is completed. 3. Cleaning checklists are completed by assigned staff. 4. Visual inspection of shelves, counters and floors to ensure free of debris. 5. Visual inspection of fryer, oven, stove, pots, pans and baking sheets to ensure free of grease, debris, carbon buildup and substance. The dietary manager or designee will report audit findings to QAPI committee until substantial compliance is met. On 07/08/2024 F812 was added to QAPI agenda until substantial compliance is met.	08/04/2024

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F868	• The facility will maintain quarterly quality assurance and improvement program (QAPI) committee meetings with the required members to comply with F 868 QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) • 7/10/24 medical director was supplied QAPI meeting noted from August 2023 through June 2024. • 7/3/24 Medical director attended QAPI meeting. • On 6/27/24 the Medical director notified of SOD and educated on required attendance to QAPI meeting. • Administrator, or designee will ensure all required QAPI members will participate in QAPI meeting as required to maintain compliance with F 868 QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) • Administrator, or designee will Audit the attendance of required QAPI members monthly x3 then quarterly until substantial compliance is met for F 868 QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) • DON, Administrator, or designee will report audit findings to QAPI committee until substantial compliance is met. • On 7/8/24 F868 was added to QAPI agenda until substantial compliance is met	8/4/24

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 880	• Facility will maintain proper infection control practices while providing care to all residents. • Facility will provide appropriate documentation of tuberculosis testing on all residents. • On 7/19/24 Nursing staff educated on F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) & A4086 by DON to include appropriate documentation of TB testing, with date results read, hand washing, and changing gloves. • Residents 12, 24, 28, 30 provided appropriate documentation of tuberculosis testing on 7/10/24. • Resident # 76 provided appropriate documentation of annual tuberculosis screening on 7/10/24 • Facility wide audit date completed of Resident TB testing for appropriate documentation and corrected all concerns on 7/12/24 • DON or designee will audit 3 random residents for appropriate documentation of tuberculosis testing weekly x4 and then monthly until substantial compliance is met. • DON or designee will complete 3 random staff competencies on peri care weekly x4 then monthly until substantial compliance is met. • Don or designee will report audit findings and competency findings to QAPI committee until substantial compliance is met. • On 7/8/24 F880 & A4086 was added to QAPI agenda until substantial compliance is met.	8/4/24

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:	Community Manor
Street Address, City, Zip:	783 Weber Road, Farmington, MO 63640
Date of Survey:	06/21/2024

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
A4075	See F658 and F698	08/04/2024
A4081	See F688	08/04/2024
A4086	See F880	08/04/2024
A5001	See F692	08/04/2024
A7015	See F812	08/04/2024
A7067	See 812	08/04/2024

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