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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 565		

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

RBlanco 2/12/25

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failed to respond to or act upon the grievances and dietary recommendations for five residents (Resident #7, #17, #40, #45, and #62) out of 17 sampled residents, six residents (Resident #4, #6, #10, #28, #35, and #66) outside the sample and had the potential to affect all the residents in the facility. The facility's census was 67.

Review of the facility's policy titled, "Resident Council," revised January 5, 2023, showed:
- Residents of each community within each level of living (independent, assisted, and skilled nursing) may organize and participate in resident councils. The resident council shall be composed of representatives from the designated living area (independent, assisted, and skilled nursing), officers of the council and chairpersons of the standing committees;
- The purpose of the Resident Council will be to provide an orderly means of communication between residents and community administration; provide and receive necessary information for the benefit of all residents, including the interpretation of administrative policies to residents and conveying to administration suggestions regarding any phase of life and service of the community; assist with activities which will benefit resident of the community; and allow residents to retain part of the responsibility for certain action affecting their day-to-day living;
- The Executive Director shall act upon the recommendations of the Council concerning proposed policy and operational decisions affecting resident care and life in the Community;
- The Executive Director and other community staff members as determined by resident council and Executive Director will attend the resident council meetings;
- Any issues/concerns identified by the resident

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council will be brought to the attention of the Executive Director or designee and addressed at the next resident council meeting for appropriate follow-up.

1. Review of the Resident Council Minutes, dated 11/20/24, showed:
- Some residents are not seeing improvements in dietary;
- Too much white rice on the menu and residents would like to see Spanish or flavored rice;
- Over easy eggs are too hard;
- Food was cold on Sunday;
- Some items missing from trays if residents eat in their rooms;
- Not enough staff in the dining room;
- Residents ask staff for ice water of coffee and staff state that they will be right back but then never return;
- Dietary Manager asked what food was missing and if kitchen staff were bringing missing items to the residents.
- The facility did not document a response or assign a responsible staff member for follow up to other concerns.

2. Review of the Resident Council Minutes, dated 12/19/24, showed:
- Some residents are not seeing improvements in dietary;
- Too much white rice on the menu and residents would like to see Spanish or flavored rice;
- Residents have not been getting dinner until after 6:00 P.M.;
- Residents would like to see more soup on the menu during the colder months and would like more in their bowls as they are usually only half full;
- Dietary Manager stated that he would inform

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dining staff to fill the bowls with more soup;
- Staff are taking residents to the dining room too early and residents are having to wait on meals;
- Residents are having to yell to get coffee because they are in the dining room too early;
- Not enough staff in the dining room during mealtimes;
- The facility did not document a response or assign a responsible staff member for follow up to other concerns.

3. Review of the Resident Council Minutes, dated 01/15/25, showed:
- Some residents are not seeing improvements in dietary;
- Too much white rice on the menu;
- Residents would like to see more meat and less rice with meals;
- Residents would like to see more soup and bigger bowls of soup;
- Residents would like to see less cabbage on the menu;
- Staff are still taking them too early to the dining room for meals;
- Residents are still having to yell for dietary staff to get coffee;
- The facility did not document a response or assign a responsible staff member for follow up to other concerns.

During an interview on 01/27/25 at 1:14 P.M., Resident #7 said the food is cold sometimes.

During an interview on 01/27/25 at 1:25 P.M., Resident #17 said the food is cold sometimes.

During an interview on 01/27/25 at 1:29 P.M., Resident #10 said the chicken is poorly cooked. It is really hard on the outside and just doesn't

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have a good flavor.

During an interview on 01/27/25 at 1:39 P.M., Resident #6 said the food needs help. The potatoes at lunch today were raw. His/Her sister was in the room and had to microwave them. Food is cold by the time he/she gets his/her hall tray and meals are consistently late.

During an interview on 01/27/25 at 1:51 P.M., Resident #4 said food is warm most of the time when he/she gets it in his/her room. Staff will drop the tray off and leave without telling him/her, and when he/she realizes it's there, the food is cold.

During an interview on 01/28/25 at 9:50 A.M., Resident #45 said the food is not good and sometimes it's not hot when he/she gets his/her hall tray. He/She always eats in his/her room.

During an interview on 01/29/25 at 10:30 A.M., six members of the Resident Council (Resident #6, #28, #35, #40, #62, and #66) collectively said they would like to have extra people in the dining room to assist them and to help get refills and to help take other residents back to the room after eating. The food isn't perfect all the time, but it is good sometimes. Sometimes the food is cold even if it is served in the dining room.

During an interview on 01/30/25 at 10:47 P.M., the Dietary Manager (DM) said there had been a few residents complain about food temperatures, but they were located at the end of the halls. He/She would expect food to be served to residents at a temperature within the recommended guidelines per regulation.

During an interview on 01/30/25 at 2:20 P.M., the

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F 565	Continued From page 5 Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Infection Preventionist (IP) collectively said the dietary manager is new, but they would expect food to be served to residents at a temperature within the recommended guidelines per regulation. During an interview on 02/07/25 at 10:44 A.M., the Administrator said if the issue is related to food, then the dietary manager would address it. The Social Services Designee follows up to make sure issues are addressed and reports to me.	F 565		
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 interview and record review, the facility failed to follow physician's orders for three residents (Resident #7, #9, and #36) out of 17 sampled residents. The facility's census was 67. The facility did not provide a policy regarding following physician's orders for weighing residents. 1. Review of Resident #7's medical record showed: - An admission date of 05/24/21; - Diagnoses of heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs), chronic respiratory	F 658		

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failure with hypoxia (a serious condition where the body's respiratory system can't remove enough oxygen from the blood), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause airflow obstruction and breathing problems).

Review of the resident's Physician's Order Sheet (POS), dated January 2025, showed an order to weigh daily, dated 12/06/24.

Review of the resident's weights summary and Treatment Administrator Record (TAR), dated December 2024 - January 2025, showed:
- Staff were documenting weights in either the weights summary or the TAR;
- No weights recorded in either location for 12/21/24, 12/22/24, 01/01/25, 01/11/25, and 01/12/25, for a total of five out of 54 opportunities missed.

2. Review of Resident #9's medical record showed:
- Admitted on 09/27/24;
- Diagnoses of Type 2 diabetes (the body has trouble controlling blood sugar), hypertensive heart and chronic kidney disease (chronic kidney disease caused by or significantly worsened by uncontrolled high blood pressure), emphysema (chronic lung disease), and heart failure (heart does not pump correctly).

Review of the resident's POS, dated January 2025, showed an order for daily weights, weigh daily in morning for congestive heart failure (CHF), dated 11/09/24.

Review of the resident's weights summary and Treatment Administrator Record (TAR), dated

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December 2024 - January 2025, showed:
- Staff were documenting weights in either the weights summary or the TAR;
- No weights recorded in either location for 12/3/24, 12/5/24, 12/6/24, 12/8/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24, 12/16/24, 12/17/24, 12/18/24, 12/19/24, 12/20/24, 12/21/24, 12/23/24, 12/25/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 01/1/25, 01/2/25, 01/4/25, 01/5/25, 01/6/25, 01/7/25, 01/8/25, 01/9/25, 01/10/25, 01/11/25, 01/12/25, 01/13/25, 01/14/25, 01/15/25, 01/17/25, 01/18/25, 01/20/25, 01/21/25, 01/22/25, 01/23/25, 01/27/25, 01/28/25, for a total of 47 out of 62 opportunities missed.

Review of Resident #9's progress notes showed starting on 12/11/24, notations saying the scale was broken, so weights were not being documented for the resident.

3. Review of Resident #36's medical record showed:
- Admitted on 12/09/19;
- Diagnoses of Type 2 diabetes, hypertensive chronic kidney disease, and edema (fluid retention).

Review of the resident's POS, dated January 2025, showed an order for weekly weights every Friday, dated 12/13/24.

Review of the resident's weights summary and Treatment Administrator Record (TAR), dated December 2024 - January 2025, showed:
- Staff were documenting weights in either the weights summary or the TAR;
- No weights recorded in either location for 01/03/25, 01/17/25, and 01/24/25 for a total of

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three out of six opportunities missed.

During an interview on 01/30/25 at 11:06 A.M., Registered Nurse (RN) D said the previous Director of Nursing (DON) had been made aware of the lift not working. He/She had mentioned it more than once to the previous DON.

During an interview on 01/30/25 at 11:38 A.M., the Infection Preventionist (IP) said he/she had seen notes saying the scale wasn't working, but when he/she worked that hall the other week the lift was working fine. The aides working the hall are responsible for completing the weights. Staff should know who needs weighed each day because it's listed on the daily sheet, is written on a white board in the nurses station, is on the TAR and it also lights up in the electronic charting. He/she did not know why the scale was listed as not working because it worked fine for him/her. The Assistant Director of Nursing (ADON) may know more about it.

During an interview on 01/30/25 at 11:43 A.M., the ADON said there are two lifts. One of them is working, so staff should be able to weigh Resident #9. He/She would check the scale to make sure it's in working order.

During an interview on 01/30/25 at 11:54 A.M., the ADON said he/she checked and the facility actually has four lifts, but one doesn't have a scale and two are not calibrated accurately, so they only have one that will weigh accurately. He/she will call the company and request the others be recalibrated and see if they can have a scale added to the one that doesn't have a scale. The aide working the hall should do the weight, but the staff work as a team, so any of the

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F 658	Continued From page 9 nursing staff can do it to help out. It's possible at times staff were grabbing the non-working scales not realizing there was a working one, but could not say for sure. He/She will move the non-working scales to a different area, so only the working one will be on that hall for staff to use since Resident #9 is the only resident requiring a lift. During an interview on 01/30/25 at 2:20 P.M., the Administrator, DON, ADON, and IP collectively said they would expect the staff to follow physician's orders and weigh residents as ordered. During an interview on 02/06/25 at 4:50 P.M., the Administrator said most of the time the aides document the weights under tasks, like vital signs. The nurse documents on the TAR also. When the nurse documents it on the TAR from the weight on the vital sign sheet, the paper sheet that the aides write their vitals on for the nurses, they may document it also. Staff are still learning this new system. Staff are having trouble seeing the notes the nurses wrote as to why a weight did not get done, resident out of building, refused, etc.	F 658		
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,	F 695		

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and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to follow physician's orders for supplemental oxygen therapy and oxygen tubing and humidifier changes for one resident (Resident #7) out of 17 sampled residents. The facility's census was 67.

Review of the facility's policy titled, "Oxygen Therapy", revised 10/08/21, showed:
- Oxygen is treated as a medication ordered by the physician;
- The order includes the amount per minute to be delivered, the device used for delivery, and during what times to deliver oxygen therapy;
- Change tubing once a week or when soiled. Date, time, and initial tubing when changed;
- Non-disposable refillable humidifier bottles are changed every seven days;
- Date and initial each non-disposable refillable humidifier when changed every seven days or if contaminated;
- Document on the Medication Administration Record (MAR)/Treatment Administration Record (TAR).

1. Review of Resident #7's medical record showed:
- An admission date of 05/24/21;
- Diagnoses of heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs), chronic respiratory failure with hypoxia (a serious condition where the body's respiratory system can't remove enough oxygen from the blood), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause airflow obstruction and

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breathing problems.)

Review of the resident's Physician's Order Sheet (POS), dated 01/29/25, showed:
- An order for oxygen at two liters to maintain oxygen saturation above 92%, dated 12/06/24;
- An order to change oxygen tubing and clean concentrator filter weekly every Sunday night shift, dated 12/06/24;
- An order for oxygen tubing and humidifier change every Sunday night shift, dated 12/06/24.

Review of the resident's MAR, dated January 2025, showed:
- The resident received oxygen at two liters on day shift, evening shift, and night shift on 01/27, 01/28, and 01/29;
- The resident received oxygen at two liters on day shift on 01/30.

Review of the resident's TAR, dated January 2025, showed:
- Oxygen tubing changed and concentrator filter cleaned on 01/05, 01/12, 01/19, and 01/26;
- Oxygen tubing and humidifier changed on 01/05, 01/12, 01/19, and 01/26.

Review of the resident's TAR, dated December 2024, showed:
- Oxygen tubing changed and concentrator filter cleaned on 12/08, 12/15, 12/22, and 12/29;
- Oxygen tubing and humidifier changed on 12/08, 12/15, 12/22, and 12/29.

Observation of Resident #7 showed:
- On 01/27/25 at 1:14 P.M., the resident sat on the side of the bed wearing oxygen at four liters per nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils) with tubing dated

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12/23/24 and humidity bottle dated 01/08/25;
- On 01/28/25 at 1:23 P.M., the resident sat on the side of the bed wearing oxygen at four liters per nasal cannula with tubing dated 12/23/24 and humidity bottle dated 01/08/25. Resident removed the cannula from his/her nose while eating lunch;
- On 01/29/25 at 2:11 P.M., the resident sat in a recliner using a second oxygen concentrator, wearing oxygen at two liters per nasal cannula, the humidity bottle dated 12/9 and no date on tubing. The concentrator by the resident's bed with tubing dated 12/23/24 and the humidity bottle dated 01/08/25;
- On 01/30/25 at 9:21 A.M., the resident lay in bed wearing oxygen at four liters per nasal cannula with tubing dated 12/23/24 and humidity bottle dated 01/08/25.

During an interview on 01/27/25 at 1:14 P.M., Resident #7 was unable to say if or when staff changed his/her oxygen tubing.

During an interview on 01/30/25 at 1:24 P.M., Registered Nurse (RN) D said staff are supposed to change tubing every Sunday on night shift and they should be dating it when they change it.

During an interview on 01/30/25 at 2:20 P.M., the Administrator said oxygen orders should be followed with the exception of a resident with low oxygen saturation. In that case, it would be nursing judgment to increase the oxygen liter flow and call the physician, but a resident should not be at an incorrect liter flow for an extended amount of time without a physician's order. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Infection Preventionist agreed that residents should receive oxygen as

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	265583	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMINGTON PRESBYTERIAN MANOR	500 CAYCE STREET 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 695	Continued From page 13 ordered and residents' tubing and humidity bottles should be changed on Sundays and dated with the date changed.	F 695		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe and functional environment for the residents by allowing items to be stored on top of over bed light fixtures for residents in ten resident rooms. Storing items on the over bed light creates a hazard of the items falling on the resident below and does not utilize the light fixtures as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 67. The facility did not provide a policy for over bed lighting safety. 1. Observation on 01/29/25 at 12:26 P.M. of Room 44 showed seven stuffed animals on top of the light fixture above the resident's bed. 2. Observation on 01/29/25 at 12:28 P.M. of Room 50 showed four baseball caps on top of the light fixture above the resident's bed. 3. Observation on 01/29/25 at 12:30 P.M. of Room 35 showed: - Six bird figurines and two birdhouses on top of the light fixture on the far right wall of the room;	F 921		

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	265583	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 921	Continued From page 14	F 921		

- Six glasses and a painting on top of the light fixture on the far left wall of the room.

4. Observation on 01/30/25 at 12:40 P.M. of Room 59 showed a cup, pictures, and other knick knacks on top of the light fixture above the resident's bed.

5. Observation on 01/30/25 at 12:44 P.M. of Room 61 showed multiple framed photos on top of the light fixture above the resident's bed.

6. Observation on 01/30/25 at 12:50 P.M. of Room 63 showed three painted canvas pictures on top of the light fixture above the resident's bed.

7. Observation on 01/30/25 at 12:55 P.M. of Room 64 showed a framed painting, a Valentine heart decoration, and a Christmas flower arrangement on top of the light fixture to the right of the resident's bed.

8. Observation on 01/30/25 at 1:10 P.M. of Room 13 showed a large painting on top of the light fixture above the resident's bed.

9. Observation on 01/30/25 at 1:10 P.M. of Room 46 showed:
- A stuffed animal and a white board on top of the light fixtures on the far right wall of the room;
- Five stuffed animals on top of the light fixture on the far left wall of the room.

10. Observation on 01/30/25 at 1:12 P.M. of Room 27 showed:
- Five paintings on top of the light fixture above the resident's bed;
- Three paintings on top of the light fixture across the room.

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	265583	A. BUILDING _____ B. WING _____	C 01/30/2025

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FARMINGTON PRESBYTERIAN MANOR	**500 CAYCE STREET FARMINGTON, MO 63640**

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F 921	Continued From page 15 During an interview on 01/30/25 at 2:20 P.M., the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Infection Preventionist (IP) collectively said items should not be placed on the light fixtures due to a possible hazard.	F 921		

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	06181	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMINGTON PRESBYTERIAN MANOR	500 CAYCE STREET FARMINGTON, MO 63640

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A2003	19 CSR 30-85.022(2)(E) No Fire Hazard General Requirements. (E) No section of the building shall present a fire hazard. I/II This regulation is not met as evidenced by: Class II Refer to F921.	A2003		
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to follow appropriate infection prevention practices for two out of ten employee tuberculosis (TB-a contagious lung disease) screenings when the facility failed to ensure that employee TB tests were read according to regulatory guidelines and the facility's policy. The facility's census was 67. Review of 19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities showed:	A4031		

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A4031	Continued From page 1 - Long Term Care Employees and Volunteers: All new long-term care facility employees and volunteers who work ten (10) or more hours per week are required to obtain a Mantoux Purified Protein Derivative (PPD) (Mantoux, TB skin test, tuberculin skin test, and PPDs are often used interchangeably. Mantoux refers to the technique for administering the test. Tuberculin (also called PPD) is the solution used to administer the test) two (2)-step tuberculin test within one (1) month prior to starting employment in the facility. If the initial test is zero to nine millimeters (0-9 mm), the second test should be given as soon as possible within three (3) weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one (1) subsequent annual test within the past two (2) years. It is the responsibility of each facility to maintain a documentation of each employee's and volunteer's tuberculin status. (E) Employees and volunteers with an initial zero to nine millimeters (0-9 mm) Mantoux PPD two (2)-Step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record. Review of the facility's policy titled, "Immunization-Tuberculosis (TB) testing for Employee, Volunteer and Resident," revised 09/19/24, showed: - TB skin testing is administered to and/or reviewed with each new resident and employee upon admission or employment, and per Centers for Disease Control (CDC) guidelines unless they have documentation of a previous positive reaction; - Procedure: New Hire/Volunteer: Complete individual TB risk assessment, Two-step TB testing for new employees; Testing should be performed within seven days of	A4031		

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A4031	Continued From page 2	A4031		

employment/admission and read 48-72 hours after PPD injection. If first step is negative, repeat skin test anytime in the next seven to twenty-one days, unless documentation is provided indicating a Mantoux PPD test in the past six months and at least one subsequent annual test in the past two years;
- Documentation must include the date of the initial and second skin tests, dated the tests were read, measurements of induration in millimeters, and manufacturer's information.

1. Review of Employee A's personnel file showed:
- A hire date of 12/04/24;
- A first-step TST administered on 12/01/24 and read 0 millimeters (mm) on 12/01/24;
- The facility failed to read the TST within the 48-72 hour timeframe after the test had been administered.

2. Review of Employee B's personnel file showed:
- A hire date 08/26/24;
- A second-step TST administered on 09/10/24 and read 9/13/24 with no measurements or results documented.
- The facility failed to document the results of the second-step TST.

During an interview on 01/30/25 at 11:56 A.M., the Assistant Director or Nursing (ADON) said that the previous Director of Nursing (DON) did the employee TB tests and tracked them. The ADON has since taken over those duties in the past five days. The ADON has a spreadsheet that the TB tests are tracked on, and there is also a binder of the hard copy paperwork in the office.

During an interview on 01/30/25 at 2:20 P.M., the Administrator, DON, ADON and Infection Preventionist (IP) collectively said that they would

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A4031	Continued From page 3 expect TB tests to be given and read per guidelines.	A4031		
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 F695.	A4075		
A8020	19 CSR 30-88.010(20) Exercise Rights/Voice Grievances Each resident shall be encouraged and assisted, throughout his or her period of stay, to exercise his or her rights as a resident and as a citizen and to this end a resident may voice grievances and recommend changes in policies and services to facility personnel or to outside representatives of his or her choice. A staff person shall be designated to receive grievances and the residents shall be free to voice their complaints and recommendations to the staff designee, an ombudsman or to any person outside the facility. Residents shall be informed of and provided a viable format for recommending changes in policy and services. The facility shall assist residents in exercising their rights to vote. II/III This regulation is not met as evidenced by: Class III Refer to F565.	A8020		

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PLAN OF CORRECTION

Provider/Supplier Name:	Farmington Presbyterian Manor
Street Address, City, Zip:	500 Cayce Street, Farmington MO 63640
Date of Survey:	January 27, 2025 thru January 30, 2025

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
	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal or state law. This provider maintains that the alleged deficiencies do not jeopardize the health and safety of residents nor are they of such character as to limit the provider's capacity to render adequate care. This plan of correction constitutes a written allegation of substantial compliance with State, Federal Medicare and Medicaid requirements. Without waiving the foregoing statement, the provider states the following: The alleged deficiencies and the plan of correction will be provided to the provider's Quality Assurance Committee for review and action on 2/18/2025.	
F565 SS=E A8020	**Resident/Family Group and Response CRF(s): 483.10(f)(5)(i)-(iv)(6)(7)**	
	Pursuant to the statement alleging a finding that the community failed to respond to or act upon the grievances and dietary recommendations for five residents, the community reviewed its guidelines related to 483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response, CSR 30-88.010(20) Exercise Rights/Voice Grievances. Corrective action for those residents found to have been affected by the alleged deficient practice: The Executive Director has provided instruction to the Dietary Manager, the Social Services Designee and the Director of Nursing to assign staff to resident issues and develop a plan for resolution.	

RBland ED

	All issues were addressed by the Dietary manager, Director of Nursing and Assistant Director of Nursing by 2/5/2025 . All department Directors have acknowledged understanding and have demonstrated competency. All department Directors will be expected to follow up with residents and report the outcomes to the Social Services Director and Executive Director at least monthly. Social services Director will document outcomes on the Resident Council meeting minutes and give to Executive Director for review. All directors will be educated on the process regarding resident council meetings and resolution of any issues that are voiced during these meetings. This education will be completed by 2/21/2025. Actions taken and staff performance will be reviewed by the Risk Committee at least monthly. The community will identify other residents having the potential to be affected by the same alleged deficient practice: The community has identified no other residents as having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurrence of the alleged deficient practice: The Executive Director has provided instruction to the Dietary Manager, the Social Services Designee and the Director of Nursing to assign staff to resident issues and develop a plan for resolution. All department Directors have acknowledged understanding and have demonstrated competency. All department Directors are expected to follow up with residents and report the outcomes to the Executive Director at least monthly following resident council meetings. Substantial compliance will be measured by: Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by: 3/13/2025	2/5/2025 2/21/2025 3/13/2025
F658 SS=D A4075	**Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)**	
	Pursuant to the statement alleging a finding that the community failed to follow physician's orders for three residents, the community reviewed its guidelines related to 483.21(b)(3)(i) Services Provided Meet Professional Standards, CSR 30-85.042(66) Nursing Care per Resident Condition. Corrective action for those residents found to have been affected by the alleged deficient practice:	

	Resident #7, #9 and #36 will receive services ordered by their physician starting immediately. The community management team has provided re-instruction to staff on the expectation to follow physician's orders. *The community management team has assured the availability of working scales and provided instruction on the location for documentation and response to issues preventing the completion of assigned tasks. *Staff have acknowledged understanding and have demonstrated competency. Staff education will be started immediately and completed by 2/28/2025. Actions taken and staff performance will be reviewed by the Risk Committee at least weekly through the process of weekly audits. A minimum of 3 random audits will be completed weekly and reviewed by Risk committee weekly times 8 weeks and then monthly. The community will identify other residents having the potential to be affected by the same alleged deficient practice: The community has identified no other residents as having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurrence of the alleged deficient practice: *The community management team has provided re-instruction to staff on the expectation to follow physician's orders. *The community management team has assured the availability of working scales and provided instruction on the location for documentation and response to issues preventing the completion of assigned tasks. Staff education will be completed by2/28/2025. Staff have acknowledged understanding and have demonstrated competency. Substantial compliance will be measured by: A minimum of 3 random audits will be completed weekly and reviewed by Risk committee weekly times 8 weeks and then monthly. Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by: 3/13/2025	1/30/2025 2/28/2025 2/28/2025 3/13/2025

F695 SS=D A4075	**Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)**	
	Pursuant to the statement alleging a finding that the community failed to follow physician's orders for supplemental oxygen therapy and oxygen tubing and humidifier changes for one resident, the community reviewed its guidelines related to 483.25(i) Respiratory/Tracheostomy Care and Suctioning, CSR 30-85.042(66) Nursing Care per Resident Condition. Corrective action for those residents found to have been affected by the alleged deficient practice: Resident #7 will receive services ordered by the physician. O2 was set at the rate ordered immediately, 1/30/2025. All 02 tubing and humidifiers were changed and labeled immediately, 1/30/2025.	1/30/2025
	*Staff have received re-training on the physician's orders, standards of practice, required changing of 02 tubing and humidifier, labeling tubing with date changed, following physician's orders for flow rate of oxygen, documentation and the expected performance. Staff have acknowledged understanding and have demonstrated competency. Staff education was started immediately and will be completed by2/28/2025.	2/28/2025
	Actions taken, staff performance and resident response will be reviewed at least weekly by the Risk Committee through the process of weekly audits. A minimum of 5 random audits will be completed weekly times 8 weeks and then monthly if no issues are found. Results will be reviewed by weekly Risk Committee. Audits will begin on	2/17/2025
	The community will identify other residents having the potential to be affected by the same alleged deficient practice: The community identified no other residents having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurrence of the alleged deficient practice: *Staff have received training on the standards of practice regarding oxygen therapy and care of equipment and the expected performance. *Staff have acknowledged understanding and have demonstrated competency. Staff education will be completed by2/28/2025.	2/28/2025
	Actions taken, staff performance and resident response will be reviewed at least weekly by the Risk Committee through the process of weekly audits.	

	A minimum of 5 random audits will be completed weekly times 8 weeks and then monthly if no issues are found. Results will be reviewed by weekly Risk Committee Substantial compliance will be measured by: Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by: 3/13/2025	3/13/2025
F921 SS=D A2003	**Safe/Functional/Sanitary/Comfortable Environ CFR9S): 483.90(i)**	
	Pursuant to the statement alleging a finding that the community failed to provide a safe and functional environment by allowing items to be stored on top of over bed light fixtures, the community reviewed its guidelines related to 483.90(i) Safe/Functional/Sanitary / Comfortable Environment. Corrective action for those residents found to have been affected by the alleged deficient practice: The Director of Nursing, Assistant Director of Nursing and the Director of Environmental services have informed residents and staff of the hazards of using the light fixtures as a shelf and have removed all items. All items were immediately removed from the light fixtures. The residents have been given the opportunity to have a shelf installed in a safe and convenient location. The Director of Environmental services and the Director of Nursing will provide instruction to staff and residents/representatives on the requirements of the regulations and safety practices. Education for residents and staff will be completed by 2/28/2025 Environmental services staff and Nursing staff will conduct routine inspections of resident rooms to ensure a safe environment. Results of inspections will be reviewed by the Risk Committee at least monthly. The community will identify other residents having the potential to be affected by the same alleged deficient practice: The community identified no other residents having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurrence of the alleged deficient practice: The Director of Nursing, Assistant Director of Nursing and the Director of Environmental services has informed residents and staff of the hazards of using the light fixtures as a shelf and have	1/30/2025 2/28/2025

	removed all items. The residents have been given the opportunity to have a shelf installed in a safe and convenient location. The Director of Environmental services and the Director of Nursing will provide instruction to staff and residents/representatives on the requirements of the regulations and safety practices. Education for residents/representatives and staff will be completed by 2/28/2025. Environmental staff and Nursing staff will conduct routine inspections of resident rooms to ensure a safe environment. Results of inspections will be reviewed by the Risk Committee at least monthly. Substantial compliance will be measured by: Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by: 3/13/2025	2/28/2025 3/13/2025
A4031	**19 CSR 30-85.042(27) Communicable Disease-Employees**	
	Pursuant to the statement alleging a finding that the community failed to follow appropriate infection prevention practices for two employee TB screenings, the community reviewed its guidelines related to CSR 30-85.042(27) Communicable Disease – Employees. Corrective action for those residents found to have been affected by the alleged deficient practice: Licensed nursing staff who are involved in the TB testing process have received re-education related to the requirements of TB testing for staff, including timeframes and documentation. Education began immediately and will be completed by 2/21/2025. The staff have acknowledged understanding and have demonstrated competency. 5 random audits of TB testing for staff will be performed monthly and reviewed by the Risk Committee. Audits will begin March 2025. The community will identify other residents having the potential to be affected by the same alleged deficient practice:	2/21/2025 3/2025

	The community has identified no other residents as having had the potential to be affected by the alleged deficient practice. Measures to prevent re-occurrence of the alleged deficient practice: Licensed nursing staff who are involved in the TB testing process for staff have received re-education related to the requirements of TB testing, including timeframes and documentation. Education will be completed by 2/21/2025. The staff have acknowledged understanding and have demonstrated competency. 5 random audits of TB testing for staff will be performed monthly and reviewed by the Risk Committee. Substantial compliance will be measured by: Actions taken will be reviewed by the QAA Committee at least quarterly. The community will be in substantial compliance by: 3/13/2025	2/21/2025 3/13/2025

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.