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F 565 SS=D	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

[signature] | LNHA | 12/20/24

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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failed to respond or act upon grievances, and failed to keep documentation of inventory for two residents (Residents #23 and #48) out of 15 sampled residents. The facility census was 59.

Review of the facility's policy titled, "Grievance Protocol," undated, showed:
- The purpose of the grievance/complaint report and grievance log is to provide a written record of each resident and family concern and to insure proper follow-up through the appropriate discipline;
- The Social Service Director (SSD) is responsible for the program, although the Administrator is ultimately responsible for the proper implementation;
- Grievance complaint should be filled out for resident articles that are lost or cannot be located;
- Social Services and Administrator evaluate the monthly grievance log for trends or patterns and devise an action plan to correct issues. A new log should be completed each month.

The facility did not provide an inventory policy.

Review of the facility's Grievance Log showed an empty binder with no documentation of any reported resident grievances.

During an interview on 12/03/24 at 1:59 P.M., Resident #48 said he/she was missing an electronic tablet and a cell phone. The items went missing within the last two - three weeks. He/She made the SSD and the Administrator aware of the missing items, but they were not doing anything about it.

During an interview on 12/04/24 at 9:16 A.M., the

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SSD said he/she was not aware of Resident #48's missing items until 12/02/24, and did not initiate a grievance related to the incident. He/She helped the resident look through his/her room for the missing items, but they were not found. The facility did not have inventory sheets for the resident's belongings, but he/she did normally try to get inventory lists completed for the residents. SSD had not been initiating or completing grievances.

During an interview on 12/04/24 at 10:11 A.M., Resident #23 said he/she was missing a cereal cup full of quarters and two electronic tablets. One tablet had been missing longer than a year, but the second tablet and cup of quarters were missing within the past two months. He/She told the SSD about the missing items and had never heard anything else about them.

During an interview on 12/04/24 at 10:42 A.M., the SSD said he/she did remember hearing about the missing money for Resident #23, but did not remember anything about a missing tablet. The SSD told the resident it was safer to keep money in the front business office. The SSD did not initiate or complete a grievance for the reported incident and did not have an inventory sheet for Resident #23. SSD said there should be a grievance form filled out when a resident reports a concern and an inventory sheet completed for each resident at the facility.

During an interview on 12/04/24 at 11:15 A.M., Certified Nursing Assistant (CNA) G said he/she did know about the items missing for Resident #48. Any time items were reported missing by a resident, he/she will help search and then notify the charge nurse on duty.

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F 565	Continued From page 3 During an interview on 12/04/24 at 11:01 A.M., Registered Nurse (RN) F said he/she was aware that Resident #48 had missing items. When staff were told items were missing, he/she will help search and make the Director of Nursing (DON) aware. During an interview on 12/04/24 at 11:08 A.M., the DON said she was aware of the missing items for Resident #23 and Resident #48. When items were reported missing, there should be an investigation started immediately and inventory sheets reviewed. During an interview on 12/04/24 at 10:45 A.M., the Administrator said he was unsure about the grievance policy, but they did work together as a team to try and handle missing items. He had never replaced items for residents in the past.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		

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inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to obtain a physician's order for code status for two residents (Residents #14 and #38) and consistently document a resident's code status with Full Code (cardiopulmonary resuscitation (CPR - an emergency procedure consisting of chest compressions if the heart stops beating or the person stops breathing) or Do Not Resuscitate (DNR - does not want CPR) for one resident (Resident #35) out of 15 sampled residents. The facility census was 59.

Review of the facility's policy titled, "DNR

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Protocol," not dated, showed:
- The Social Services Designee (SSD) will be responsible to print all DNR order forms on lavender paper to be placed in the admission packet;
- Once the DNR form is signed by the resident or legal representative it is to be signed by the physician;
- The SSD will then complete the following: a green paper with Full Code or a red paper with DNR will be placed in the very front of the medical record in a plastic sheet protector; on the Physician Order Sheet (POS) in the menu section located in the right upper corner of the POS, the SSD will add the heading of Code Status;
- The resident's code status will be periodically reviewed and renewed with the resident and/or legal representative, no less than quarterly during care plan review with the resident or resident's representative signing the care plan;
- The SSD will monitor the resident code status monthly, with new admission, readmissions, and as a resident's code status is changed to ensure all components of the program are current.

1. Review of Resident #14's medical record showed:
- Admission date of 06/15/24;
- Face sheet with Full Code status;
- Full Code written on spine of the hard chart.

Review of the resident's December 2024 Physician Order Sheet (POS) showed:
- No order for the resident's code status.

Review of the resident's revised care plan, dated 09/23/24, showed:
- Full Code status.

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2. Review of Resident #35's medical record showed:
- Admission date of 07/19/24;
- Face sheet with DNR code status;
- A red dot for DNR on the spine of the hard chart.

Review of the resident's December 2024 POS showed:
- An order for Full Code status.

Review of the resident's revised care plan, dated 11/26/24, showed:
- Full Code status.

3. Review of Resident #38's medical record showed:
- An admission date of 03/08/21;
- Face sheet with Full Code status;
- A green dot for Full Code on the spine of the hard chart.

Review of the resident's December 2024 POS showed:
- No order for the resident's code status.

Review of the resident's revised care plan, dated 10/14/24, showed:
- Full Code status.

During an interview on 12/06/24 at 10:20 A.M., the Director of Nursing (DON) said the Social Service Director (SSD) made sure what the code status was at admission. An order should be obtained for the code status. She would expect the code status to match anywhere it was documented.

During an interview on 12/06/24 at 10:25 A.M., Licensed Practical Nurse (LPN) I said if there was

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F 578	Continued From page 7 a code called, he/she would look at the hard chart and see what the code status was. A green dot on the spine of the binder meant the resident was a Full Code. A red dot on the spine of the binder meant the resident was a DNR. The face sheet and a purple sheet should be in the chart when the resident was a DNR. During an interview on 12/06/24 at 10:33 A.M., the MDS (a federally mandated assessment instrument completed by the facility staff) Coordinator said the SSD will let staff know if a resident had changed his/her mind and/or if the code status changed. The SSD would change the face sheet, however the SSD couldn't write an order. The resident was a full code until the DNR paperwork had been signed by the physician. During an interview on 12/06/24 at 10:40 A.M., the Quality Assurance (QA) Nurse and the DON said they would expect the orders for the code status to be on the physician orders.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		

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physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 59.

The facility did not provide a homelike environment policy.

1. Observations on 12/03/24 at 2:42 P.M., and

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F 584	Continued From page 9 12/04/24 at 9:20 A.M., of the 100 Hall showed: - A seat cushion cover worn with several peeled areas on a chair next to the bed near the door in Room 103; - Several areas of wallpaper peeled with exposed sheetrock located behind the bed near the window in Room 107; - A seat cushion cover worn with several peeled areas on a chair next to the bed near the door in Room 107; - Dark scuff marks and a three inch (in.) area of exposed sheetrock and peeled paint on the wall next to the door in Room 109. 2. Observations on 12/05/24 at 10:37 A.M., of the 300 Hall showed: - A loose and cracked piece of molding on the right side of the door frame in Room 303; - A cracked piece and a missing piece of molding on the left side of the door frame in Room 305; - An area of loose sheetrock tape on the ceiling by the privacy curtain track near the bed by the door in Room 307; - A seat cushion cover worn with a large area of peeled material on a chair next to the bed near the door in Room 309. 3. Observations on 12/06/24 at 12:45 P.M., of the Spa Room next to the mechanical room showed: - Several bed mattresses stacked against the wall by the toilet; - Several cupcake pans stacked on top of the left side clothes cabinet; - A mattress, step ladder and other miscellaneous items stacked against the left side of the clothes cabinet; - Cluttered shower chairs, a red trash can with lid, and miscellaneous debris inside and on the shower stall floor.	F 584		

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Review of the Maintenance Log Book, dated 09/20/24 - 12/02/24, showed no documentation of areas of concern addressed.

During an interview on 12/03/24 at 10:23 A.M., the resident in Room 309 said he/she would like for his/her chair to be either replaced or fixed. He/She doesn't know why staff would take a good chair out of his/her room and replace it with one that looked so bad because he/she had visitors that sit in the chair and it's not very appealing to look at.

During an interview on 12/06/24 at 9:05 A.M., Housekeeper C said he/she verbally told the maintenance department if there was something that needed to be fixed. He/She did not know if there was a maintenance log and had not seen anything recently to report other than a toilet not working.

During an interview on 12/06/24 at 9:20 A.M., Housekeeper D said if he/she noticed something that needed fixed, he/she let someone know on the hall. He/She had not seen anything to report and was not aware of a maintenance log to write down any environment concerns.

During an interview on 12/06/24 at 9:32 A.M., the Maintenance Supervisor (MS) said it would be easier to keep up with environmental issues if staff would write the concerns found on the maintenance log. MS had asked staff to write down the environment concerns because it made it hard to remember things throughout the day when staff didn't write environmental concerns down to be addressed and prioritized in a timely manner.

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F 584	Continued From page 11 During an interview on 12/06/24 at 10:50 A.M., the Quality Assurance (QA) nurse said the facility had several chairs in storage that could replace the worn chairs. He/She would let the Administrator know. During an interview on 12/06/24 at 12:41 P.M., the Administrator said he would expect staff to use the maintenance log book located at the nurses' station to write down any environmental concerns in addition to verbally telling the MS.	F 584		
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 accurately code the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) for two residents (Residents #4 and #51) out of 15 sampled residents. The facility census was 59. Review of the facility's policy titled, "MDS and Care Planning Guidelines," revised 10/01/15, showed: - It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI - a tool used to assist facility staff to gather defined information on a resident's strengths and needs) Manual, any published interim RAI manual errata (error) documents, and applicable federal guidelines as the authorative	F 641		

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guide for completion of MDS, care area assessments (CAAs) and resident care planning;
- The policy did not address the accuracy of MDS assessments.

1. Review of Resident #4's annual MDS, dated 02/28/24, showed:
- The resident did not receive an anticoagulant (medication to prevent and treat blood clots in the blood vessels and the heart).

Review of the resident's December 2024 Physician Order Sheet (POS) showed:
- Diagnosis of personal history of thrombophlebitis (vein inflammation that happens in connection with one or more blood clots);
- An order for desmopressin (an anticoagulant) 0.1 milligram (mg) 1/2 tablet oral twice daily, dated 12/05/22;

Review of the resident's care plan, revised 02/12/24, showed:
- The resident received anticoagulant therapy.

2. Review of Resident #51's annual MDS, dated 05/12/24, showed:
- The resident received an anticoagulant.

Review of the resident's December 2024 POS showed:
- Diagnosis of stroke;
- An order for aspirin (a nonsteroidal anti-inflammatory drug) 325 mg oral daily, dated 12/28/22.

Review of the resident's care plan, revised 10/24/24, showed:
- The resident received anticoagulant therapy.

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F 641	Continued From page 13 During an interview on 12/06/24 at 9:12 A.M. , the MDS Coordinator said if a resident took an anticoagulant, it should be indicated on the resident's MDS assessment. If a resident didn't take an anticoagulant, it should not be indicated as an anticoagulant on the resident's MDS assessment. During an interview on 12/06/24 at 10:18 A.M. , the Director of Nursing (DON) said if a resident took an anticoagulant, it should be indicated on the resident's MDS assessment. If a resident didn't take an anticoagulant, it should not be indicated as an anticoagulant on the resident's MDS assessment.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph	F 645		

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(k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental

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disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder, to determine the level of care needed) for two residents (Residents #4 and #43) out of two sampled residents. The facility census was 59.

The facility did not provide a policy for a PASARR.

1. Review of Resident #4's medical record showed:
- An admission date of 03/16/21;
- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and post traumatic stress disorder (PTSD - psychological distress following a traumatic event);
- No documentation of the required level one PASARR screening upon admission to the facility.

2. Review of Resident #43's medical record showed;
- An admission date of 01/08/20;
- Diagnoses of bipolar (a mental disorder that causes unusual shifts in mood) and schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave

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F 645	Continued From page 16 clearly, sometimes including delusions or hallucinations); - No documentation of the required level one PASARR screening upon admission to the facility. During an interview on 12/05/24 at 11:15 A.M., the Social Service Director (SSD) said a level one PASARR should be completed on a resident prior to admission to the facility. Resident #4's level one screening still needed to be completed and submitted. Resident #43's level one screening was rejected due to no psychiatric documentation that wasn't sent. During an interview on 12/06/24 at 1:05 P.M., the Administrator said he would expect a resident to have a level one PASARR completed prior to the resident being admitted to the facility.	F 645		
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;	F 692		

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§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 implement, monitor, and modify interventions to maintain acceptable parameters of nutritional status for one resident(Resident #14) out of two sampled residents. The facility census was 59.

Review of the facility's policy titled, "Weight Champion Program," not dated, showed:
- Each community should designate a weight champion to assist in the oversight and monitoring of residents that have or are at risk for weight loss;
- The purpose of this program is to take a proactive stance against weight loss and collaborate to decrease weight loss numbers;
- The weight champion will be responsible for keeping the weight variance report from Matrix, as well being custodian of the daily, weekly and monthly facility weight lists;
- The champion will review for completion during the next stand up meeting. The champion will request and monitor re-weights of residents;
- Weights should be reviewed weekly in our Interdisciplinary Team (IDT) meeting;
- Weights should be assessed by the IDT at the time that the loss is noted. If a supplement is necessary, food items should be tried first, the exception is that of those resident drinking is more feasible for the resident. This must be documented;
- Examples of food interventions are snacks, fortified (a fortified food used to provide extra

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calories, proteins and vitamins) milk , fortified soups, extra portions, supercereal (a fortified cereal used to provide extra calories, proteins and vitamins), smaller more frequent meals, super pudding (a fortified pudding used to provide extra calories, proteins and vitamins), fortified food program.

Review of the facility's policy titled, "Registered Consultant Dietitian (RD)," dated May 2015, showed:
- Monthly visits to each facility to assist in compliance of regulatory requirements in food service and residents' dietary care with a report of findings;
- Consultation with the Director of Nursing (DON) on all residents who are at risk for poor nutrition, have significant weight loss, have pressure sores, or that are fed per tube.

1. Review of Resident #14's Physician Order Sheet (POS), dated December 2024, showed:
- An order for Level 7 Regular diet (easy to chew), reduced concentrated sweets (RCS), dated 06/21/24;
- An order for Boost very high calorie drink (VHC) 120 millimeters (ml) with supper meal, dated 12/03/24;
- An order for a referral to gastroenterologist (specialist in organs of the digestive system), dated 12/04/24;
- No order for a multivitamin as recommended by the RD on 06/18/24;
- No order for weekly weights as recommended by the RD on 12/03/24.

Review of the resident's Weight Variance Report, dated 06/15/24 through 12/04/24, showed:
- On 06/15/24, the resident weighed 235.8

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pounds (lbs);
- On 06/20/24, the resident weighed 235.8 lbs;
- On 06/25/24, the resident weighed 233.7 lbs;
- On 07/02/24, the resident weighed 233.7 lbs;
- On 07/09/24, the resident weighed 230.4 lbs;
- On 08/02/24, the resident weighed 228.0 lbs;
- On 09/03/24, the resident weighed 221.0 lbs;
- On 10/01/24, the resident weighed 216.9 lbs;
- On 11/04/24, the resident weighed 210.4 lbs;
- On 12/04/24, the resident weighed 206.6 lbs;
- From 06/15/24 - 08/02/24, the resident had a 4.98% weight loss in 3 months;
- From 06/15/24 - 12/04/24, the resident had a 10.38% weight loss in 6 months.

Review of the Dietary assessments showed:
- An initial assessment completed on 06/18/24, with a regular diet,restricted concentrated sweets, and recommendations to add a multivitamin;
- A quarterly nutrition review completed on 09/12/24, with a regular diet and restricted concentrated sweets. Notes weight was down six pounds in 30 days, edema (swelling) contributing;
- A significant weight change in status completed on 12/03/24, with greater than 7.5% wt. loss in 90 days. Resident with significant weight change for 90 days and 180 days. Recommended to add VHC 120 ml to supper meal and monitor weekly weights;
- No documentation the RD assessed the resident in October and November 2024.

Review of the resident's Care Plan, last reviewed, 09/23/24, showed:
- A regular diet, no concentrated sweets;
- Did not address weight loss with interventions.

Observations of the resident on 12/03/24, 12/05/24, and 12/06/24, during the lunch meal

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F 692	Continued From page 20 showed: - The resident ate in the main dining room. The resident #14 ate approximately 50-100% of his/her meals. During an interview on 12/03/24 at 2:14 P.M., Resident #14 said he/she was not trying to lose weight and was not on any medications to aid in weight loss. During an interview on 12/05/24 at 3:25 P.M., the Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) Coordinator said the Restorative Nurse Aide (RNA) weighed the residents. The MDS Coordinator and the DON received a copy of the weight variance report and reviewed it. The facility did not have meetings where they discussed residents weights. During an interview on 12/05/24 at 3:34 P.M. the Quality Assurance (QA) Nurse said the RD needed to be reviewing any weight loss in the facility. The weight variance report should be reviewed by the DON and any resident with weight loss should be seen by the RD. During an interview on 12/11/24 at 9:53 A.M., the RD said it would be good if the facility held weight meetings within the facility on a bi-weekly basis. During an interview on 12/11/24 at 10:30 A.M., the MDS Coordinator said Resident #14's family brought it to the attention of the facility of the resident's weight loss.	F 692		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		

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F 759	Continued From page 21 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 37 opportunities with three errors made, resulting in an error rate of 8.11% for three residents (Residents #20, #34 and #38) out of eleven sampled residents. The facility's census was 59. Review of the facility's policy titled, "Specific Medication Administration Procedures," dated July 2021, showed: - Prime insulin pen prior to use; - Dial up two units; - Hold pen upright and push the button on the end of the pen so a small drop of insulin appears; - Dial insulin to the desired insulin dose to be administered to the resident. Review of the Humalog/lispro (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) Kwik Pen (Insulin in a pen-type device) instructions, revised, July 2023, showed: - Prime the pen by turning the dose knob to two units; - Hold the pen with the needle pointing up; - Tap the cartridge holder gently to collect air bubbles at the top; - Push the dose knob in until it stops, and zero is seen in the dose window, count to five slowly, insulin will be visible at the tip of the needle;	F 759		

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- Select the dose;
- Give the injection after selecting the area and cleaning the site with an alcohol swab.

Review of the Novolog/Fiasp/aspart (fast-acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen administration instructions, dated September 2021, showed:
- Prime the pen by turning the dose selector to two units;
- Keep the needle upwards and press the push-button until the dose selector reads zero;
- Turn the dose selector to select the number of prescribed units.

1. Review of Resident #20's Physician Order Sheet (POS), dated December 2024, showed:
- An order for Humalog insulin pen 100 units per milliliter (ml) subcutaneous (injection under the skin) with meals per a sliding scale if blood sugar is 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, blood sugar greater than 450, call the physician, dated 06/10/24.

Observation of Resident #20's medication administration on 12/04/24 at 11:16 A.M., showed:
- Registered Nurse (RN) J administered 12 units of Humalog subcutaneously per order of the sliding scale for a blood sugar of 433 with the resident's Humalog Kwik Pen;
- RN J failed to prime the Humalog Kwik Pen per the manufacturer's instructions prior to the administration to the resident.

2. Review of Resident #34's POS, dated December 2024, showed:

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F 759	Continued From page 23 - An order for ondansetron (anti-nausea medication) 4 milligrams (mg) disintegrating tablet three times daily with meals for weight loss, dated 04/10/23. Observation of Resident #34's medication administration on 12/05/24 at 11:30 A.M., showed: - Certified Medication Technician (CMT) K administered the tablet with water; - CMT K failed to instruct the resident to hold the medication on or underneath the tongue for medication to be effective; - The resident swallowed the tablet instead of it disintegrating. 3. Review of Resident #38's POS, dated December 2024, showed: - An order for Novolog Flex insulin pen 100 units per ml subcutaneous with meals per a sliding scale if blood sugar is 150-175=1 unit, 176-200=2 units, 201-225=3 units, 226-250=4 units, 251-275=5 units, 276-300=6 units, 301-325=7 units, 326-350=8 units, 351-375=9 units, 376-400=10 units, if greater than 400, call nurse practitioner (NP)/physician's assistant (PA), dated 10/16/24. Observation of Resident #38's medication administration on 12/04/24 at 11:23 A.M., showed: - RN J administered 9 units of Novolog subcutaneously per order of the sliding scale for a blood sugar of 249 with the resident's Novolog Flex pen; - RN J failed to prime the Novolog Flex Pen per the manufacturer's instructions prior to the administration to the resident.	F 759		

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F 759	Continued From page 24 During an interview on 12/04/24 at 11:45 A.M., RN J said he/she thought the insulin pens only needed to be primed when the pen was new, not for each insulin administration. During an interview on 12/06/24 at 9:30 A.M., the Director of Nursing (DON) said staff should prime insulin pens with two units of insulin with every insulin administration. During an interview on 12/06/24 at 10:55 A.M., the Quality Assurance (QA) Nurse said the facility followed the insulin manufacturer's recommendations.	F 759		
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 §483.71 and following	F 880		

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F 880	Continued From page 25 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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.	F 880		

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§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 implement Enhanced Barrier Precautions (EBP) during wound care for one resident (Resident #6) out of one sampled resident. The facility failed to use proper hand hygiene during blood sugar testing for four residents (Residents #3, #10, #20 and #38) out of four sampled residents. This deficient practice had the potential to affect all residents in the facility. The facility census was 59.

Review of the facility's policy, titled, "Enhanced Barrier Precautions to Infection Control Guidelines," updated 2024, showed:
-To prevent broader transmissions of multi-drug resistance organisms (MDROs) and to help protect patients with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed;
- Examples of MDROs include, but are not limited to, methicillin-resistant staphylococcus aureas (MRSA), vancomycin-resistant enterococci (VRE), extended spectrum beta-lactamase (ESBL-producing enterobacterais) and drug-resistant streptococcus pneumoniae;
- Who requires EBP, residents known to be infected or colonized with a MDRO, residents with an indwelling medical device, and residents with a wound, regardless of their MDRO status;
- When to use EBP, during high-contact resident care activities, such as, performing wound care;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265614	A. BUILDING _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARVIEW NURSING CENTER	430 SALCEDO ROAD SIKESTON, MO 63801

(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 - Gown and gloves are required when conducting high-contact resident care activities, such as wound care. Review of the facility's policy titled, "Diabetic Infection Control," undated, showed: - Gloves are to be worn when performing finger sticks and changed between resident contacts; - Remove and discard gloves in appropriate receptacles after each procedure that involves potential exposure to blood or body fluids, including finger stick blood sampling; - Perform hand hygiene (i.e., hand washing with soap and water or use an alcohol-based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use on another resident. 1. Observation on 12/05/24 at 1:28 P.M., of Resident #6's wound care showed: - No EBP signage posted outside of the resident's room; - Registered Nurse (RN) J did not put on isolation gown, did not perform hand hygiene, put on gloves, and entered the resident's room; - RN J removed the saturated dressing from the resident's left neck area; - RN J performed hand hygiene and changed gloves; - RN J used wound cleanser and gauze to clean the wound, did not perform hand hygiene, did not change gloves, and patted the wound dry with clean gauze; - RN J performed hand hygiene and put on clean gloves; - RN J applied a 2x2 gauze dressing and secured with medical tape; - RN J took the biohazard bag outside of the resident room and disposed of the bag in the	F 880		

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F 880	Continued From page 28	F 880		

trash can attached to the treatment cart;
- RN J removed the gloves and did not perform hand hygiene.

During an interview on 12/03/24 at 10:01 A.M., Resident #6 said he/she didn't know why they had a dressing applied to his/her neck.

2. Observation on 12/04/24 at 11:10 A.M., of Resident #10's blood sugar testing showed:
- RN J did not perform hand hygiene and put on gloves;
- RN J performed the resident's blood sugar testing;
- RN J removed the gloves and did not perform hand hygiene.

3. Observation on 12/04/24 at 11:16 A.M., of Resident #20's blood sugar testing showed:
- RN J did not perform hand hygiene and put on gloves;
- RN J performed the resident's blood sugar testing;
- RN J removed the gloves and did not perform hand hygiene.

4. Observation on 12/04/24 at 11:23 A.M., of Resident #38's blood sugar testing showed:
- RN J did not perform hand hygiene and put on gloves;
- RN J performed the resident's blood sugar testing;
- RN J removed the gloves and did not perform hand hygiene.

5. Observation on 12/04/24 at 11:26 A.M., of Resident #3's blood sugar testing showed:
- RN J did not perform hand hygiene and put on gloves;

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F 880	Continued From page 29 - RN J performed the resident's blood sugar testing; - RN J removed the gloves and did not perform hand hygiene. During an interview on 12/06/24 at 9:30 AM, the Director of Nursing (DON) said Resident #6 should have been on EBP. With EBP, staff should be putting on a gown and gloves and removing the gown and gloves within the resident's room. She said nurses should be performing hand hygiene prior to putting on gloves and after removing gloves for any procedure, including blood sugar testing.	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced	F 947		

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F 947	Continued From page 30	F 947		

by:
Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service and failed to provide the required annual competencies of Dementia Care (care of a resident with an impaired ability to remember, think, or make decisions) for two certified nurse assistants (CNA) (CNA A and CNA B) of two nurse aides sampled. The facility census was 59.

The facility did not provide a nurse aide in-service policy.

Review of the facility assessment, revised 02/06/24, showed:
- Required in-service training for nurse's aides:
1. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;
2. Include dementia management training and resident abuse preventions training;
3. Address areas of weakness as determined by the facility assessment and address the special needs of residents to as determined by the facility staff;
4. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

1. Review of the facility's August 2023 - July 2024 in-service records showed:
- CNA A's hire date of 08/13/22;
- CNA A attended a total of seven monthly in-services;
- No time duration documented on the monthly in-service sheets;
- CNA A did not attend an annual competency in-service on Dementia Care.

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F 947	Continued From page 31 2. Review of the facility's November 2023 - October 2024 in-service records showed: - CNA B's hire date of 11/02/21; - CNA B attended a total of six monthly in-services; - No time duration documented on the monthly in-service sheets; - CNA B did not attend an annual competency in-service on Dementia Care. During an interview on 12/06/24 at 10:50 A.M., the Director of Nursing (DON) said nurse aid education training should include Dementia Care. Nurse-aides should receive 12 hours of education training to meet the annual in-service requirement. During an interview on 12/06/24 at 10:56 A.M., the Administrator said nurse aid education training should include Dementia Care. Nurse-aides should receive 12 hours of education training to meet the annual in-service requirement.	F 947		

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	19913	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARVIEW NURSING CENTER	430 SALCEDO ROAD SIKESTON, MO 63801

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A4026	19 CSR 30-85.042(22) In-service Training-Nursing Personnel The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs related to problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency. II/III This regulation is not met as evidenced by: Class III Refer to F947	A4026		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II Refer to F759	A4055		
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 F692	A4075		

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	19913	A. BUILDING: _____ B. WING _____	12/06/2024

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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 amended. I/II This regulation is not met as evidenced by: Class II Refer to F880	A4086		
A4106	19 CSR 30-85.042(97) DMH Referral, Treatment/Habilitation Plan Residents admitted to a facility on referral by the Department of Mental Health shall have an individualized treatment plan or individualized habilitation plan on file which is updated annually. III This regulation is not met as evidenced by: Class III Refer to 645	A4106		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to-	A4108		

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A4108	Continued From page 2 (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III Refer to F641	A4108		
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean Walls and ceilings, including doors, windows and skylights, shall be clean and maintained in good repair. III This regulation is not met as evidenced by: Class III Refer to F584	A6015		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to	A8010		

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A8010	Continued From page 3 advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class III Refer to 578	A8010		
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	A8020		

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A8020	Continued From page 4 This regulation is not met as evidenced by: Class III Refer to F565	A8020		

PLAN OF CORRECTION

Provider/Supplier Name:	Clearview Nursing Center
Street Address, City, Zip:	430 W Salcedo Rd., Sikeston, MO 63801
Date of Survey:	12/06/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction ("POC") is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Clearview Nursing Center as to the accuracy of the surveyors' findings, nor the conclusions drawn there from. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Corrections	
F565 (D)	The facility will respond and act upon any grievance brought upon from resident and or family member. Facility will also keep documentation and log grievance process. Facility will also keep documentation of inventory of resident's belonging. Facility will keep a grievance log and an inventory list for resident #23, #48, and all other affected residents. Administrator in serviced SSD regarding grievance protocol and appropriate documentation of grievance log and inventory list of residents' belongings. SSD has established a grievance log for tracking of any grievances. SSD will obtain inventory of all residents' belongings and document in medical record	01/20/2025

	Administrator or designee will monitor grievance log weekly; and monitor inventory list of any new residents to the facility x 4 months. All results will be reported to QA&A committee	
F578 (D)	Residents will be allowed to request, refuse, discontinue treatment and formulate an advance directive. The facility will obtain a physician's order for all residents a code status (the type of treatment a person would or would not receive if their heart or breathing were to stop). The facility will ensure the accuracy of a resident's #14, #38 and all other affected advance directives regarding resuscitation code status in the facility. The QA nurse will conduct an in-service with Administrator, Social Services, DON and all licensed personnel in regards to all residents needing a code status. •Nursing Staff will be in-serviced on the importance of the accuracy of the clearly identifying code status. Staff will be properly trained and CPR certified and will be available on all shifts and at all times to provide CPR when needed. Facility will direct staff to initiate CPR when cardiac arrest occurs for residents who have requested CPR in their advanced directives, who have not formulated an advanced directive, or who do not have a DNR order. •All Medical Records will have on the inside sleeve a GREEN FULL CODE sheet or a RED (DNR) sheet as indicated by the resident or responsible party's wishes. This will also be updated in the Electronic medical records and care plans for all residents in the facility. The Social Services Designee will audit (3) current residents and or any newly admitted residents' charts x 12 weeks for correct Code status in charts and in electronic medical records. Audits will be submitted to the administrator to monitor compliance. All results will be reported to QA&A committee	01/20/2025
F584 (D)	The facility must provide a safe, clean, and comfortable homelike environment for all residents.	01/20/2025
	*Room 103- the chair with peeled cushion will be replaced. *Room 107- Any areas of exposed sheetrock on walls will be repaired and painted; worn, peeled chair will be discarded and replaced. *Room 109- Areas of dark scuffed marks, exposed sheetrock, and peeled paint on walls will be cleaned, repaired and painted.	01/20/2025

	*Room303- Broken area of molding on door frame will be repaired/and or replaced *Room 305- Broken area of molding on door frame will be repaired/and or replaced *Room 309 – worn, peeled chair will be discarded and replaced *Spa Room next to mechanical room will be cleaned, decluttered and all items will be appropriate storage areas	
	Maintenance supervisor will make all necessary repairs. A visual inspection of the repairs will be completed by _1/20/2025_ All employees will be in-service on correct usage of maintenance repair log by _1/20/2025. Log is kept at nurses' station. Administrator will in-service maintenance supervisor on use of maintenance log and preventative maintenance schedule. Administrator will monitor the maintenance log and preventative maintenance schedule monthly x 4 to ensure compliance. All results will be reported to QA&A committee	01/20/2025
F641 (D)	Facility will have accurate MDS assessments to reflect resident's status and diagnosis. Resident #4 and resident #51 and all other affected residents will have the correct coding and diagnosis listed on their MDS assessments. MDS coordinator will be in-service by 01/20/2025 regarding the importance of accuracy of MDS and diagnosis on assessments. Adminstrator or designee will audit 2(two) MDS assessments weekly x 3 months for anticoagulant and antiplatelet coding and diagnosis accuracy. All results will be reported at QA&A committee	01/20/2025
F645 (D)	The facility will provide documentation of completion of Level 1 Preadmission Screening and Resident Review (PASARR) for individuals with a mental disorder and individuals with intellectual disability. Facility (SSD) will complete and provide documentation of PASARR for residents #4, #43, and all other affected residents. Social Services designee/director will complete Level 1 Preadmission Screening and Resident Review (PASARR) on all residents, including those with mental disorders and/or	01/20/2025

	intellectual disabilities. PASARR will be completed within COMRU guidelines. Administrator will monitor and ensure all affected residents will have PASARR completed and will provide documentation of completion. Administrator will audit x 3 months any new resident to facility for completion of PASARR. All results will be reported to QA&A committee	
F692 (D)	Nutrition/Hydration Status Maintenance	
	The facility will ensure that a resident (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight ranges, electrolyte balance, unless the residents clinical condition demonstrates that it is not possible or the resident preferences indicate otherwise; (2) Is offered sufficient fluid intake to maintain proper hydration and health; Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	01/20/2025
	One (1) resident was affected by the alleged deficient practice.	
	Weight Champion Program will be followed and is inclusive of; 1. All residents will be weighed monthly unless otherwise indicated or resident declines to be weighed; 2. Residents with significant weight loss at time of monthly weight will be weighed weekly; 3. Residents with weight variance will be re-weighed for accuracy; 4. Weights will be entered into the EMR; 5. Weekly weights will be reviewed weekly in IDT with corresponding progress notes entered into the EMR; 6. Physician and Registered Dietitian will be informed of significant weight change. 7. Registered Dietitian will address all significant and insidious weight changes. 8. Registered Dietitian recommendations will be implemented timely. 9. Nutritional Care plans will be updated to include weight and any nutritional interventions. Resident #14 care plan will be updated to include weight changes and all nutritional interventions. Weights will be monitored by the IDT weekly and the Registered Dietitian during regular scheduled visits. Nursing staff and the Registered Dietitian will be in-serviced by the Quality Assurance Nurse on or before _____01/20/2025_regarding the following: (1) Evaluation of significant and insidious weight changes (2) IDT notes and weight loss interventions	01/20/2025

	Care Planning	
	The Director of Nursing or designee will oversee the Weight Champion Program, monitor residents with significant and insidious weight change, inform MD and RD of significant weight changes, monitor completion of RD documentation and completion of recommendations, update and monitor nutritional care plans for residents with significant or insidious weight change. The Administrator will monitor the Weight Champion Program weekly. Report findings to the QA&A committee and for 90 days thereafter.	01/20/2025
F759 (D)	The facility must ensure that its medication error rates are NOT 5(five) percent or greater. Resident #20, #34 and #38 and all other affected residents will have error free medication administration. DON will in-service all licensed nursing staff for correct medication administration of priming insulin pens, and correct administration of oral disintegrating medication. DON or designee will audit medication administration of insulin pens and disintegrating medication weekly x 4 months. All results will be reported to QA&A committee	01/20/2025
F880 (D)	The facility must provide establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the transmission of communicable diseases and infections. Facility must provide care in which proper hand hygiene and glove usage is utilized. Residents #3, #10, #20, #38, and all other affected residents should be care completed with proper hand hygiene and glove usage. Resident #6 and all other affected residents on enhanced barrier precautions will require use of gown and gloves when conducting high contact care activities due to wound care or other ailments meeting requirements. DON will in-service all of nursing staff on correct hand washing technique and glove usage per P&P. DON or designee will audit 2 (two) staff members weekly for correct hand washing and glove usage including during wound care and blood glucose checks x 4 months	01/20/2025

	DON will perform skill checks on all licensed nursing staff on blood glucose checks, handwashing, and glove usage. All staff will be in serviced by QA nurse consultant regarding Enhance Barrier Precautions (EBP), including the definition, which resident is on EBP precautions, and when to use EBP precautions. DON will audit correct usage of EBP precautions on 3 affected residents weekly x 3 months and ongoing All results will be reported to QA&A committee	
F947 (D)	The facility will ensure there is a system of in-service training for all nursing personnel which identifies training needs related to problems, needs, and care of residents. The DON or designee will maintain a tracking tool for completed in-service hours of all staff, including certified nurses' aides. Administrator/DON or designee will ensure all CNAs will complete mandated 12 hours of in-service training annually. Inservice training will include abuse prevention training and dementia management training. All results will be reported to QA&A committee	01/20/2025

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.

PLAN OF CORRECTION

Provider/Supplier Name:	Clearview Nursing Center
Street Address, City, Zip:	430 Salcedo Rd Sikeston, MO 63801
Date of Survey:	12/06/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction ("POC") is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Clearview Nursing Center as to the accuracy of the surveyors' findings, nor the conclusions drawn there from. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Corrections.	
A4026	Refer to 947 The facility will ensure there is a system of in-service training for all nursing personnel which identifies training needs related to problems, needs, and care of residents. The DON or designee will maintain a tracking tool for completed inservice hours of all staff, including certified nurses' aides. Administrator/DON or designee will ensure all CNAs will complete mandated 12 hours of inservice training annually. Inservice training will include abuse prevention training and dementia management training. All results will be reported to QA&A committee	01/20/2025
A4055	Refer to 759 The facility must ensure that its medication error rates are NOT 5(five) percent or greater. Resident #20,#34 and #38 and all other affected residents will have error free medication administration.	01/20/2025

	DON will inservice all licensed nursing staff for correct medication administration of priming insulin pens, and correct administration of oral disintegrating medication. DON or designee will audit medication administration of insulin pens weekly x 4 months. All results will be reported to QA&A committee	
A4075	Refer to 692 Weight Champion Program will be followed and is inclusive of; 1. All residents will be weighed monthly unless otherwise indicated or resident declines to be weighed; 2. Residents with significant weight loss at time of monthly weight will be weighed weekly; 3. Residents with weight variance will be re-weighed for accuracy; 4. Weights will be entered into the EMR; 5. Weekly weights will be reviewed weekly in IDT with corresponding progress notes entered into the EMR; 6. Physician and Registered Dietitian will be informed of significant weight change. 7. Registered Dietitian will address all significant and insidious weight changes. 8. Registered Dietitian recommendations will be implemented timely. 9. Nutritional Care plans will be updated to include weight and any nutritional interventions. Resident #14 care plan will be updated to include weight changes and all nutritional interventions. Weights will be monitored by the IDT weekly and the Registered Dietitian during regular scheduled visits. Nursing staff and the Registered Dietitian will be in-serviced by the Quality Assurance Nurse on or before _____01/20/2025_regarding the following: (1) Evaluation of significant and insidious weight changes (2) IDT notes and weight loss interventions Care Planning	01/20/2025
A4086	Refer to 880 The facility must provide establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the transmission of communicable diseases and infections. Facility must provide care in which proper hand hygiene and glove usage is utilized. Residents #3, #10,#20,#38,and all other affected residents should be care completed with proper hand hygiene and glove usage. Resident #6 and all other affected residents on enhanced barrier precautions will require use of gown and gloves when conducting high contact care activities due to wound care or other ailments meeting requirements.	01/20/2025

	DON will inservice all of nursing staff on correct hand washing technique and glove usage per P&P. DON or designee will audit 2 (two) staff members weekly for correct hand washing and glove usage including during wound care and blood glucose checks x 4 months DON will perform skill checks on all licensed nursing staff on blood glucose checks, handwashing, and glove usage. All staff will be inserviced by QA nurse consultant regarding Enhance Barrier Precautions (EBP), including the definition, which resident is on EBP precautions, and when to use EBP precautions. DON will audit correct usage of EBP precautions on 3 affected residents weekly x 3 months and ongoing All results will be reported to QA&A committee	
A4106	Refer to 645 The facility will provide documentation of completion of Level 1 Preadmission Screening and Resident Review (PASARR) for individuals with a mental disorder and individuals with intellectual disability. Facility (SSD) will complete and provide documentation of PASARR for residents #4, #43, and all other affected residents. Social Services designee/director will complete Level 1 Preadmission Screening and Resident Review (PASARR) on all residents, including those with mental disorders and/or intellectual disabilities. PASARR will be completed within COMRU guidelines. Administrator will monitor and ensure all affected residents will have PASARR completed and will provide documentation of completion. Administrator will audit x 3 months any new resident to facility for completion of PASARR. All results will be reported to QA&A committee	01/20/2025
A4108	Refer to F641 Facility will have accurate MDS assessments to reflect resident's status and diagnosis. Resident #4 and resident #51 and all other affected residents will have the correct coding and diagnosis listed on their MDS assessments. MDS coordinator will be inserviced by 01/20/2025 regarding the importance of accuracy of MDS and diagnosis on assessments. Administrator or designee will audit 2(two) MDS assessments weekly x 3 months for anticoagulant coding and diagnosis accuracy. All results will be reported at QA&A committee	01/20/2025
A6015	Refer to F584	01/20/2025

	The facility must provide a safe, clean, and comfortable homelike environment for all residents. *Room 103- the chair with peeled cushion will be replaced. *Room 107- Any areas of exposed sheetrock on walls will be repaired and painted; worn, peeled chair will be discarded and replaced. *Room 109- Areas of dark scuffed marks, exposed sheetrock, and peeled paint on walls will be cleaned, repaired and painted. *Room303- Broken area of molding on door frame will be repaired/and or replaced *Room 305- Broken area of molding on door frame will be repaired/and or replaced *Room 309 – worn, peeled chair will be discarded and replaced *Spa Room next to mechanical room will be cleaned, decluttered and all items will be appropriate storage areas Maintenance supervisor will make all necessary repairs. A visual inspection of the repairs will be completed by _1/20/2025_ All employees will be inserviced on correct usage of maintenance repair log by _1/20/2025. Log is kept at nurses' station. Administrator will in-service maintenance supervisor on use of maintenance log and preventative maintenance schedule. Administrator will monitor the maintenance log and preventative maintenance schedule monthly x 4 to ensure compliance. All results will be reported to QA&A committee	
A8010	Refer to F578 Residents will be allowed to request, refuse, discontinue treatment and formulate an advance directive. The facility will obtain a physician's order for all residents a code status (the type of treatment a person would or would not receive if their heart or breathing were to stop). The facility will ensure the accuracy of a resident's #14,#38 and all other affected advance directives regarding resuscitation code status in the facility. The QA nurse will conduct an in-service with Administrator, Social Services, DON and all licensed personnel in regards to all residents needing a code status. •Nursing Staff will be in-serviced on the importance of the accuracy of the clearly identifying code status. Staff will be properly trained and CPR certified and will be available on all shifts and at all times to provide CPR when needed. Facility will direct staff to initiate CPR when cardiac arrest occurs for residents who have requested CPR in their advanced directives,	01/20/2025

	who have not formulated an advanced directive, or who do not have a DNR order. •All Medical Records will have on the inside sleeve a GREEN FULL CODE sheet or a RED (DNR) sheet as indicated by the resident or responsible party's wishes. This will also be updated in the Electronic medical records and care plans for all residents in the facility. The Social Services Designee will audit (3) current residents and or any newly admitted residents' charts x 12 weeks for correct Code status in charts and in electronic medical records. Audits will be submitted to the administrator to monitor compliance. All results to QA&A committee	
A8020	Refer to F565 The facility will respond and act upon any grievance brought upon from resident and or family member. Facility will also keep documentation and log grievance process. Facility will also keep documentation of inventory of resident's belonging. Facility will keep a grievance log and an inventory list for resident #23, #48, and all other affected residents. Administrator inserviced SSD regarding grievance protocol and appropriate documentation of grievance log and inventory list of residents' belongings. SSD has established a grievance log for tracking of any grievances. SSD will obtain inventory of all residents' belongings and document in medical record Administrator or designee will monitor grievance log weekly; and monitor inventory list of any new residents to the facility x 4 months. All results will be reported to QA&A committee	01/20/2025

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.

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