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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 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	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 8/30/24

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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§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, comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 86.

The facility did not provide a policy on the environment.

1. Observations on 08/05/24 at 10:21 A.M., and 08/08/24 at 1:05 P.M., of Room 404 showed:
- On 08/05/24 at 10:21 A.M., the bathroom wall to the left of the toilet with a three foot (ft.) area of scratched and/or peeled off paint.

2. Observations of the 300/400 Hall common area showed:
- On 08/05/24 at 10:15 A.M., the ceiling tile and the vent near the 300 Hall covered in a brown/black substance,
- On 08/05/24 at 10:17 A.M., the wall to the left of the exit door with a four ft. by one inch (in.) hole above the cove base;
- On 08/08/24 at 2:10 P.M., a brown substance on the ceiling vent outside the 300/400 Hall.

3. Observation on 08/07/24 at 3:30 P.M., of Room 401 showed a hole at the bottom of the outside bathroom door.

During an interview on 08/08/24 at 2:58 P.M., the Maintenance Director said there were forms on each hall to fill out with what needed to be looked at. He/She didn't know of any current issues.

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F 584	Continued From page 2 During an interview on 08/08/24 at 4:40 P.M., the Administrator said she would expect all residents to have a homelike environment.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff provided the necessary care and services in accordance with professional standards of practice by failing to notify the physician immediately of one resident's (Resident #22) significant change in status and by failing to provide emergency treatment in a timely manner for one resident (Resident #58) out of two sampled residents. The facility's census was 86. Review of facility policy titled, "Change in a Resident's Condition or Status," dated February 2021, showed: - The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, and/or a need to transfer the resident to a hospital/treatment center;	F 684		

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- A significant change of condition is a major decline or improvement in the resident's status.

1. Review of Resident #22's medical record showed diagnoses of chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), stroke, diabetes mellitus (a chronic condition that affects the way the body processes glucose), and hypertrophic cardiomyopathy (a condition in which the heart muscle becomes abnormally thick making it hard for the heart to pump blood).

Review of the resident's progress notes showed:
- On 6/22/24 at 6:23 P.M., the resident lay in bed lethargic (lack of energy or sluggish) and skin felt warm to the touch. Resident used accessory muscles (muscles that provide assistance to the main breathing muscles when additional power is needed) to breathe. Lungs sounds were coarse with congestion throughout. Vital signs of blood pressure (BP) 86/55, heart rate (HR) 99, respirations (resp) 32, temperature (temp) 101.4 degrees Fahrenheit (F), oxygen saturation 84% on room air. Applied oxygen at 3 liter per minute (lpm) per nasal cannula (NC - a flexible tube used to administer supplemental oxygen through the nose). Blood sugar was 61. Fed resident dairy products and resident drank two cups of orange juice.
- On 06/22/24 at 9:00 P.M., the resident's vital signs of BP 106/66, HR 107, resp 28, temp 102.5 F, oxygen saturation 84% on oxygen at 3 lpm per NC. Administered two Tylenol 325 milligram (mg) by mouth per as needed;
- On 06/22/24 at 10:35 P.M., contacted the physician on call and received an order to send the resident to the hospital;

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- On 06/22/24 at 10:45 P.M., report was called to the hospital emergency room (ER) nurse;
- On 06/22/24 at 11:00 P.M., the ambulance arrived to transport the resident to the hospital;
- On 6/23/24 at 9:54 A.M., the resident was admitted to the intensive care unit (ICU) for possible sepsis (a life-threatening medical emergency that arises when the body's attempt to fight off an infection results in the immune system damaging tissues and organs). Would be on intravenous antibiotics;
- On 7/01/24 at 1:45 P.M., the resident returned from the hospital stay via facility transport. No signs and symptoms of distress. No complaints voiced.

The facility failed to notify the physician immediately of the resident's significant change of status.

Review of the resident's hospital discharge summary, dated 7/01/24, showed:
- The resident was admitted to ICU for acute and chronic respiratory failure with hypercapnia (occurs when the lungs cannot release enough oxygen into the blood or remove carbon dioxide from the blood causing multiple organ failure), septic shock (a widespread infection causing organ failure and dangerously low blood pressure), healthcare associated pneumonia (infection that causes inflammation and fluid in the lungs), abnormal urine analysis, acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), acute encephalopathy (inflammation of the brain), acute dehydration (the absence of enough water in the body), elevated D·dimer (a piece of protein that is made when a blood clot dissolves).

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During an interview on 08/16/24 at 10:55 A.M., Licensed Practical Nurse (LPN) E said he/she worked the night of 06/22/24. He/She remembered sending Resident #22 out to the hospital, but did not remember the events leading up to the transfer.

During an interview on 8/08/24 at 3:10 PM, LPN D said he/she would notify the Director of Nursing (DON) and the resident's provider if a resident was short of breath with an elevated temperature. He/She would implement the orders and follow up as needed. If an alert resident had a low blood sugar, he/she would have them drink a sugary drink or give them a snack. If an unresponsive resident had a low blood sugar, he/she would administer a glucagon (a hormone that raises blood sugar) injection. The physician would be notified. The blood sugar would be rechecked in 20 to 30 minutes. If the blood sugar had not increased, he/she would contact the physician.

During an interview on 08/16/24 at 10:50 A.M., Nurse Practitioner (NP) F said he/she was on call the night of 06/22/24, and confirmed he/she was contacted by the facility at 10:30 P.M., regarding Resident #22's change in condition. He/She would have expected to be contacted immediately following the resident's assessment at 6:23 P.M., when the resident had a low oxygen level and an elevated temperature. The nurse completing the assessment should have checked Resident #22's oxygen level immediately after applying the oxygen.

During an interview on 8/08/24 at 5:00 P.M., the Administrator said she would expect the physician to be notified immediately when a resident had a significant change in condition.

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2. Review of Resident #58's medical record showed:
- Severe cognitive impairment;
- Diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), diabetes mellitus (a chronic condition that affects the way the body processes glucose), and asthma (a chronic lung disease that inflames and narrows the airways in the lungs).

Review of the resident's progress notes showed:
- On 08/02/24, at 6:25 P.M., earlier in the shift, the resident was found slumped over in his/her wheelchair and the resident's BP could not be obtained. The DON was notified of the resident's condition and gave instructions to send the resident to the ER. The nurse instructed the Certified Nurse Assistants (CNAs) to place the resident on the bed. The resident had excoriated areas to his/her abdominal folds and coccyx. The ambulance arrived and left with the resident at 5:36 P.M.;
- On 08/03/24 at 9:43 A.M., the nurse spoke to the hospital and the resident was admitted to ICU with a diagnosis of acute kidney injury.

Review of resident's hospital History and Physical, dated 08/02/24, showed:
- The resident admitted with acute metabolic encephalopathy, septic shock, UTI, and acute kidney failure;

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- Admitted to the ICU.

During an interview on 08/06/24 at 3:30 P.M., LPN B said that he/she was notified by a CNA the resident was found unresponsive. He/She assessed the resident, was unable to obtain a BP, and called the DON. LPN B instructed the CNAs to move the resident to the bed to make it easier to get the resident on the stretcher when the ambulance came and to clean the resident up. The ambulance was called after the resident was cleaned up, which took about 20 minutes from the time the resident was found unresponsive and the ambulance was called. The resident became more responsive during care. LPN B tried again to check the resident's BP and it was really low. He/She did not remember what the BP reading was.

During an interview on 08/08/24 at 4:02 P.M., LPN B said he/she contacted the resident's physician after he/she spoke with the DON. The resident was transferred to the bed and cleaned because he/she was soiled.

During an interview on 08/07/24 at 9:07 A.M., the DON said she thought the ambulance was called while the nurse was still on the phone with her that evening. She would expect staff to call an ambulance for a resident who was unresponsive immediately after contacting her.

During an interview on 08/19/24 at 9:54 A.M., NP F said he/she was contacted regarding Resident #58's status on 08/02/24 at 4:58 P.M. He/She did not specifically remember all the details of the call but did remember that he/she gave orders to send the resident to the ER. He/She did not feel it was appropriate to delay calling the ambulance in

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F 684	Continued From page 8 order to clean the resident up. The facility failed to provide emergency treatment in a timely manner. NP F gave an order to send the resident to the ER on 08/02/24 at 4:58 P.M. LPN B instructed the CNAs to place the resident on the bed and provide incontinent care to the resident. LPN B did not call the ambulance until after the resident's incontinent care was provided. The resident was transported by ambulance to the ER on 08/02/24 at 5:36 P.M.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 692		

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review, the facility failed to timely and effectively address significant weight loss for one resident (Resident #58) out of 20 sampled residents. The facility's census was 86.

Review of the facility's policy titled, "Weight Assessment and Intervention," revised March 2022, showed:
- Any weight change of 5% of more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will notify the dietician;
- Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time.;
- The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss=(usual weight - actual weight)/(usual weight) x 100]: For one month - 5% weight loss is significant; greater than 5% is severe. For three months - 7.5% weight loss is significant; greater than 7.5% is severe. For six months - 10% weight loss is significant; greater that 10% is severe;
- Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or resident's legal surrogate.

Review of Resident #58's Electronic Medical Record (EMR) showed:
- Admitted on 05/14/24
- Admission weight was 215 pounds (lbs);
- Diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), congestive

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heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension (abnormally high blood pressure), diabetes mellitus (a chronic condition that affects the way the body processes glucose);
- On 05/14/24 resident's weight was 215 lbs;
- On 06/07/24 resident's weight was 211 lbs;
- On 07/08/24 resident's weight was 192 lbs with a 23 lb and 10.7% weight loss in less than 60 days;
- On 08/01/24 resident's weight was 163 lbs with a 52 lb and 24.2% weight loss in less than 90 days;
- The resident had significant weight loss in less than 90 days.

Review of the resident's Admission Dietary History and Initial Screening, dated 05/14/24, showed:
- Mechanical diet;
- Few/broken/poor condition of teeth/mouth sore;
- Resident preferences for beverages: water and tea;
- Resident likes: ice cream and chips.

Review of the resident's Physician's Order Sheet (POS), dated August 2024, showed:
- An order for mechanical soft diet, dated 05/14/24;
- An order to change the diet to a regular diet, regular consistency and thin liquids, dated 07/09/24;
- No other weight loss interventions.

Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument), dated 05/21/24, showed:
- Severe cognitive impairment;

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- Required supervision for eating;
- Weight 215 lbs;
- No significant weight loss;
- Mechanically altered diet.

Review of the resident's care plan, dated 05/24/24 showed the care plan did not identify or address interventions related to the resident's weight loss.

Review of the resident's Nutritional Progress Notes showed:
- On 05/14/24, the resident received a mechanical diet and no current dislikes. Loved ice cream and chips;
- On 07/09/24, the resident's diet was changed to a regular diet by the physician.

Review of the Registered Dietician (RD) Care form, dated 07/19/24, showed:
- Consult with resident;
- The resident with a weight loss for the past 30 and 60 days;
- Add large portions at breakfast every day;
- Add ice cream or an extra item of choice every day x 30 days.

Review of resident's Progress Notes showed:
- On 05/18/24, the resident complained of bad teeth and says there was no food he/she could eat;
- On 07/11/24, the resident was out with family. The family reported the resident ate 25%;
- On 07/20/24, the resident still refused to eat meals or take medication. The resident told the nurse it had been a week without him/her having a drink of water. The resident had water at that time;
- On 07/22/24, the resident moved to a new room

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and said he/she hadn't had anything to drink in months;
- On 07/26/24, the resident refused medication and refused to eat. Multiple staff asked multiple times;
- On 07/29/24, the resident continued to refuse medication and food;
- On 07/31/24, Invega Sustenna (an antipsychotic medication) given related to unspecified dementia, severe with psychotic disturbance;
- On 08/01/24, the resident continued to refuse medication and meals;
- On 08/02/24, the resident slumped over in the chair and not responding. The resident was sent to the emergency room.
- On 08/03/24, the resident admitted to intensive care unit with a diagnosis of acute kidney injury.

Review of the resident's Behavioral Health (BH) Notes showed:
- On 06/25/24, Psychiatric Physician's Assistant (PA) H documented the resident refused medications, to shower, to change clothes and refused care. The resident had paranoid thoughts and thought the staff were trying to poison him/her. The resident told other residents and people that the staff was withholding food from him/her. On interview there, was some confusion and the resident was somewhat circumstantial. The resident said people are trying to kill him/her and cut him/her open. Resident states he/she is not eating because they were putting poison in the food. The resident said no one would give him/her anything to drink. Gave the resident a cup and the resident said he/she did not want to drink out of the sink. He/She made several persecutory and delusional comments. The resident thought he/she was being poisoned. He/She thought staff were trying to kill him/her;

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	265387	A. BUILDING _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER ACRES CARING CENTER	628 NORTH WEST STREET 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 692	Continued From page 13 - On 07/02/24, Psychiatric PA H documented the resident made several delusional comments. The resident began by saying something about some small children being in his/her room and this caused the resident to vomit every time he/she was in his/her room. The resident said something about a little girl trying to get in his/her bed. When asked if he/she knew where he/she was, the resident said it had changed since the last visit. The resident was quite delusional and would likely require an antipsychotic medication moving forward; - On 07/30/24, Psychiatric PA H documented that according to staff, the resident still had delusional thinking that lead to him/her refusing medical treatments and cares as well as food and medications. Ordered Invega Sustenna as he/she now had a guardian. The resident needed something to treat his/her delusional thinking as it was interfering with his/her hygiene and medical treatments and overall health. During an interview on 08/08/24 at 4:25 P.M., Certified Medication Technician (CMT) G said that the resident was able to feed himself/herself so staff did not assist. During an interview on 08/19/24 at 4:41 P.M., the Registered Dietician (RD) said he/she saw the resident on 07/19/24, and the resident was a tough case because he/she didn't want to eat. The RD recommended to add large portions and ice cream or an extra item of the resident's choice for 30 days on the 07/19/24 visit. During an interview on 08/08/24 at 5:00 P.M., the DON said the RD was scheduled to come every two weeks, but was only required to see the residents monthly.	F 692		

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F 692	Continued From page 14 During an interview on 08/08/24 at 5:05 P.M., the Administrator said she would expect a resident with a significant weight loss to be seen by the RD at least monthly. During an interview on 08/20/24 at 1:11 P.M., the resident's physician said that he/she agreed with psychiatry that the resident's weight loss was related to his/her behaviors of refusing medications and meals. The resident was being watched carefully and the resident refused everything they tried to do for him/her.	F 692		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §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 36 opportunities with two errors made, resulting in an error rate of 5.56% for two residents (Resident #12 and #30) out of five sampled residents. The facility's census was 86. Review of the facility's policy titled, "Administering Medications," dated April 2019, showed: - Medications are administered in accordance with prescriber orders, including any required time frame; - Medications are administered within one hour of their prescribed time, unless otherwise specified	F 759		

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F 759	Continued From page 15	F 759		

(for example, before and after meal orders).

1. Review of Resident #12's Physician Order Sheet (POS), dated August 2024, showed:
- An order for Novolog FlexPen (a type of insulin - medication used to lower blood sugar) 5 units subcutaneously (an injection below the skin) with meals for diabetes mellitus (a chronic condition that affects the way the body processes glucose), dated 6/04/24;
- An order for Novolog FlexPen per sliding scale subcutaneously before meals and at bedtime for blood sugar of 70-180 = 0 units, 181-240 = 4 units, 241-290 = 6 units, 291-340 = 8 units, and 400-1000 = call the physician, for diabetes mellitus, dated 6/04/24.

Observation of Resident #12's medication pass on 8/07/24 at 12:13 P.M., showed:
- The resident's blood sugar was 102;
- Licensed Practical Nurse (LPN) D did not administer the resident's scheduled Novolog 5 units before lunch;
- The facility failed to administer the resident's Novolog insulin as ordered.

During an interview on 8/07/24 at 12:20 P.M., LPN D said Resident #12 did not have any Novolog insulin in the building and it would have to be ordered from the pharmacy.

2. Review of Resident #30's POS, dated August 2024, showed an order for Crestor (cholesterol medication) 40 milligrams (mg) one tablet by mouth daily for hyperlipidemia (high cholesterol in the blood), dated 6/29/24.

Observation of Resident #30's medication pass on 8/07/24 at 8:34 A.M., showed:

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F 759	Continued From page 16 - Certified Medication Technician (CMT) C did not administer Crestor; - The facility failed to administer the resident's Crestor as ordered. During an interview on 8/07/24 at 8:34 A.M., CMT C said the resident was out of Crestor and more would need to be ordered from the pharmacy. During an interview on 8/07/24 at 1:57 P.M., CMT C said the Crestor for Resident #30 had still not arrived. During an interview on 8/08/24 at 5:00 P.M., the Administrator said he/she would expect residents not to run out of medications. She would expect medication be ordered from the pharmacy prior to the resident running out. During an interview on 8/08/24 at 5:00 P.M., the Director of Nursing (DON) said she would expect residents not to run out of medications. She would expect medication to be ordered from the pharmacy prior to the resident running out.	F 759		

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	07345	A. BUILDING: _____ B. WING _____	C 08/08/2024

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class III. Refer to F584.	A3038		
A3039	19 CSR 30-85.032(39) Rooms Neat, Orderly, Cleaned Daily Rooms shall be neat, orderly and cleaned daily. II/III This regulation is not met as evidenced by: Class III. Refer to F584.	A3039		
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: Calss II. Refer to F759.	A4055		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition	A4075		

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A4075	Continued From page 1 Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II. Refer to F684.	A4075		
A4079	19 CSR 30-85.042(70) Sufficient Fluids/Hydration The facility must provide each resident the opportunity to access sufficient fluids to maintain proper hydration in accordance with the resident's medical condition and goals of treatment as documented in the medical record. I/II This regulation is not met as evidenced by: Class II. Refer to F692.	A4079		
A5001	19 CSR 30-85.052(1) Nutritional Needs Met, Assess Res, Inform Dr Each resident shall be served nutritious food, properly prepared and appropriately seasoned, taking into consideration resident food preferences, to provide an adequate diet in accordance with the physician ' s order and as recommended by the National Research Council. Nutritional needs of residents shall be met and shall be based on the individual ' s circumstances, medical condition and goals of treatment as determined and justified by the physician. A qualified professional, such as a dietitian or registered nurse, shall regularly	A5001		

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A5001	Continued From page 2 assess these needs and shall keep the physician informed of the nutritional status of the resident. I/II This regulation is not met as evidenced by: Class II. Refer to F692.	A5001		

PLAN OF CORRECTION

Provider/Supplier Name:	Hunter Acres Caring Center
Street Address, City, Zip:	628 North West Street Sikeston, MO 63801
Date of Survey:	8/8/24

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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F584 SS=D	Safe/Clean/Comfortable Homelike Environment CFR(s): 483.10(i)(1)-(7) The facility failed to ensure a safe, clean, comfortable and homelike environment. • Room 404: the three-foot area of scratched off paint, left at the toilet, will be repaired by maintenance. • The ceiling tile and vent near the 300-hall covered in brown/ black substance was cleaned by maintenance on 8/7/24. • The brown substance on the ceiling vent outside the 300/400 hundred hall was cleaned by maintenance on 8/7/24. • The 4 feet by 1 inch hole above the cove base, on the wall, left the exit door, was repaired by maintenance on 8/30/24. • Room 401: the hole at the bottom of the outside bathroom door will be repaired by maintenance. A new door will be purchased. The administrator or designee will complete training with staff on use of the maintenance work order system for any facility maintenance. The administrator or designee will ensure the facility maintains a safe, clean, comfortable home environment by monitoring of the resident rooms, common rooms and restrooms. The administrator or designee will monitor weekly for 4 weeks and then monthly for 3 months. Issues of noncompliance will be addressed upon discovery and during monthly Quality Assurance Performance Improvement meetings.	9/22/24

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

PLAN OF CORRECTION

Provider/Supplier Name:	Hunter Acres Caring Center
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F684 SS=D	Quality of Care CFR(s): 483.25 The facility failed to ensure staff provided the necessary care and services in accordance with professional standards of practice by failing to notify the physician immediately of one resident's (Resident #22) significant change in status and by failing to provide emergency treatment in a timely manner for one resident (Resident #58). Resident #22 – returned to the facility Resident #58- disposition after hospitalization unknown The Director of Nursing or Designee will audit all residents who have a reported change in condition (Monday through Friday) for 2 weeks, weekly for 4 weeks and monthly for 2 months to ensure all residents who experience a change in condition receive immediate attention, physician notification and transfer to hospital if indicated. The Director of Nursing or designee will complete education with all nursing personnel on the required assessment for change in condition to include abnormal vital signs, oxygen saturation levels, signs and symptoms of sepsis, hypoglycemia, elevated temperature, physician notification and transfer to hospital policy. Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	9/22/24

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F692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1-3) The facility failed to timely and effectively address significant weight loss for one resident, Resident #58. Resident #58 disposition unknown; resident no longer resides in the facility. The Director of Nursing (DON) or Designee will audit all residents who have a reported weight loss of 5% or greater to ensure the weight is repeated the following day for accuracy, the dietitian is consulted if weight loss is verified, and recommendations are implemented. The consulting pharmacist and provider will be consulted when indicated. The reported weight losses will be reviewed at the weekly quality improvement meeting. The Director of Nursing or designee will complete education with all nursing personnel on the required assessment and documentation of residents with a 5% or greater weight loss. Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	9/22/24

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F759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s):483.45(f)(1) The facility must ensure that its medication error rates are not 5 percent or greater. **Resident #12:** The Licensed Practical Nurse failed to administer Novolog 5 units before lunch, as ordered. The Novolog 5 had not been reordered timely. The Novolog was reordered and received in the facility at 1300. The physician was not notified of the missed Novolog 5 dose. The next scheduled dose, prior to the dinner meal, was given at 1700. **Resident #30:** The Certified Medication Technician failed to administer Crestor 40mg. The medication was reordered and received in facility at 1800. The physician was not notified. The medication was given the next day, 8/8/24, at the scheduled time. The director of nursing completed coaching with the LPN and CMT on process of medication re-ordering and medication errors (failure to administer) according to physician order and policy. The director of nursing will complete education with all nursing staff administering medications on the policy of medication administration, order refill through Point Click Care and 24-hour on-call pharmacist for medications that are depleted. The director of nursing or designee will monitor medication passes 2 times weekly for 4 weeks and then one time weekly for 2 months to ensure appropriate and safe medication administration occurs in the facility. Issues of noncompliance will be addressed upon discovery and during monthly Quality Assurance Performance Improvement meetings	9/22/24

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety Please see F584	9/22/24
A3039	19 CSR 30-85.032(39) Rooms Neat, Orderly, Cleaned Daily Please see F584	9/22/24
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System Please see F759	9/22/24
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Please see F684	9/22/24
A4079	19 CSR 30-85.042(70) Sufficient Fluids/Hydration Please see F692	9/22/24
A5001	19 CSR 30-85.052(1) Nutritional Needs Met, Assess Res, Inform Dr Please see F692	9/22/24

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