| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265632 | A. BUILDING _____ B. WING _____ | C 05/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY MANOR | 209 HICKORY STREET LICKING, MO 65542 |

| (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 677 | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to provide showers for one resident (Resident #1) out of four sampled residents. The facility's census was 39<br><br>Review of facility's policy titled, Bath, Shower/Tub dated 2001, showed:<br>- The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Resident will have bath/shower per their request;<br>- Documentation: the date, time the shower/tub bath was performed; name and title of who performed shower/tub bath; all assessment data (skin assessment) obtained during shower/tub bath; If resident refused the shower/tub bath and reasons; Notify supervisor if the resident refuses the shower/tub bath with reasons.<br><br>Review of Resident #1's medical record showed:<br>- An admission date of 02/04/25;<br>- Diagnoses of hypertension (high blood pressure), Peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), chronic obstructive pulmonary disease (a group of lung diseases that block airflow, making it difficult to breath), chronic pain, arthritis, Stage Three Pressure Ulcers ( involves full-thickness skin loss, exposing the subcutaneous tissue) and Stage Two Pressure Ulcer (involves | F 677 | | |

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

Linda Schmitt | Administrator | 06-17-25

A ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that o afeguards 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/17/2025

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| F 677 | Continued From page 1 | F 677 | | |

partial-thickness skin loss, exposing the dermis, and may present as a shallow open ulcer with a red or pink wound bed, or as an intact or open/ruptured blister. The wound bed should be viable);
- Minimum Data Set (MDS) showed resident is dependent, requires partial/moderate assistance with shower/bathing and personal hygiene;
- Progress notes, 04/24/25 to 5/22/25 showed no documentation related to refusal of showers or not receiving showers.

Review of facility's shower assignment sheet showed resident was scheduled for showers every Wednesday and Saturday.

Review of Resident #1's weekly shower sheets 05/02/25 to 05/22/2025 showed He/She received a shower on Monday, 05/02/25, and Thursday, 05/15/25

Observation of Resident #1 showed his/her hair to be greasy and a general unkempt appearance.

During an interview on 05/22/25 at 1:00 P.M. Resident #1 said:
- He/She has not had a shower in the past ten days;
- He/She frequently went without showers for ten to fourteen days;
- He/ She did want his her showers twice a week.

During an interview on 05/22/25 at 1:20 P.M., Certified Nurse Assistant (CNA) A said:
- Residents are scheduled for showers at least twice a week;
- A shower sheet is completed for resident and the CNA signs off and turns it in to the charge nurse;

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|---|---|---|---|---|
| F 677 | Continued From page 2 | F 677 | | |

- If a resident refuses a shower, the resident signs a refusal if able and it is reported to the charge nurse to follow up on;
- Any abnormalities or problems are reported to the charge nurse.

During an interview on 05/22/25 at 1:28 P.M., Licensed Practical Nurse (LPN) B said:
- Residents are assigned showers twice a week;
- Shower list is at the nurses station;
- If a resident refused a shower, staff will go back later and offer shower again;
- The CNAs complete shower sheets and turn in to charge nurse and charge nurse reviews them, signs them and turns them in to the Director of Nurses.

During an interview on 05/22/25 at 4:00 P.M., the Director of Nurses (DON) said:
- Residents are assigned showers twice a week;
- Shower list is at the nurses station;
- If resident refused shower, staff will go back later and offer shower again;
- The CNAs complete shower sheets and turn in to charge nurse and charge nurse reviews them, signs them and turns them in to the Director of Nurses;
- Resident # 1 did not complain about not getting showers twice a week so did not know there was a problem about him/her not getting showers;
- Residents should receive showers at least twice a week and should have follow up to ensure they are receiving showers.

Compliant #MO00254267

# PLAN OF CORRECTION

| | |
|---|---|
| **Provider/Supplier Name:** | Hickory Manor |
| **Street Address, City, Zip:** | 209 Hickory Street , Licking, Mo 65542 |
| **Date of Survey:** | 05-27-2025 |

| PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | |
|---|---|

| ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
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| F677 | This plan of correction is submitted as required under state law. The submission of this plan does not constitute an admission on the part of Hickory Manor as to the accuracy of the surveyor's findings or the conclusions drawn therefrom.<br><br>The plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding any of the deficiencies cited are correctly applied.<br><br>The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil action or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility.<br><br>Any changes to the facility policies and procedures should be considered to be subsequent remedial measures such as that employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.<br><br>Please accept this plan of correction with completion dates as our written credible allegation of compliance.<br><br>DON or Designee will complete education on bath policy and bath schedule process with facility bath aide, CNA;s, CMT's, and nurses and any new nursing staff.<br><br>Shower sheets and bath log will be reviewed daily in Daily Clinical meeting.<br><br>Facility shower logs will be reviewed weekly on Thursday in QA meeting and monthly during QAPI meeting. | 06-16-2025 |
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**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.**