STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN OAKS CARING CENTER	1310 HOVIS STREET MOUNTAIN GROVE, MO 65711

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cassie Mallett	RN, Administrator	4/30/25

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(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed provide timely notification to each resident family member/representative when staff failed to notify the family of one resident (Resident #1) after significant bruising was identified on the resident resulting in an ordered x-ray and temporary medication changes. The facility census was 65.

Review of the facility's current policy titled "Change in a Resident's Condition or Status," dated February 2021, showed the following:
-The facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status;
-Unless otherwise instructed by the resident, a nurse will notify the resident's representative when, the resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
-Except in emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical condition or status.

1. Review of Resident #1"s face sheet (brief resident profile sheet) showed the following:

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F 580	Continued From page 2 -Admission date of 01/30/25; -Diagnoses included heart failure (heart can't pump enough blood to meet the body's needs), atrial fibrillation (a-fib - irregular heartbeat), nonrheumatic tricuspid valve insufficiency (the valve between the right atrium and the right ventricle doesn't' close properly causing blood to leak backward), and depression (persistent sadness). Review of the resident's care plan, dated 01/30/25, showed the following: -Resident at risk for falls; -Resident at risk for impaired skin integrity; -Resident takes anticoagulant (thins the blood to prevent clots); -Dependent with pants and shoes and wheelchair use; -Required substantial assist with toileting, showering, dressing, personal hygiene, sit to stand and transfers. -Resident at risk for pain. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/05/25, showed the following information: -Moderately impaired cognitive skills; -Substantial assistance from staff with toileting, personal hygiene, showers, and upper body dressing; -Dependent upon staff for lower body dressing. Review of the resident's March 2025 Physician's Order Sheet (POS), showed the following: -An order, dated 01/30/25, for Eliquis (blood thinner) 2.5 milligrams (mg), give one tablet by mouth two times per day for a-fib;	F 580		

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F 580	Continued From page 3 -An order, dated 01/30/25, for Tylenol (pain reliever) 325 mg, give two tablets by mouth every four hours as need for pain/temp. Review of the facility's resident abuse investigation, started 03/09/25, showed the following: -Date of incident was night of 03/09/25; -Date incident reported 03/10/25; -When staff got the resident up on 03/10/25, staff noted brusing to right side of chest, torso, underarm and going to backside; -Staff notified physician on 03/10/25; -Staff noted resident was own representative and no other representative was notified; -Conclusion of investigation, resident was transferred to bed with a gait belt on night of 03/09/25, the following morning of of 03/10/25 the resident woke up with bruising. Resident takes Eliquis two times per day for a-fib and has not fallen recently. Resident does bruise easily due to Eliquis and has thin, frail skin. Review of the resident's March 2025 POS showed an order, dated 03/10/25, for two view arm/shoulder x-ray due to pain, swelling, and bruising. Review of the resident's Shower Sheet, dated 03/11/25, showed facility staff documented bruising on the resident's front of the upper left arm, bruising on the front upper left arm and chest, bruising on the back of both the left and right upper arms. Review of the resident's skin assessments, dated 03/13/25, showed skin issue, bruising to the right chest and lateral ribs. Staff did not document notification of the resident representative.	F 580		

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F 580	Continued From page 4 Review of the resident's Shower Sheet, dated 03/14/25, showed hospice staff documented bruising to the resident's right chest, torso, arms, thighs and legs. Resident was unsure how the bruising was obtained and facility made aware. Review of the resident's skin assessments showed the following: -On 03/20/25, staff noted skin issue of bruising to the right chest and lateral ribs. Resident was noted to have very thin frail skin with large bruising to the right side of chest, lateral ribs, and generalized bruising to all extremities. The resident's Eliquis placed on hold for four days due to increased bruising. Staff did not document notification of the resident's representative; -On 03/27/28, staff noted skin issue of bruising to chest, arms, and legs. Resident noted to have very thin, frail skin with large bruising to right side of chest and lateral ribs and generalized bruising to all extremities. Staff did not document notification of the resident's representative. Review of the resident's March 2025 progress notes showed staff did not document notification of the resident's representative of the x-ray of two view arm/shoulder due to pain, swelling, and bruising or the bruises observed by facility staff. During an interview on 04/04/25, at 8:58 A.M., the resident said he/she wasn't aware of any bruising on his/her chest until someone told him/her. The facility tells his/her child when he/she has a change in condition. During an interview on 04/04/25, at 11:43 A.M., Certified Nurse Aide (CNA) A said the following: -He/she didn't remember exactly when he/she	F 580		

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F 580	Continued From page 5 saw bruising on the resident. It was maybe a couple of weeks ago. He/she saw a large bruise on the breast area, under the arm, and the right side; -He/she tells the charge nurse when there is a change in condition and he/she did tell the nurse about the bruising. The nurse assessed the resident and asked the resident what happened. The resident complained of pain. During an interview on 04/04/25, at 12:10 P.M., Licensed Practical Nurse (LPN) B said the following: -He/she did document in the record seeing bruising on the resident; -The resident had bruising on the his/ her arm and face; -When there is bruising the family is notified. He/she didn't know if the resident's family was notified of the brusing. During an interview on 04/04/25, at 12:32 P.M., the Assistant Director of Nursing (ADON) said he/she did not see the bruising on the resident. When there was a change in condition, including bruising, the family would be notified. During an interview on 04/04/25, at 12:43 P.M., the Director of Nursing (DON) said the following: -He/she was told about the bruising on the resident during the morning meeting; -Hospice brought the bruising to the facility's attention and a investigation was completed to try to determine if it was an inappropriate transfer; -When a resident has bruising staff would notify the family. The DON was not sure if the resident's family was notified of the bruising. During an interview on 04/04/25, at 1:00 P.M.,	F 580		

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F 580	Continued From page 6 Registered Nurse (RN) C said the following: -Hospice found the bruising on the resident and they told him/her; -He/she looked at the bruising. It was under the right breast, down the arm, and on the side; -He/she told everyone in the morning meeting including the Administrator, DON, and ADON; -They tried to figure out what caused the bruising; -He/she didn't know if anyone notified the resident's family, but they should be notified. During an interview on 04/04/25, at 1:39 P.M., the Administrator said when there was a change in condition the family is notified. He/she was not sure if the resident's family was notified. He/she did not notify the family.	F 580		
	MO00251044			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to keep all residents free from possible accident hazards, when staff failed to transfer one resident (Resident #1) in a manner to prevent possible injury and failed to care plan regarding the resident's transfer needs/preferences. The facility had a census of 65.	F 689		

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Review of the facility's policy titled "Safe Lifting and Movement of Residents," dated revised July 2017, showed the following:
-In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents;
-Nursing staff in conjunction with the rehabilitation staff shall assess individual residents needs for transfer assistance on an ongoing basis;
-Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts);
-Safe lifting and movement of residents is part of an overall facility employee health, provides training on safety, ergonomics and proper use of equipment and continually evaluates the effectiveness of workplace safety and injury prevention strategies.

1. Review of Resident #1"s face sheet (brief resident profile sheet) showed the following:
-Admission date of 01/30/25;
-Diagnoses included heart failure (heart can't pump enough blood to meet the body's needs), atrial fibrillation (a-fib - irregular heartbeat), nonrheumatic tricuspid valve insufficiency (the valve between the right atrium and the right ventricle doesn't' close properly causing blood to leak backward), and depression (persistent sadness).

Review of the resident's care plan, dated 01/30/25, showed the following:
-Resident was at risk for falls;
-Resident was at risk for infection;
-Resident was at risk for impaired skin integrity;
-Resident took an anticoagulant (blood thinner);
-Resident required substantial assist with

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F 689	Continued From page 8 toileting, showering, dressing, personal hygiene, sit to stand, and transfers. -Resident was at risk for pain. (Staff did not care plan regarding how to the transfer the resident, the number of staff to transfer the resident, or any resident preferences or refusals related to transfers.) Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/05/25, showed the following information: -Moderately impaired cognitive skills; -Substantial assistance required from staff with toileting, personal hygiene, showers, and upper body dressing; -Dependent upon staff for lower body dressing. During an interview on 04/04/25, at 8:58 A.M., the resident said the following: -He/she was able to transfer okay, but he/she was not able to come to a standing position and needed help to sit down; -He/she broke his/her hip in the past and also had leg problems; -The staff do not use a belt (gait belt - a belt used for support when transferring) when they assist the resident with transferring; -The staff have him/her put his/her hands around their neck and they help pull him/her up. During an interview on 04/04/25, at 11:43 A.M., Certified Nurse Aide (CNA) A said the following: -He/she had been trained on gait belt use. He/she put the belt around the resident, ensuring there are two finger spaces between the belt and the resident. He/she puts his/her hands under the gait belt on each side towards the back. He/she	F 689		

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said 1, 2, 3 and the resident stands up while the staff are assisting with the belt;
-The resident doesn't like the gait belt because the resident says the belt squeezes him/her. He/she tried to talk the resident into letting him/her use the gait belt;
-He/she transferred the resident by hugging the resident under his/her arms and the resident put his/her arm around the staff's neck. They stand up and pivot to the wheelchair.

During an interview on 04/04/25, at 1:18 P.M., CNA D said the following:
-All nursing staff were trained to use a gait belt and should be using it anytime they're assisting a resident up or down, and when walking with the resident;
-The resident was a one person assist and needed a gait belt;
-The resident did refuse to wear the gait belt. He/she would tell the resident she had to for safety;
-It was not appropriate to have a resident hug staff's neck and staff hug them to transfer.

During an interview on 04/04/25, at 1:30 P.M., physical therapy said the following;
-He/she had not worked with the resident;
-He/she would prefer the staff use a gait belt when transferring residents.

During an interview on 04/04/25, at 12:10 P.M., Licensed Practical Nurse (LPN) B said the following:
-All nursing staff are trained to use a gait belt;
-Staff should be using a gait belt to transfer all residents, including the resident;
-It would not be appropriate to use the hug technique to transfer a resident, unless staff use

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the gait belt too;
-He/she was not aware of the resident refusing to let staff use the gait belt.

During an interview on 04/04/25, at 1:00 P.M., Registered Nurse (RN) C said the following:
-Staff were trained to use a gait belt;
-Staff should be using a gait belt when they transfer or they're walking with a resident;
-The belt should be put around the lower waist, with two fingers in between the belt and resident;
-Staff were to grab with both hands on each side and assist the resident to standing;
-It was not appropriate to have the resident hug staff's neck and staff to hug the resident when transferring. This was not safe;
-The resident was a one person assist and required a gait belt due to weakness.

During an interview on 04/04/25, at 12:32 P.M., the Assistant Director of Nursing (ADON) said the following:
-All staff caring for residents are trained on how to use a gait belt;
-Anytime staff move a resident from one place to another, they should be using a gait belt;
-The belt should be placed around the resident's upper waist, snug, but not too tight. The staff should place their hands under the belt towards the back side, and say 1,2,3 and assist the resident to a standing position;
-It is not appropriate to hug a resident and have them hug you for a transfer. This could cause injury to the resident and the staff;
-The resident was a one assist and staff should be using the gait belt to transfer the resident.

During an interview on 04/04/25, at 12:43 P.M., the Director of Nursing (DON) said the following:

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F 689	Continued From page 11 -All nursing staff are trained to use a gait belt; -They should be using the gait belt when transferring, anytime need to move them, and walking with residents; -Staff put the gait belt on the resident, snug but should be able to get a couple of fingers between the gait belt and the resident; -Staff should be telling the resident what they're doing; -Staff place the hands on each side to assist the resident to a standing position and guide and pivot the resident; -It would not be appropriate to hug the resident and have the resident put his/her hands around the staff. The staff could lose their footing and fall with the resident; -The resident required a gait belt for all transfers because he/she was weak; -It would not be appropriate to use the hug method with the resident. During interviews on 04/04/25, at 1:39 P.M., and on 04/07/25, at 12:45 P.M., the Administrator said the following: -Nursing staff are trained on how to use gait belts; -They should be using gait belts when transferring residents, or walking with residents; -The belt should be up under the arms, breast area; -There should be two fingers space between the belt and the resident's skin; -The staff's hand should be on each side of the belt, and the resident and staff will lift up and pivot; -It would not be appropriate to hug a resident and have a resident to grab staff for transferring; -With the resident the staff does most of the work and he/she was a one person assist.	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN OAKS CARING CENTER	1310 HOVIS STREET MOUNTAIN GROVE, MO 65711

(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) COMPLETE DATE
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F689. MO00251044	A4074		
A4088	19 CSR 30-85.042(79) Notify Responsible Party-Change in Condition In the event of accident, injury, or significant change in the resident's conditions, facility staff shall immediately notify the person designated in the resident's record as the designee or responsible party. III This regulation is not met as evidenced by: 1. Please refer to F580. MO00251044	A4088		

PLAN OF CORRECTION

Provider/Supplier Name:	AUTUMN OAKS CARING CENTER
Street Address, City, Zip:	1310 HOVIS STREET MOUNTAIN GROVE, MO 65711
Date of Survey:	04/04/2025

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
	This plan of correction is submitted as required under the State Law. The submission of this plan does not constitute an admission on the part of **Autumn Oaks Caring Center** as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute an admission on the part of **Autumn oaks Caring Center** that the findings cited are accurate, that the scope and severity regarding any of the deficiencies cited are correctly applied. 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. Any changes to the facility policies and procedures should be considered to be subsequent remedial measures as that employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction with completion dates as our written credible allegation of compliance.	

F 580 **SS=D**	**Notify of Changes (Injury/Decline/Room, etc.)** **CFR(s): 483.10(g)(14)(i)-(iv)(15)** The facility will timely notify each resident family member/representative of Resident #1 going forward, and all other residing residents' family member/representative, for any significant change, such as bruising is identified and resulting in an ordered x-ray and temporary medication changes. -Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source. Staff will document an attempt to notify the resident's representative in the event of a change in condition. On 4/25/2025, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were educated regarding notifying the residents' representative in a timely manner when resident(s) have changes in condition including bruising, and physician orders/medication changes. On 4/25/2025, licensed staff were educated regarding notifying the residents' representative in a timely manner when resident(s) have changes in condition including bruising and physician order/medication changes. To monitor compliance, the DON or designee will review all physician orders including and 24-hour report documentation, daily as they occur, and discuss those in Daily QA Meetings to ensure resident representative(s) have been notified timely. Any noncompliant issues will be addressed and corrected at the time they are observed. Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	**05/16/2025**

F 689 **SS=D**	**Free of Accident Hazards/Supervision/Devices** **CFR(s): 483.25(d)(1)(2)** The facility will keep all residents free from possible accident hazards, staff will transfer Resident #1 in a manner to prevent possible injury and will care plan regarding the resident's transfer needs/preferences. The facility Director of Nursing (DON) provided re-education to the facility Nursing leadership team regarding the Resident Free of accidents and Hazards policy. Education began at 8:30 am on 3/10/25, by the Director of Nursing, Administrator, and/or designee for facility Nursing staff , MDS Coordinator, and all other nursing staff not currently in the facility and will continue education for all other staff, prior to the start of their shift ongoing on the following to include: Staff will avoid and prevent potential incidents and hazards for all residents residing in the facility. Staff will ensure residents' transfer needs/preferences are indicated on the residents' care plan Staff will transfer residents according to the guidance from residents' care plans indicating their needs/preferences. Facility DON or designee will monitor to ensure staff are using proper transfer technique with each assisted resident transfer, during facility rounds 3-5 times per week for two weeks; then 2 times per week for two weeks then randomly thereafter during facility daily rounds. Findings will be reviewed at the monthly QAPI meeting, monthly times 3, quarterly times 3, and ongoing until deemed no longer necessary by the committee. Incidents and Accidents will be reviewed at the facility Daily (Monday-Friday) QA Meetings with the facility Administrator. Any noncompliant issues will be addressed and corrected at the time they are observed.	**05/16/2025**

	F 689 continued... Any non-compliance issues will be brought to the attention of the Administrator and reviewed in the monthly QA Meeting for 3 months; including education, re-education, and disciplinary processes recommended by the QA Committee as needed.	

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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A4074	**19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave; Class II** Please refer to F689 MO00251044	**05/16/2025**
A4088	**19 CSR 30-85.042(79) Notify Responsible Party-Change in Condition; Class III** Please refer to F580. MO00251044	**05/16/2025**

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