STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265393	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Hills Living Center	996 State Highway 248 Branson, MO 65616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to obtain a physician order, care plan the use of and monitor one resident's (Resident #1) cardiac life vest (a portable device that monitors and protects individuals at risk for sudden cardiac arrest (sudden, unexpected loss of heart function, breathing, and consciousness)) out of a sample size of 7 residents. The facility census was 78.Review of the facility policy titled, Physician Orders, undated, showed a current list of orders must be maintained in the clinical record of each resident to avoid confusion and errors. Physician orders must be reviewed and renewed. Review of the facility policy titled, Care Plan Comprehensive, undated, showed the following:-An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest well-being;-The comprehensive care plan will be based on a thorough assessment;-A well-developed care plan will be oriented to preventing avoidable declines in functioning; managing risk factors to the extent possible; applying current standards of practice in the care planning process; evaluating treatment of measurable goals, timetables and outcomes of care; and assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs;-Involve the direct care staff with the care planning process relating to the resident's outcomes,-The interdisciplinary team (IDT) is responsible for updating of care plans when changes occur that impact a resident's care. Review of the [NAME] (manufacturer of the cardiac life vest) website showed the following:-The life vest is designed to detect certain life-threatening rapid heart rhythms and, if needed, deliver a treatment shock to save a person's life;-While wearing the life vest, a patient may hear an alert. It is important to know what the alert means and how to respond;-Patients should always wear the life vest, including when sleeping;-The life vest should only be removed when showering or bathing;-It is important to care for the life vest by charging the battery and a second battery every day;-The life vest should be washed every one to two days. 1. Review of the Resident #1's face sheet (document that gives a resident's information at a quick glance) showed the following:-admission date of 09/16/25; -Diagnoses included congestive heart failure (CHF - chronic condition in which the heart does not pump blood as well as it should) and chronic obstructive pulmonary disease (COPD - a group of kung diseases that block airflow and make it difficult to breathe).Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), showed the resident had moderate cognitive impairment. Review of the resident's admission assessment, dated 09/16/25, showed staff did not address the use of a cardiac life vest. Review of the resident's nursing progress note, dated 09/16/25, showed the resident had a life vest on to monitor heart rate and rhythm. Review of the resident's care plan, dated 09/17/25, showed staff did not address the use of a cardiac life vest. Review of the resident's nursing progress note, dated 09/18/25, showed the resident reported the life vest's Velcro was scratchy. Review of the resident's physician progress note, dated 09/22/25, showed staff did not (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document if the resident was utilizing a cardiac life vest. Review of the resident's physician progress note, dated 09/24/25, showed no documentation regarding the use of the cardiac life vest.Review of the resident's physician progress note, dated 09/28/25, showed no documentation regarding the use of the cardiac life vest. Review of the resident's current Physician Order Sheet (POS) showed staff did not obtain and document orders related to the resident's cardiac life vest, including when to apply, change the battery, cleanse, or monitor the resident's cardiac life vest. During an interview on 10/07/25, at 10:40 A.M., Licensed Practical Nurse (LPN) E said the facility had no current residents that utilized a life vest. He/she had sent the resident out to the hospital recently and he/she was wearing a life vest. He/she did not have experience with cardiac life vests and had no training on the use of it. The resident cared for the vest and would ask nursing staff if a battery change was required. A resident should have orders to wear a cardiac life vest. An order for a life vest should include skin assessments under the vest and battery checks. Nurses should be responsible for the life vest monitoring and battery changes. A cardiac life vest should be included in the care plan. During an interview on 10/07/25, at 11:05 A.M., Certified Nurse Assistant (CNA) A said the facility had a resident that wore a cardiac life vest recently. He/she did not work on the hall of the resident the wore the life vest resided on. A cardiac life vest should be in the care plan for the nursing staff to be aware of it. During an interview on 10/07/25, at 11:11 A.M., LPN B said he/she was responsible for physician orders, allergies, and diagnoses upon resident admission. The nurses working on the floor are responsible for the clinical admission assessment. There are no current residents with a cardiac vest at the facility. He/she was unsure if the resident had a life vest. Cardiac life vests should have orders to monitor the vest is in place, assess the skin underneath the vest, and monitor and change the battery. Nurses are responsible for the life vest. A cardiac life vest should be included in the care plan. During an interview on 10/07/25, at 11:15 A.M., Registered Nurse (RN) C said he/she does not recall a resident utilizing a life vest. He/she remembered the resident wearing a back brace. He/she had never cared for a resident that wore a life vest and did not know about them. A cardiac life vest should have an order. Nurses should assess that the vest was in place and the skin underneath the vest every shift. A life vest should be included on the care plan. During an interview on 10/07/25, at 11:20 A.M., LPN D said the facility does not admit residents that require the use of a cardiac life vest. He/she did not care for the resident. A resident with a life vest should have an order to ensure it is in place, to check the skin under the brace, make sure the battery is charged, and ensure a backup battery is available. Nurses should be aware of a cardiac life vest, and it should be included on the care plan. The nurse is responsible for the care and monitoring of a resident wearing a cardiac life vest. During an interview on 10/07/25, at 11:25 A.M., Certified Medication Technician (CMT) F said the resident was supposed to wear some type of brace around the waist but was unsure what it was. A brace should be included in the care plan, so staff are aware of it. During an interview on 10/07/25, at 12:15 P.M., the MDS Coordinator said he/she used information from the progress notes and resident diagnoses to create the care plan. He/she updates the care plan with new resident information discussed in the morning meeting or the nurse will notify him/her. He/she heard the resident had a life vest through discussions with the nurses and aides after the resident was admitted . A cardiac life vest should have a physician order and be included on the care plan. He/she she did not see the life vest mentioned while reviewing notes to create the resident's care plan.During an interview on 10/07/25, at 12:20 P.M., the Assistant Director of Nursing (ADON) said one resident utilized a cardiac life vest. He/she thinks the resident's use of a life vest was mentioned by the hospital during the resident's referral to the facility. The resident informed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her that he/she utilized a cardiac life vest after admission to the facility. Life vests should have an order d be included on the care plan. This was his/her first experience with a cardiac life vest, and he/she did not receive education about the life vest from the facility. Facility should educate nurses on the care and use of a cardiac life vest. He/she was unable to find order or information in the care plan on the resident use of a life vest. During an interview on 10/07/25, at 12:00 P.M., the Director of Nursing (DON) said no current residents utilized a cardiac life vest. He/she learned of the resident's use of a cardiac life vest when he/she was transferred to the hospital. The nurse reported to him/her the resident was wearing a life vest during the hospital transfer. The life vest should have been noted upon the resident admission to the facility. Nurses should be educated on the use of a cardiac life vest. Life vests should have physician orders. The order should contain battery changes and monitoring and skin assessments under the vest. The nurse should monitor the life vest and battery. The nurse should have notified the physician and obtain an order if a resident was found wearing a cardiac life vest. During an interview on 10/07/25, at 12:43 P.M., the Administrator said the resident was admitted to the facility without a life vest on. The life vest was delivered with the rest of his/her belongings a few minutes after he/she arrived. The resident did not have any orders to utilize the life vest. The life vest should have a physician order prior to use and included on the care plan. Nursing staff should be educated on the use of a cardiac life vest.Complaint #2633767