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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265559	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maples Health and Rehabilitation, The	610 West Sunset Street Springfield, MO 65807

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN - form CMS-10055) or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits for one resident (Resident #18) who remained in the facility upon discharge from Medicare Part A services. The facility census was 89 at the time of survey. Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C -09-20), dated 01/09/09, showed the following information: -The Notice of Medicare Provider Non-Coverage (NOMNC - form CMS-10123) is issued when all covered Medicare services end for coverage reasons; -If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by use of either the SNFABN (form CMS-10055) or one of the five uniform denial letters; -The SNFABN provides an estimated cost of items or services in case the beneficiary has to pay for them his/herself or through other insurance they may have; -If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. 1. Review of Resident #18's SNF Beneficiary Protection Notification Review showed the following information: -On 11/19/24, Medicare Part A skilled services started; -On 12/12/24, the last covered day of Medicare Part A service; (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Facility staff did not provide the resident or his/her legal representative the required SNFABN form CMS-10055 or an alternative denial letter. During an interview on 03/05/25, at 3:26 P.M., the Business Office Manager (BOM) said she did not complete SNF ABN form for the resident. The BOM said she checked the electronic records and the resident's paper file, and the form was not there. It was her responsibility to complete the form, and she doesn't know why it wasn't completed. During an interview on 03/07/25, at 2:24 P.M., the Social Service Director (SSD) said she goes over insurance and billing information with residents - including the SNFABN - form. As SSD for rehabilitation, she fills out the form and then sends the information to the BOM. She was unable to find that the form had ever been completed for the resident. During an interview on 03/07/25, at 3:45 PM, the Administrator said the SNFABN - form should be completed for all residents who qualify. It is the responsibility of the SSD to complete the form, and for the BOM to ensure the form was completed, and to keep it as resident records.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. Based on record review and interview, the facility failed to give written information to the resident and/or resident's representative of the facility's bed-hold policy for one resident (Resident #65) who was transferred out to the hospital. The facility census was 89. Review of the facility's policy titled Bed-Holds and Returns, undated, showed the following information: -All residents/representatives were provided written information regarding the facility and state bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalizations or therapeutic leave); -Residents, regardless of payor source, are provided written notice about these policies at least twice: in the admission packet and at the time of transfer (or, if the transfer was an emergency, within 24 hours); -The written bed-hold notices provided to the resident/representative shall explain in detail the duration of the bed hold, the reserve bed payment (for Medicaid residents), the facility per-diem rate required to hold a bed (for non-Medicaid residents), and the facility return policy. 1. Review of Resident #65's face sheet (brief resident profile sheet) showed the following information: -admission date of 02/06/25; -Resident was his/her own responsible party. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/10/25, showed the resident was cognitively intact. Review of the resident's nurse's note dated 02/14/25, at 8:22 P.M., showed a nurse documented that the resident was reporting increased pain and increased swelling to the left upper extremity since initially reporting the previous day. The resident was requesting to go to the emergency room (ER). Staff notified the physician and received orders to send the resident to the ER for evaluation and treatment. (Staff did not document providing the resident or his/her representative a copy of the bed hold policy.) Review of the resident's medical record showed the following information: -A facility-initiated transfer form was completed; -Date of transfer was 02/14/25; -Date of notice was 02/17/25; -Resident was transferred to the ER on ly; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notice was hand delivered to the resident; -No other information noted. During an interview on 03/06/25, at 12:05 P.M., Business Office Manager (BOM) said that he/she sends out all the hospital transfer/discharge bed holds. He/she does not put a bed payment amount on the form. The BOM said that he/she also does not list a reason for the transfer, only that the facility cannot meet their needs. There was not a place on the form that asks for payment amount per day or the reason why they are leaving the facility. The BOM said that he/she doesn't know that information. The nurse knows that information, but the nurse does not fill out the form. During an interview on 03/07/25, at 09:40 A.M., Licensed Practical Nurse (LPN) H said the administrative staff complete the bed holds for all residents that are transferred or discharged from the facility. The nursing staff will complete a change in condition form and LPN H said that administration must run a report to know which residents have transferred from the facility. During an interview on 03/07/25, at 11:15 A.M., Director of Social Services - Long Term Care (LTC) said that he/she did all the bed holds for all LTC residents, but he/she did not do the resident's bed hold. He/she said that the Admissions Director did his/her bed hold. During an interview on 03/07/25, at 11:20 A.M., Admissions Director said that he/she doesn't have anything to do with bed holds. The Admissions Director said that he/she had never done a bed hold. During an interview on 03/07/25, at 10:30 A.M., the Director of Nursing (DON) said that the BOM completed all bed holds. The BOM was notified of the transfers during the daily stand-up meetings. During an interview on 03/07/25, at 1:50 P.M., the Administrator said that either the BOM or the Director of Social Services completes the bed hold transfers. They discuss the transfers in their daily stand-up meetings. The Administrator will email the ombudsman monthly of all the transfers and discharges.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan consistent with each resident's medical needs when staff failed to care plan urinary care concerns, including urine retention and urology referral, for one resident (Resident #65). The facility census was 89. 1. Review of Resident #65's face sheet (brief resident profile sheet) showed the following information: -admission date of 02/06/25; -Diagnoses included stage 5 chronic kidney disease, end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Review of the resident's February 2025 Physician Order Sheet (POS) showed the following information: -An order, dated 02/06/25, give finasteride (medication used to treat benign prostatic hyperplasia (bph - a condition where the prostate gland is enlarged, causing frequent urination, difficulty starting or stopping urination, and a weak stream) 5 milligram (mg) tablet, daily; -An order, dated 02/08/25, for staff may straight catheter every six hours as needed for complaints of urinary retention. Review of the resident's February 2025 Treatment Administration Record (TAR) showed staff straight catheterized the resident on 02/08/25. Review of the resident's progress note, dated 02/08/25, showed the following information: -Straight catheter completed and 150 milliliters (ml) of dark brown, creamy white urine was removed; -Resident tolerated the sterile procedure well. Review of the resident's February 2025 POS showed an order, dated 02/09/25, for staff to monitor resident every shift for urinary retention. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/10/25, showed the following information: -Cognition intact; -Independent with mobility; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required setup assistance with shower and dressing; -Required substantial assistance with toileting hygiene. Review of the resident's February 2025 POS showed an order, dated 02/16/25, for staff to set-up urology follow up appointment for resident concerns. Review of the resident's February 2025 TAR showed staff straight catheterized the resident on 02/24/25. Review of the resident's progress note, dated 02/24/25 showed the following information: -Straight catheter completed and 250 ml of amber colored urine was removed; -The resident immediately stated he/she felt so much better. Review of the resident's February 2025 TAR showed staff straight catheterized the resident on 02/28/25. Review of the resident's progress note, dated 02/28/25, showed the following information: -The resident insisted on having a urinalysis (UA - a laboratory test that analyzes a urine sample to detect various substances and conditions) obtained due to pain and burning with urination: -Straight catheter completed and 40 ml of urine collected; -Specimen placed in laboratory refrigerator for morning pick-up; -Laboratory order placed for urinalysis. Review of the resident's care plan, revised 03/03/25, showed staff to monitor/document/report signs and symptoms of renal insufficiency. (Staff did not care plan related to urinary care concerns (including straight catheterization, urinary retention, or referral to urology.) During an interview on 03/07/25, at 9:20 A.M., the Director of Nursing (DON) said urinary retention should have been placed on the resident's care plan and got missed.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a system in place to ensure each resident's code status preference was clear and accurate when staff failed to update a do not resuscitate (DNR - an order that instructs providers not to start cardiopulmonary resuscitation (CPR - an emergency procedure that is done when a person stops breathing or heart stops) if a person stops breathing or heart stops) to a full code (every possible measure, including CPR, to save a person's life) in the resident record for one resident (Resident #10). The facility census was 89. Review of a facility policy titled 'Advance Directives, dated [DATE], showed the following: -Advance directives will be respected in accordance with state and federal law policies; -Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so; -Prior to or upon admission, the Social Services Director (SSD) will inquire about the existence of any written advance directives; -The plan of care for each resident will be consistent with his or her documented treatment preferences; -The Interdisciplinary team (IDT) will review annually with the resident his or her advance directives to ensure such directives are still the wishes of the resident; -The resident has the right to revoke an advance directive at any time by physical destruction, written revocation, or oral revocation. 1. Review of the Resident #10's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admission date of [DATE]; -Diagnoses included atrial fibrillation (a type of irregular heartbeat), weakness, and chronic kidney disease (progressive damage of the kidneys which decrease the ability to filter blood). -Resident was a full code. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated [DATE], showed the resident had moderate cognitive impairment. Review of resident's Outside Hospital Do Not Resuscitate Order (OHDNR), dated [DATE], shows the order signed and dated by physician and resident representative. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's February 2025 Physician Order Sheet (POS) showed an order, dated [DATE], for CPR. Review of a facility form titled Code Status, dated [DATE], showed the resident signed the form indicating he/she wanted to be a full code. Review of the resident's February 2025 POS showed an order, dated [DATE], for DNR. Review of the resident's care plan, revised on [DATE], showed the following: -Resident code status was DNR; -If resident's heart stopped beating or the resident stopped breathing, CPR will not be initiated per the resident's/responsible party's wishes and the physician's order; -Staff will acknowledge the resident's right to revoke DNR status at any time in any manner. Review of the resident's [DATE] POS showed an order, dated [DATE], for CPR. During an interview on [DATE], at 10:50 A.M., the resident said he/she would like to be a full code. During an observation on [DATE], at 11:02 A.M., showed the resident's code status indicated as DNR on paper inside a armoire in the resident's room. During an interview on [DATE], at 10:52 P.M., Certified Nursing Aide (CNA) A said the following: -He/she would ask the nurse any questions about a resident's code status -He/she did not know where to locate a resident's code status, but would ask the nurse; -He/she would get the nurse if a resident appeared to need CPR. During an interview on [DATE], at 11:03 A.M., CNA D said the following: -A resident's code status was in the computer and the care plan; -He/she did not know the resident's code status. During an interview and observation on [DATE], at 10:56 A.M., Licensed Practical Nurse (LPN) B said the following: -The code status was located on the care plan on the closet door in resident's room; -There was a list with resident code status at the nurses' station; -The resident's name was not on the list on the list. The LPN viewed the resident's code status in the resident's chart and reported it was a DNR; (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Social services reviewed code status at care plan meetings and upon admission. During an interview on [DATE], at 10:59 A.M., LPN C said the following: -A resident's code status was in the computerized medical record, on the care plan, and on the armoire door in the resident's room; -The resident was a DNR; -Nurses discuss code status with residents and contact the physician for any changes; -The Social Service Director (SSD) would advise the nurse if a resident had questions over code status. During an interview on [DATE], at 11:06 A.M., the SSD said the following: -He/she usually followed up with resident code status after admission; -He/she confirmed the resident wanted to be a DNR if they come to facility with a DNR form; -He/she would have the resident complete a code status form if they would like to change their code status and then it would be changed and uploaded in the computer; -SSD would make sure upon admission code status paperwork was signed and initialed by resident; -The Assistant Director of Nursing (ADON) made the necessary changes in resident chart. During an interview on [DATE], at 11:10 A.M., the ADON said the following: -The SSD was responsible for resident's code status; -The admission Coordinator would obtain code status upon admission and the SSD will confirm with the resident; -The ADON or the Director of Nursing (DON) were responsible for changing code status in the resident's care plan and chart; -Medical records scans all the code status paperwork into the chart; -The SSD would have a resident sign a revocation on the DNR form if a resident requested a change in status; -The code status would be changed in computer after paperwork is signed. During an interview on [DATE], at 11:40 A.M., the DON said the following: -Code status was reviewed during the admission process; (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The SSD followed up with the resident and obtained a signature on the DNR form; -Code status was reviewed in every care plan meeting; -The SSD would discuss and review code status with the resident if a change was requested; -The DON or ADON would change code status once the form to change status were signed; -Medical records was responsible for uploading the signed forms; -The resident had a DNR form sent from the hospital upon admission and the full code form was signed with the admission Coordinator. During an interview on [DATE], at 1:55 P.M., the Administrator said the following: -The admission Coordinator reviewed code status during the admission process; -Code status was discussed at stand-up meetings every morning; -The ADON and SSD were responsible for resident code status changes; -A change in code status should be updated immediately.

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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 interview, and record review, the facility failed to provide care per standards of practice for all residents when staff failed to failed to obtain ordered labs for possible infection in a timely manner for two residents (Resident #65 and #59). The facility census was 89. Review of a facility policy titled, Lab and Diagnostic Test Results - Clinical Protocol, dated [DATE], showed the following: -The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs; -The staff will process test requisitions and arrange for tests; -The laboratory will report test results to the facility; -When test results are reported to the facility, a nurse will first review the results; -If the staff who first received or reviewed lab results cannot follow the remainder of the procedure for reporting and documenting results and their implications, another nurse in the facility should follow or coordinate the procedure; - Before contacting the physician, the person who is to communicate the results should be prepared to discuss the following individual's current condition and any acute changes; diagnosis, allergies, current medications, and lab work; reason lab and diagnostic tests were obtained; and how results may relate to individuals' treatment or condition; -A nurse will identify the urgency of communicating with the physician based on the request, seriousness of the abnormality, and individual's current condition; -A nurse will try to determine whether the test was done for a routine screen or follow up, a condition change, or to monitor a drug level. -Nursing staff will consider the following to identify situations requiring prompt physician notifications concerning lab results physician request to be notified as soon as result is received; whether the result should be conveyed to the physician regardless of other circumstances; and if the resident has signs and symptoms of an acute illness or condition change. -A physician can be notified by phone, fax, voicemail, e-mail, pager, or telephone message. 1. Review of Resident #65's face sheet (brief resident profile sheet) showed the following information: -admission date of [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included stage 5 chronic kidney disease, end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Review of the resident's February 2025 Physician Order Sheet (POS) showed the following information: -An order, dated [DATE], give finasteride (medication used to treat benign prostatic hyperplasia (bph - a condition where the prostate gland is enlarged, causing frequent urination, difficulty starting or stopping urination, and a weak stream) 5 milligram (mg) tablet, daily; -An order, dated [DATE], for staff may straight catheter every six hours as needed for complaints of urinary retention. Review of the resident's February 2025 Treatment Administration Record (TAR) showed staff straight catheterized the resident on [DATE]. Review of the resident's progress note, dated [DATE], showed the following information: -Straight catheter completed and 150 milliliters (ml) of dark brown, creamy white urine was removed; -Resident tolerated the sterile procedure well. Review of the resident's February 2025 POS showed an order, dated [DATE], for staff to monitor resident every shift for urinary retention. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated [DATE], showed the following information: -Cognition intact; -Independent with mobility; -Required setup assistance with shower and dressing; -Required substantial assistance with toileting hygiene. Review of the resident's February 2025 POS showed an order, dated [DATE], for staff to set-up urology follow up appointment for resident concerns. Review of the resident's February 2025 TAR showed staff straight catheterized the resident on [DATE]. Review of the resident's progress note, dated [DATE] showed the following information: -Straight catheter completed and 250 ml of amber colored urine was removed; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident immediately stated he/she felt so much better. Review of the resident's February 2025 TAR showed staff straight catheterized the resident on [DATE]. Review of the resident's progress note, dated [DATE], showed the following information: -The resident insisted on having a urinalysis (UA - a laboratory test that analyzes a urine sample to detect various substances and conditions) obtained due to pain and burning with urination: -Straight catheter completed and 40 ml of urine collected; -Specimen placed in laboratory refrigerator for morning pick-up; -Laboratory order placed for urinalysis. Review of the resident's progress note, dated [DATE], showed the resident's urine sample was not collected in time by the lab and would have to be collected again. (Staff did not document an attempt to obtain the sample between [DATE] and [DATE]). Review of the resident's care plan, revised [DATE], showed staff to monitor/document/report signs and symptoms of renal insufficiency. During an interview on [DATE], at 10:30 A.M., the resident said that the nurse collected a urine specimen a few days ago via straight catheter. The resident said he was still waiting on the results of the UA. The resident said that he had a history of having urinary tract infections (UTI's) and will need to take antibiotics if it comes back positive. During an interview on [DATE], at 9:30 A.M., the resident's spouse said the resident did not catheterize himself. The the nurses catheterize him/her and that the nurse catheterized the resident on [DATE] around 6:30 A.M. and told them that he/she put a urine specimen in the refrigerator and that we should have the results back in a few days. They are still waiting on the results. They are worried since he/she may have a UTI. During an interview on [DATE], at 9:40 A.M., Licensed Practical Nurse (LPN) H said that he/she had never had to straight catheter (cath) the resident, but he/she did have orders to do so if needed. The resident had needed to be straight cathed a few times after dialysis. Sometimes they don't pull off enough fluid and the resident will feel full and uncomfortable. The nurse straight caths the resident. The resident doesn't cath himself/herself. A specimen was collected and placed in the refrigerator [DATE]. The lab doesn't pick up specimens on weekends so that specimen expired. It doesn't look like there was any follow up with that. During an interview on [DATE], at 9:20 A.M., the Director of Nursing (DON) said that the resident straight catheterized himself/herself and had been doing it at home. The nurses don't straight catheter him/her. The resident had not had any issues while here. The facility had not had to send out any UAs on the resident since admission. The urinary retention should have been placed on the resident's care plan and got missed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 10:00 A.M., the Nurse Consultant said that after reviewing the resident's record it appeared that the nurse did collect a urine specimen and placed it in the refrigerator on [DATE]. That specimen expired and it was recollected on [DATE]. That order was not put in the system after the specimen was collected, therefore, the second specimen also expired. The nurse consultant said that it may need to be recollected for a third time. During an interview on [DATE], at 1:40 P.M., the Assistant Director of Nursing (ADON) said nurses enter an order for a urinalysis into the electronic medical record and the laboratory website. The lab results are faxed and sent directly to the results tab in the electronic medical record by the lab. The DON was responsible for lab result audits. During an interview on [DATE], at 1:55 P.M., the Administrator said that nurses should collect urine specimens when needed, place them in the lab refrigerator, put an order in the electronic medical record and report any abnormal results to the physician. The lab collected specimens 7 days per week. The DON followed up with all lab results. 2. Review of Resident #59's face sheet showed the following: -admission date of [DATE]; -Diagnoses included dementia (loss of memory, problem solving, language and other thinking abilities that interfere with daily life). Review of the resident's quarterly minimum data set (MDS), dated [DATE], showed the following: -Resident had severe cognitive impairment; -Dependent on staff assistance with dressing, transfers, and bed mobility; -Resident did not have any behavioral symptoms. Review the resident's progress note, dated [DATE], showed the resident continued to scream with changes and even light touching. Resident resists care and said, I hate you to staff. Review of the resident's progress note, dated [DATE], showed the resident continued to be verbally and physically aggressive with staff when attempting to provide cares. Resident noted to have soiled clothes during dinner and when aide approached resident to provide peri care, resident became agitated. The nurse and aide were able to assist resident to toilet and resident became agitated when staff attempted to provide peri care. Review of resident's care plan, revised on [DATE], showed the following: -Required one staff assistance with showers, toileting, mobility, and dressing; -Resident was incontinent of bladder and bowel; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to monitor and document signs and symptoms of UTI including pain, blood-tinged urine, cloudiness, no output, urine color, increased pulse or temperature, urine frequency, foul smelling urine, altered mental status, and change in behavior or eating patterns. Review of the resident's progress note, dated [DATE], showed it required two aides to convince resident to allow them to assist to bathroom to check brief. Resident yelled at staff. Review of the resident's progress note, dated [DATE], showed staff informed nurse that resident gets combative when toileted and refused to sit on the toilet. Review of the resident's progress note, dated [DATE], showed it took three staff to assist resident to toilet. The resident would scream out every time they attempted to transfer. After toileting, the resident sat in the hallway stating he/she hated everyone. Review of the resident's progress note, dated [DATE], showed staff informed the nurse practitioner of the resident's refusal of medications and he/she ordered a urinalysis (UA). Review of the resident's February 2025 POS showed staff did not transcribe the order for a UA. Review of the resident's physician progress note, dated [DATE], showed the resident reported mild dysuria (painful urination) with a UA pending. The resident had increased behaviors lately, and was uncooperative and refusing medications. Review of the resident's progress note, dated [DATE], showed staff collected urine and put in refrigerator for pick up (twelve days after initial order). Review of the resident's progress note, dated [DATE], showed the lab at the facility to pick up urine for UA. Review of the resident's lab results report, dated [DATE], showed a UA collected on [DATE] and received by the laboratory on [DATE]. The results reported to facility on [DATE] and showed white blood cells (WBC), red blood cells (RBC), nitrites (chemical compound that could indicate a UTI when found in urine), and leukocyte esterase (enzyme produced by WBC's that can indicate a UTI when found in urine) were present Review of the resident's progress note, dated [DATE], showed staff reported the UA results to the physician on [DATE] at 2:30 P.M. and a new order was received for Keflex (an antibiotic) 500 milligrams (mg) four times daily for seven days (reported four days after results received by facility). During an interview on [DATE], at 2:00 P.M., LPN E said the resident had no orders entered for a urinalysis. The urinalysis was ordered on [DATE] and readdressed on [DATE]. The urinalysis was collected on [DATE] and the results returned on [DATE]. There was no physician notification in chart regarding lab results on [DATE]. During an interview on [DATE], at 3:24 P.M., LPN K said increased behaviors and mood swings could indicate a UTI, He/she was unaware the resident had a urinalysis order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:20 P.M., the DON said there were no orders in the medical record for a urinalysis dated [DATE] or [DATE] for the resident. 3. During an interview on [DATE], at 1:44 P.M., CNA F said signs and symptoms of a UTI would be confusion, increased need to use the restroom, urine odor, and urine color. He/she would report UTI symptoms to the nurse. During an interview on [DATE], at 2:00 P.M., LPN E said signs and symptoms of UTI would be dysuria (painful or uncomfortable urination), urine retention, frequency, or urine odor. He/she would notify the physician to obtain urinalysis if resident had symptoms. An order for a lab should be entered in the computer and on the lab website. The family should be notified, the lab obtained, and this information should be documented. Lab results were entered into the electronic medical record by the lab and faxed to the facility. The charge nurse should check the fax for lab results throughout the day. The DON completed daily audits on lab results. The physician should be notified of abnormal results. During an interview on [DATE], at 3:24 P.M., LPN K said signs and symptoms of UTI could be confusion, increased temperature, behaviors, nausea, urine odors, cloudy urine, and burning with urination. He/she would advise the physician of resident symptoms, vital signs and obtain an order for a urinalysis. He/she would make a progress note regarding order, resident symptoms, vital signs, and physician and family notification. The lab comes every morning except weekends. The lab faxes result to facility and the DON will pick them up. Nurses can view lab results on the computer. He/she would enter a urinalysis order into chart and obtain sample right away. Nurses should not wait until [DATE] to obtain a urinalysis ordered on [DATE]. Abnormal results should be reported to physician and family immediately. During an interview on [DATE] at 1:20 P.M., the DON said an order should be entered when the physician gives the order. Lab results go to the medical record and are faxed. Nurses should monitor lab results. The DON does daily audits to confirm lab results are picked up from the fax and notify nurses. The physician should be notified within 24 hours of abnormal lab results. Signs and symptoms of a UTI are different for everyone. Nurses should not have waited two weeks to obtain an ordered urinalysis. -Nurses should notify physician immediately for abnormal results. During an interview on [DATE], at 1:40 P.M., the ADON said nurses should enter an order for a urinalysis into the electronic medical record and the laboratory website. Lab results are faxed and sent directly to the results tab in the electronic medical record by the lab. Nurses were responsible for checking the fax for any results multiple times per shift. The DON was responsible for lab result audits. Nurses should notify the physician of any abnormal results when they are received. During an interview on [DATE], at 1:55 P.M., the Administrator said the nurse should carry out an order for a urinalysis when received. Nurses should report abnormal lab results to the physician prior to the end of shift.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure resident weight loss was unavoidable when staff failed to notify the physician and dietician of weight loss, failed to care plan actual weight loss and new interventions, and failed to implement current care planned inventions to prevent future weight loss for one resident (Resident # 43). The facility census was 89. Review of the facility policy titled Weight Assessment and Intervention, dated September 2008, showed the following: -The nursing staff will measure resident weights on admission, the next day, and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly; -Any weight change of 5% or more since the last weight will be retaken the next day for conformation. If the weight is verified, nursing will immediately notify the dietician; -The dietary manager will review all weight records by the 5th of the month to follow weight trends over time. The treatment team will evaluate negative trends; -The threshold for significant unplanned and undesired weight loss will be based on the following criteria 1 month of 5% weight loss is significant, greater than 5% is severe; 3 months of 7.5% is significant, greater than 7.5% is severe; 6 months of 10% is significant, greater than 10% is severe; -Assessment information shall be analyzed by the multidisciplinary team and conclusions made regarding the resident's target weight range; calorie, protein, and other needs compared with resident current intake; relationship between current medical or clinical situation and recent fluctuations in weight; and whether and to what extent weight stabilization or improvement can be anticipated; -Physician and multidisciplinary team will identify conditions and medications that may be cause or risk of weight loss including cognitive or functional decline; chewing or swallowing abnormalities; pain; medication related consequences; environmental factors; increased calorie needs; poor digestion or absorption; and fluid and nutrient loss; -Care planning for weight loss will be a multidisciplinary effort; -Individualized care plans shall address identified cause of weight loss, goals and benchmarks for improvement, and time frames; -Interventions for undesirable weight loss shall be based on careful consideration of resident choice and preferences, nutrition and hydration needs, functional or environmental factors, chewing and swallowing abnormalities, medications, supplementations, end of life decisions. 1. Review of Resident #43's face sheet (brief resident profile sheet) showed the following information: -admission date of 01/25/19; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included epilepsy (seizure disorder), hemiplegia (a condition characterized by paralysis or weakness on one side of the body) of left non dominate side, depression, and anxiety disorder. Review of the resident weight, dated 12/03/24 showed, the the resident weighed 148.2 pounds. Review of the resident's care plan, revised 01/03/25, showed the following information: -Allow resident ample time to ingest meal; -Encourage meals in dining room; -Resident feeds self in restorative dining room for assistance as needed. Resident uses plate guard to aide in meal independence; -Weights per physician orders and notify physician of significant weight changes; -Monitor, document, and report any signs of dysphagia (difficulty swallowing foods or liquids); -Monitor, record, and report to physician significant weight loss equal to or above 5% in a month, equal to or above 7.5% in 3 months, or equal to or above 10% in 6 months; -Registered dietician (RD) to evaluate and make diet change recommendations as needed; -Provide and serve diet as ordered, monitor intake, and record every meal. Review of the resident's dietary profile, dated 01/06/25, showed the resident was on a mechanical soft diet and receiving health shakes three times daily. The resident noted to have a fair appetite. The resident required total assistance with feeding and used a plate guard. Review of the resident's nutrition assessment, dated 01/07/25, showed the resident was on a regular mechanical soft diet and had no chewing or swallowing difficulty. The resident dined in the restorative dining room, utilized a plate guard, and had a good appetite averaging 50% per meal. The resident had a 7% weight loss in one month. Current nutrition regimen appropriate. Review of the resident weight, dated 01/07/24 showed, the the resident weighed 136.8 pounds (a loss of 11. 4 pounds, 7.7% loss in one month). Review of the resident's weekly weight progress note, dated 01/09/25, showed the resident triggered for a 5% weight loss. Diet changed to regular enhanced, mechanical soft diet with the use of a plate guard. Resident continued to eat in the restorative dining room. Review of the resident's progress notes showed staff did not document physician notification of the weight loss. Review of the resident's current care plan showed staff did not update the care plan with the new weight loss or new interventions to prevent future weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/09/25, showed the following information: -Severe cognitive impairment; -Required staff assistance with eating; -Loss of 5% or more in last month or 10% or more in last six months. Review of the resident's current physician order sheet (POS), dated 03/07/25, showed an order, dated 01/09/25, for a regular enhanced diet mechanical soft (soft easy to chew foods that are easy to swallow) texture. Review of the resident's weekly weight note, dated 01/24/25, showed the resident weight on 01/14/25 was 136.8 pounds, which was a 7.7% weight loss. Diet indicated as regular enhanced mechanical soft in restorative dining with use of a plate guard. Current intake was 30% of meals. Snack at 10:00 A.M. added as intervention. Review of the resident's progress notes showed staff did not document physician notification of the weight loss. Review of the resident's current care plan showed staff did not update the care plan with the new weight loss or new intervention. Review of the resident's nurse practitioner (NP) progress note, dated 02/01/25, showed staff felt resident was eating and sleeping well. (The NP did not address recent weight loss.) Review of the resident's weight, dated 02/03/25, showed the resident weighed 137.5 pounds. Review of the resident's current POS, dated 03/07/25, showed an order, dated 02/05/25, for a regular puree diet. Review of the resident's progress note, dated 02/05/25, showed the resident noted to be pocketing food this morning. Puree diet trial started for three days. Resident consumed 100% of evening meal with maximum assistance. Review of the resident's care plan, updated 02/10/25, showed staff regular diet, pureed texture, regular consistency to the care plan. (Staff did not update to show actual weight loss the intervention of a 10:00 A.M. snack.) Observation on 03/03/25, at 12:05 P.M., showed the resident in the restorative dining room with a meal ticket indicating plate guard. An aide was assisted the resident with eating and provided encouragement. The resident's plate did not have a plate guard and had diced chicken and vegetables with potatoes and gravy and ice cream. The resident consumed 50% of meal. Observation on 03/04/25, at 11:52 A.M., showed the resident ate pureed spaghetti, vegetables, and ice cream in the restorative dining room with no plate guard. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's weight, dated 03/04/25, showed the resident weighed 131 pounds (a loss of 6.5 pounds in one month, 17.4 pounds total and 11.6 % in four months). Review of the resident's weekly weight note, dated 03/06/25, showed the resident's weight was 131 pounds on 03/04/25, which is a 5.1% loss in 30 days and 10.4% loss over six months. Diet indicated resident on a regular enhanced, pureed diet (current diet order does not indicate enhanced for puree diet) and Med pass 2. 0 (supplement) 60 milliliters (ml) added. Review of the resident's current POS, dated 03/07/25, showed an order, dated 03/06/25, for Med Pass 2.0 60 ml at 2:00 P.M. Observation and interview on 03/06/25, at 12:20 P.M., showed the resident ate in the restorative dining room with an aide assisting with the meal. The resident's meal ticket showed an enhanced puree diet, plate guard, and red napkin program written on it. The resident consumed about 25% of meal. The resident reported the food was good and he/she was not hungry. No plate guard noted. Observation on 03/07/25, at 12:15 P.M., showed the resident had finished eating lunch in the restorative dining room and ate less than 25% of the meal. No plate guard noted. During interviews on 03/06/25, at 12:30 P.M. and 1:44 P.M., Certified Nurse Aide (CNA) F said the resident did not eat a lot and had declined in health lately. The resident was on a puree diet and did not use any adaptive equipment with meals. He/she would ask family for assistance, offer an alternate item, or have another staff try to help if a resident was not eating. He/she would notify the nurse if a resident refused two meals during the shift. The red napkin program was for a resident that had enhanced foods due to weight loss or decreased appetite. Enhanced food would be extra food or a shake. During an interview on 03/06/25, at 3:15 P.M., CNA N said the resident ate in the restorative dining room, but was unsure of his/her diet. The resident did not appear to have any weight loss. He/she would report to the nurse if a resident did not eat at mealtime and document the amount consumed. During an interview on 03/06/25, at 2:00 P.M., Licensed Practical Nurse (LPN) E said the following: -The aides report to the nurse if a resident was observed not eating at meals; -He/she would try to find out why the resident was not eating, check on dietary preferences, contact dietary, and if there was a medical concern, call the physician; -The Assistant Director of Nursing (ADON) and dietary director were involved in weight meetings; -The ADON manages any weight changes and will initiate supplements or find out what's going on with the resident; -There was a list of weights that any aide could do; -The resident had an overall decline and had increased chewing and pocketing difficulty so the diet was changed to puree; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she did not monitor weights and did not know if resident had a weight gain or loss; -The resident was on a puree diet with thin liquids, but had two different diet orders listed; -There should not be two diet orders listed and an order probably did not get discontinued; -The red napkin program was set up assistance at mealtimes. During an interview on 03/06/25, at 3:24 P.M., LPN K said the following: -He/she would let the physician know, encourage fluids, obtain a speech evaluation, check for a dental problem, and obtain weights if a resident had a decreased appetite; -There was not a specific staff assigned to do weights; -The ADON monitored resident weights; -The resident ate in the restorative dining room and did not eat well; -The resident was on a mechanical soft diet, but had orders for puree and mechanical soft diet; -Mechanical soft is resident's main diet because it is listed first in the orders and puree must be for certain foods; -The kitchen knew if there was something he/she could not eat and would send an alternate; -The resident did not use any specialized equipment during meals. During an interview on 03/07/25, at 11:26 A.M., the Registered Dietician (RD) O said the following: -He/she visited the facility three times monthly and the ADON or Dietary Manager (DM) would contact her sooner if needed; -He/she completed an onsite recommendation and intervention form which was reviewed by the ADON and the DM; -He/she met with the ADON and DM when at the facility; -He/she reviewed residents with weight loss, wounds, dialysis, and fluid restriction while in the facility; -The resident's last assessment was in January 2025; -The resident triggered for weight loss on last visit; -The resident dined in the restorative dining room and utilized a plate guard, had house shakes three times a day, snacks, and med pass was added in the afternoon; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she had not been notified of any weight loss for the resident; -Interventions for weight loss would include an enhanced diet, assessing resident preferences, or adding a supplement shake. During an interview on 03/07/25, at 1:20 P.M., the Director of Nursing (DON) said the following: -The ADON was over the weight committee and monitored weights; -The ADON and DM attend weight meetings and enter a progress note in the resident chart; -The facility had a weight aide assigned to do weights, but does not have one currently; -If a resident had a 5% weight loss, they would go on weekly weights until stable; -The physician should be notified of a 5% weight loss and resident placed on an enhanced diet; -Notification to the physician about weight loss should be documented; -The resident diet order showed both mechanical soft and puree diets; -The nurse must have not deleted the mechanical soft diet order as resident was currently on puree; -The resident ate in the restorative dining room. The DON did not know if the resident used an assistive device with meals. During an interview on 03/07/25, at 1:40 P.M., the ADON said the following: -He/she printed out a sheet with weights that were due and assigned them to specific aides; -Residents that trigger for weight loss were discussed during weekly weight meetings; -Resident diet, restorative dining, supplements, intake, and medications are reviewed during the meeting; -The physician might be contacted if a resident is eating less than 25% of meals; -The resident was being monitored during weight meetings; -The physician had not been notified about the resident's weight loss due to losing only 10 pounds in three months; -He/she would notify the physician if resident had continued weight loss; -A plate guard should be used at each meal, but resident will push it away at times; -The DM would update orders during the weight meetings. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/07/25, at 1:55 P.M., the Administrator said a lot of factors go into weight decisions. Staff would review residents with weight loss and interventions would depend on specific perimeters and diagnosis. He/she attended the weekly weight meetings and a resident with a 5% weight loss would trigger and would be monitored.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care per standards of practice when staff obtain a physician's order for the use of and complete a care plan for the use of a CPAP (continuous positive airway pressure - a machine that uses air pressure to keep airways open while a resident sleeps) for two residents (Resident #398 and #65).The facilities census was 89. Review of the facility's policy titled, CPAP/BiPAP Support, dated March 2015, showed the following: -Purpose to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen; to improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease; and to promote resident comfort and safety; -Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask; -Review the resident's medical record to determine his/her baseline oxygen saturation; -Review the physician order to determine the oxygen concentration flow, and the pressure (CPAP, IPAP and EPAP) for the machine; -Review and follow manufacturer's instructions for CPAP machine setup and oxygen delivery. 1. Review of Resident #398's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 02/26/25, showed the following: -No cognitive impairment; -Current diagnosis for sleep apnea; -Did not use oxygen or CPAP. Observation and interview on 03/03/25, at 11:59 A.M., showed the following: -Resident sat in his/her room in a wheelchair; -The CPAP machine was on his/her nightstand next to his/her bed; -The CPAP was plugged in with hosing and face mask attached; -The resident said he/she used his/her CPAP at night; -The resident said he/she used a CPAP at the hospital and his/her family brought his/hers to the facility when he/she was admitted . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER: Maples Health and Rehabilitation, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 610 West Sunset Street Springfield, MO 65807	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current care plan, dated 02/23/25, showed staff did not care plan related to CPAP use. Review of the resident's current physician orders, dated 03/06/25, showed no physician's orders for CPAP use. Review of the resident's March 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed no record of CPAP use or administration. During an interview on 03/06/25, at 11:05 A.M., Licensed Practical Nurse (LPN) I said he/she did not know if the resident had a CPAP and did not know if the resident had an order for a CPAP. During an interview on 03/06/25, at 11:24 A.M., Registered Nurse (RN) J said the resident did use a CPAP. He/she was unsure if the resident's CPAP came from the hospital or if family brought it in. He/she was unsure if the resident had an order for a CPAP. During an interview on 03/06/25, at 12:38 P.M., the Director of Nursing (DON) said the resident used a CPAP. During an interview on 03/06/25, at 1:49 P.M., the MDS Coordinator said he/she did not know the resident had a CPAP. During an interview on 03/07/25, at 2:19 P.M., the Administrator said the resident's family brought in a CPAP for him/her to use. 2. Review of Resident #65's face sheet (brief resident profile sheet) showed the following information: -admission date of 02/06/25; -Diagnoses included cerebral infarction (stroke) and heart failure with congestive heart disease (heart does not pump blood adequately) Review of the resident's admission MDS, dated [DATE], showed the following information: -Cognition intact; -Independent with mobility; -Did not use oxygen or CPAP. Observation on 03/03/25, at 1:35 P.M., showed the following information: -The resident sat in his/her room in a recliner; -A CPAP machine sat on the nightstand next to the bed, plugged into wall with face mask attached; -A gallon of distilled water (to use with CPAP), half empty, sat on floor next to nightstand; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said he/she used the CPAP at night and was not able to sleep without it; -The resident said staff fill the reservoir with distilled water every evening and he/she put on the mask when going to bed; -The resident said he/she brought the CPAP with him/her on the first day of admission and has used it nightly since. Review of the resident's care plan, revised 03/03/25, showed staff did not care plan related the use of CPAP. Review of the resident's current POS, dated 03/06/25, showed staff did not transcribe order for use of a CPAP. Review of the resident's TAR, dated 02/01/25 through 03/06/25, showed staff did not document use of the CPAP. During an interview on 03/06/25, at 11:53 A.M., Certified Nurse Aide (CNA) P said the resident had a CPAP on his/her bedside table and the CNA's make sure that the water reservoir was filled every day. The resident kept a gallon of distilled water on the floor next to his/her bedside table to use in his/her CPAP. The resident put his/her mask on him/herself whenever he/she was ready to go to sleep at night. During an interview on 03/06/25, at 12:00 P.M., CNA Q said that the resident has a CPAP machine on his/her bedside table and staff ensure that it had water in the reservoir. The resident put on his/her mask and turns on the machine when he/she went to bed. During an interview on 03/06/25, at 12:15 P.M., the DON the resident did not have an order for a CPAP machine and didn't know that the resident had a CPAP machine in his/her room. It was not on his/her orders, or discharge orders, nor is it care planned. 3. During an interview on 03/06/25, at 10:31 A.M., CNA G said CNA's do not do anything with oxygen or CPAP machines. The nurses administer oxygen and CPAP. He/she was unaware of any residents using a CPAP currently. During an interview on 03/06/25, at 10:39 A.M., LPN H said the following: -Nurses obtain orders through the nurse practitioner (NP) or the physician; -He/she notified the DON if a resident had a CPAP; -He/she notified the DON if a resident's family brought in a CPAP; -CNA's may turn on CPAP's, but are not allowed to adjust the settings; -He/she will check medical records and contact the physician for orders if a resident needs a CPAP; -The medical records clerk inputs admission orders into the computer; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents are supposed to have orders for oxygen and CPAP; -CPAP instructions should be in the orders and in the care plan. During an interview on 03/06/25, at 11:05 A.M., LPN I said the following: -He/she asked the resident about their CPAP settings; -He/she would review hospital records for CPAP use; -He/she would notify the physician if there was no order; -If a family member brought in a CPAP for a resident, he/she would ask the family about CPAP settings and use; -Residents must have an order for a CPAP. During an interview on 03/06/25, at 11:24 A.M., RN J said the following: -Orders for medical equipment like oxygen and CPAP come from the hospital; -He/she could obtain orders from the primary physician; -He/she would expect orders and instructions for a CPAP to be in the care plan. During an interview on 03/06/25, at 12:38 P.M., the DON said the following: -Staff was to report to him/her if a resident came to the facility with a CPAP; -Staff was to report to him/her if a family member brought in a CPAP for a resident; -He/she expected a resident with a CPAP to have an order for a CPAP; -He/she expected a resident with a CPAP to have that in their care plan. During an interview on 03/06/25, at 1:49 P.M., the MDS Coordinator said the following: -Staff should notify the charge nurse if a resident had a CPAP; -Staff should notify the charge nurse if a residents family brings in a CPAP; -He/she would obtain an order for use of and update a resident's care plan if he/she was informed they have a CPAP; -She does all baseline care plans stating that during the care meeting staff review and make sure they are all in the care plan; (continued on next page)

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	265559	A. Building B. Wing	03/07/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Normally if he/she knew about a CPAP, she would put in the care plan including the setting if they had specific settings; -Normally during morning meetings, staff go over any equipment the resident had or that needed to be ordered; -If staff noticed a CPAP in a resident's room, they should notify the charge nurse, and it should be added to the care plan and the nurse should make sure they have orders. During an interview on 03/07/25, at 8:30 A.M., the facility's Physician said the following: -He/she had written protocols for the facility to continue current medications on admission and to contact him if staff have any concerns; -Residents with medical equipment need a physician order; -He/she expected the facility to obtain an order for residents using medical equipment such as oxygen and CPAP. During an interview on 03/07/25, at 2:19 P.M., the Administrator said he/she expected staff to obtain an order and update the resident's care plan for any resident using a CPAP. On admission he/she informed family members to notify staff before bringing in medical equipment or medications.

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	265559	A. Building B. Wing	03/07/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store food in accordance with professional standards of practice and protect food from possible contamination when staff did not store food properly after opening and staff did not consistently label food after opening. The facility census was 89. Review of the facility policy titled, Food Receiving and Storage, revised October 2017, showed the following: -Foods shall be received and stored in a manner that complies with safe food handling practices; -Wrappers of frozen foods must stay intact until thawing; -Other opened containers must be dated and sealed or covered during storage. Record review of the 2013 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location, and where it is not exposed to splash, dust, or other contamination. 1. Observations on 03/03/25 at 10:40 A.M., showed the following: -A box of flake cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and opened to air, and not labeled with date opened; -A box of oat cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and open to air, and not labeled with date opened; -A box of cinnamon cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and opened to air, and not labeled with date opened; -An opened to air and unsealed carton of liquid eggs with yellow substance showing on the opening of the carton and not labeled with date open. Observations on 03/05/25, at 9:56 A.M., showed the following: -A box of flake cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and opened to air, and not labeled with date opened; -A box of oat cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and open to air, and not labeled with date opened; -An opened to air and unsealed carton of liquid eggs with yellow substance showing on the opening of the carton, and not labeled with the date open. Observations on 03/06/25 at 11:30 A.M., showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A box of flake cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and opened to air, and not labeled with date opened; -A box of oat cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and open to air, and not labeled with date opened; -A large box containing a blue bag of frozen peas and carrots stored in the walk-in freezer. Both the box and the blue bag were unsealed and open to air; - A large box containing a blue bag of frozen broccoli stored in the walk-in freezer. Both the box and the blue bag were unsealed and open to air; - A large box containing a blue bag of frozen mixed vegetables stored in the walk-in freezer. Both the box and the blue bag were unsealed and open to air. Observations on 03/07/25, at 9:55 A.M., showed the following: -A box of flake cereal labeled with a resident's name and room number stored on the shelf of dry storage room, unsealed and opened to air, and not labeled with date opened; -A large box containing a blue bag of frozen broccoli stored in the walk-in freezer. Both the box and the blue bag were unsealed and open to air; -A large box containing a blue bag of frozen mixed vegetables stored in the walk-in freezer. The box was closed, but blue bag was open to air and unsealed. During an interview on 03/07/25, at 9:38 A.M., Dietary Aide (DA) L said the following: -Staff should store opened food with a label containing the item name, date opened, date used by, and initials of staff who opened it; -Staff should leave residents' personal cereal in the original box labeled with name and room number and should be closed and not open to air; -Staff should ensure opened bags of frozen vegetables are wrapped closed and the box is closed. During an interview on 03/07/25, at 9:46 A.M., Dietary [NAME] M said the following: -Staff should store opened food items in sealed zip lock bags, and label with date opened and use by date within three days; -Staff should store residents' personal cereal in original box with bag rolled up and top closed; -Staff should store an opened carton of eggs with the top pushed down to ensure it is completely closed and write the date opened in sharpie and use by manufacture's date; -Staff should twist the bag closed containing frozen vegetables and ensure the box is completely closed after opening. Staff should label with open date and use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/07/25, at 9:59 A.M., the Kitchen Supervisor said the following: -Staff should store open food in sealed gallon bags and label with the open date; -Staff should store an opened carton of liquid eggs inside of something else like a zipper bag if not sealing properly, with use by manufacture's expiration date, and it should not have yellow substance on the opening; -Staff should store residents' personal cereal boxes in the original box labeled with the resident's name and room number, date opened, and roll up the bag and make sure it is sealed and close the box; -Staff should store opened boxes of vegetables in a gallon bag with open date or at least have the bag twisted and closed inside the closed box. During an interview on 03/07/25, the Dietary Manager (DM) said the following: -Staff should ensure opened food products were sealed and labeled with the date open for storage; Staff should store residents' personal cereal boxes in the original box labeled with the resident's name and room number, bag folded, and box closed; -Staff should reclose an opened carton of liquid eggs, and if the carton does not seal, place in a plastic bag and seal, and label with open date for storage. Liquid egg cartons should not have yellow substances on the opening; -Staff should seal the bags of opened vegetables in the freezer and close the box for storage. If a small amount of frozen vegetables, transfer to a zipper bag and seal. All opened frozen vegetable containers should be labeled with the open date. During the interview on 03/07/25, at 10:55 A.M., the Registered Dietician (RD) said the following: -Staff should store opened food items in a sealed container such as a zipper bag, container with lid or if able to seal in original container, with date received and date opened, and name of item if not easily identifiable; -Staff should label and store residents' personal cereal boxes with the bag and box closed; -Staff should transfer opened liquid egg cartons to a container with lid and labeled and should not have a yellow substance on top; -Staff should tie off the bag of opened frozen vegetables and close the box for storage. During an interview on 03/07/25, at 1:02 P.M., the Director of Nursing (DON) said opened food should be sealed and labeled with the throw away date within three days.