

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Luther Manor Retirement & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3170 Highway 61 North Hannibal, MO 63401	

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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide oversight and prevent injury for two residents (Resident #1 and Resident #44) in a sample of 23 residents. Resident #1 was dependent on staff for transfers. When his/her electronic bed did not function properly, staff manually transferred the resident and caused a laceration to the resident's leg, which required emergency medical care, including sutures, antibiotic use to prevent infection, pain management medication, wound care and wound clinic appointments. Resident #44 had a history of falls and wandering and staff failed to provide oversight, resulting in an elopement that resulted in a fall with injury. The facility census was 55. The administrator was notified of a past noncompliance on 11/06/25, for Resident #44 which occurred on 08/28/25. The facility inserviced staff on wander guards and door alarms. This noncompliance was corrected on 08/29/25. Additionally, past noncompliance occurred for Resident #1 on 09/22/25. The facility inserviced staff on proper transfers, including the removal of wheelchair pedals prior to transfers and that a mechanical hand crank was available in resident closets should one be needed. The deficiency was corrected on 09/22/25.</p> <p>1. Review of Resident #1's undated face sheet showed the resident's diagnoses included dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering and reasoning, to the point that it interferes with daily life), muscle weakness, difficulty in walking, reduced mobility, need for assistance with personal care, and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high). Review of the resident's care plan, revised 07/18/25, showed the following: -Potential for alteration in skin integrity related to incontinence, decreased mobility, and multiple disease processes; -Avoid shearing resident's skin during positioning, transferring and turning; -Monitor skin during routine care and notify nurse of any abnormalities; -Provide assist of two staff using a mechanical lift for all transfers; -At risk for bleeding due to daily use of antiplatelet medication; -Avoid hitting/bumping extremities during activities of daily living (ADL's) to prevent injury; -Maintain a safe environment to decrease risk of injury; -Observe for signs of active bleeding: sudden changes in mental status, lethargy. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/04/25, showed the following: -Intact cognition; -The resident was dependent on staff for toileting, bathing, dressing, transfers and mobility; -The resident required a wheelchair for mobility and was dependent on staff for wheeling about. Review of the resident's progress note, dated 09/22/25 at 10:00 A.M., showed the following: -At 6:50 A.M., staff call Licensed Practical Nurse (LPN) P to the resident's room. The certified nurse assistant (CNA) was holding the resident's left lower extremity. A moderate amount of blood was seen on the towel. The resident had a large open laceration through several layers of skin and muscle. Staff applied pressure and called 911; -At 7:00 A.M., the resident's bleeding had stopped. The staff reported that the injury occurred with a transfer from the bed to the</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265690
		If continuation sheet Page 1 of 9

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>guards/alarms that addressed ensuring an alarm being loud enough to be heard throughout the building. 3. Review of Resident #44's undated face sheet showed the resident's diagnoses included dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering and reasoning, to the point that it interferes with daily life), Alzheimer's disease (a progressive and irreversible brain disorder that gradually destroys memory and thinking skills, eventually leading to the inability to carry out simple daily tasks). Review of the resident's significant change MDS, dated [DATE], showed the following:-The resident had intact cognition;-The resident used a walker mobility device;-The resident required supervision or touching assistance with walking;-Wander/Elopement alarm used daily. Review of the resident's care plan, revised 07/28/25, showed the following:-The resident requires wander guard secondary to increased instances of wandering and increased confusion related to dementia progression;-Check function of alarm every shift;-Personal alarm placed on resident. Review of the resident's nursing note, written by Licensed Practical Nurse (LPN) B, dated 08/28/25 at 5:00 P.M., showed the following:-While pharmacy delivery driver was at the facility making a delivery, the driver told this nurse that there was a resident with a walker sitting outside on the porch;-When the driver left, he/she came back into the facility and stated that the same resident was trying to get into his/her car and had fallen;-Upon going outside, this nurse found the resident with wander guard attached to his/her walker; had not heard alarm going off prior; checked and verified that wander guard was working. Review of the resident's nursing note, written by the ADON, dated 08/28/25 at 8:07 P.M., showed the following:-She was in her office working and overheard a conversation in the hallway that someone had fallen outside and then heard several staff members run by;-She followed the staff members outside and saw the resident sitting upright on his/her bottom in the parking lot;-The resident was just off of the sidewalk in the parking lot with his/her back leaned up against a vehicle;-The charge nurse (LPN B) and Certified Nurse Assistant (CNA) H and CNA Q were outside with the resident;-The resident was repeating that he/she fell off of the sidewalk and that his/her lower legs/feet hurt;-She assisted LPN B with assessing the resident; no injury noted in the parking lot;-Assisted the resident to stand with gait belt and assist of two; once standing, pivot transferred the resident to the wheelchair;-The pharmacy driver was standing outside of the vehicle; he/she had seen the resident outside when he/she entered the building and the resident had started walking down the sidewalk; when he/she returned to the parking lot after dropping off the medications, the resident was on the ground in front of the vehicle, so he/she went and informed the nursing team;-Took the resident inside for further assessment; the resident reported his/her wrist hurt; assessment found two injuries, an abrasion to the right hip measuring 5.0 centimeters (cm) x 5.0 cm and a second abrasion to the right elbow measuring 2.0 cm x 1.0 cm;-The resident requested to go to bed; once in bed, the resident began reporting severe pain to his/her lower legs and then reported pain to bilateral (both) hands;-The resident observed to have facial grimacing while informing this nurse about his/her pain;-Call made to resident's durable power of attorney (DPOA) regarding the unwitnessed fall outside and informed no injury noted besides two small abrasions, but that the resident was complaining of severe pain; this nurse would like to send resident out to the emergency room (ER) for evaluation to be safe;-The DPOA stated that the resident had hardware in his/her right hip and would like him/her sent to a specific hospital for evaluation since that is where his/her orthopedic surgeon was located;-ADON called 911, emergency medical services (EMS) arrived, report given, and resident taken to requested hospital ER. Review of the facility incident report, dated 08/28/25, showed the following:-The resident was outside sitting on the front porch when the pharmacy delivery driver came to deliver medications;-LPN B checked in the medications at that time and the delivery driver</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview and record review, the facility failed to update and document a facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The facility census was 55. Review of the facility's Daily Census Report, dated 09/29/25, showed the facility census was 55. Review of the facility provided, facility assessment, showed the following:-The updated facility assessment of 10/01/25 only included page one that had the facility contact information and facility licensing information;-The remaining facility assessment for review was from 05/01/23 that listed information relating to residents for that date. During an interview on 10/01/25 at 3:30 P.M., the administrator said the following:-He had not updated the facility assessment since he had been at the facility as he was taking care of other things that needed attended to first;-Page one was updated on 10/01/25, after the annual survey began, and nothing else had been addressed on the facility assessment.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Luther Manor Retirement & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3170 Highway 61 North Hannibal, MO 63401	
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)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on interview and record review, the facility failed to ensure nurse aides received the required 12 hours of in-service education annually. The facility census was 55. The facility was not able to provide a policy regarding required in-service training for Nursing Assistants upon request. Review of the facility assessment, dated 05/01/23, showed the following: -Staff competencies and annual training requirements per regulatory authority and/or facility policy: 1. Abuse, neglect, exploitation and misappropriation;2. Advanced directives;3. Behavioral health;4. Communication;5. Compliance and ethics;6. Cardiopulmonary resuscitation;7. Dementia care management;8. Equipment and assistive device training;9. Infection Control;10. -Other areas identified as areas of weakness during annual performance review/competency evaluation;11. Promoting resident's independence;12. Quality assurance and performance improvement;13. Resident rights including confidentiality of resident information, right to dignity, privacy and property;14. -Safety and emergency procedures;15. Job responsibilities and lines of authority;16. Emergency preparedness;17. Facility policies and procedures;18. Change in condition. During an interview on 10/02/25 at 4:05 P.M., the Director of Nursing (DON) said the following: -She and the nurse educator do in-services and education for the Certified Nursing Assistants (CNAs);-The nurse educator provides education during CNA classes;-She does not have documentation of inservices;-She does not track the CNA in-services to ensure they have 12 hours of annual education;-She was aware of the required 12 hours of mandatory training for CNA's, but was not aware of what specific education needed to occur within those twelve hours;-She had not seen a facility assessment indicating what in-service education was identified within that document.</p>		