STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265798	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Manor	783 Weber Road Farmington, MO 63640

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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 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 Advanced Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) to two residents (Resident #25 and #77) out of three sampled residents who were discharged from Medicare Part A services with benefit days remaining. The facility's census was 97. The facility did not provide a policy for SNF ABN or NOMNC forms. 1. Review of Resident #25's medical record showed: - The resident discharged from Medicare Part A services on 02/28/25; - The resident remained in the facility; - The facility failed to issue a NOMNC to the resident. 2. Review of Resident #77's medical record showed: - The resident discharged from Medicare Part A services on 04/30/25; - The resident remained in the facility; - The facility failed to issue a SNF ABN to the resident. During an interview on 06/05/25 at 2:29 P.M., the Social Services Designee (SSD) said she hasn't gotten this process down to a science. She said she was told by corporate to use these two forms, and pointed to two ABN forms - one dated 09/2020 and one dated 2024. She said she does a NOMNC on everyone who comes off Med A whether they have days remaining or not and pointed to the ABN form when talking about completing the NOMNC. The NOMNC for Resident #77 was sent by the insurance company. During an interview on 06/06/25 at 7:35 P.M., the Administrator and Director of Nursing (DON) said they would expect the SNF ABN and NOMNC forms to be completed per regulation and provided to and signed by the resident and/or the resident's representative when a resident was discharged from therapy with days remaining.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital for four residents (Resident #15, #23, #49, and #67) out of 20 sampled residents and failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of transfer to the hospital for three residents (Resident #23, #49, and #67) out of 20 sampled residents. The facility's census was 97. Review of the facility's policy, Bed-Holds and Returns, revised October 2022, showed: - Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies; - All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer (or, if the transfer was an emergency, within 24 hours). The facility did not provide a policy regarding notification of transfer. 1. Review of Resident #15's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]; - No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. 2. Review of Resident #23's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. 3. Review of Resident #49's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. 4. Review of Resident #67's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer or the bed hold policy was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital; - The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation that written notification of transfer was provided to the resident and/or the resident's representative for the resident's transfer to the hospital. During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing, and both Assistant Directors of Nursing said they would expect transfer notifications and bed hold policies to be given in writing to the resident or resident's representative upon discharge to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS-a federally mandated assessment completed by the facility staff) for one resident (Resident #23) out of 20 sampled residents and two residents (Resident #31 and #60) outside the sample. The facility's census was 97. Review of the facility's policy, Resident Assessments, revised October 2023, showed: - A comprehensive assessment of each resident is completed at intervals designated by OBRA (Omnibus Budget Reconciliation Act of 1987 are comprehensive evaluations of a resident's needs and condition within a nursing home, conducted by the facility staff) regulations and PPS (Prospective Payment System-a method of healthcare reimbursement where the Centers for Medicare and Medicaid Services (CMS) pays a provider a fixed amount based on the type of service rendered) requirements. Data from the MDS is submitted to the Internet Quality Improvement Evaluation System (iQIES-cloud based application developed by CMS to help measure and evaluate the quality of care for Medicare and Medicaid beneficiaries) as required; - The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments; - Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2024, showed: - N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the seven-day look-back period (or since admission/entry or reentry if less than seven days); - N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the seven-day observation period (or since admission/entry or reentry if less than seven days). 1. Review of Resident #23's medical record showed: - admission date of 05/09/23; - Diagnoses of stroke, overactive bladder, and hypertensive heart disease with heart failure (condition where the heart is affected by prolonged high blood pressure, potentially leading to heart failure). Review of the resident's Physician's Order Sheet (POS), dated 06/06/25, showed: - An order for Plavix (antiplatelet medication), 75 milligrams (mg), one tablet by mouth one time a day, dated 08/15/24; - No orders for an anticoagulant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's MDS assessments showed: - A significant change MDS assessment, dated 03/08/25, with Section N0415E coded yes for anticoagulant; - A quarterly MDS assessment, dated 02/23/25, with Section N0415E coded yes for anticoagulant; - A quarterly MDS assessment, dated 11/23/24, with Section N0415E coded yes for anticoagulant; - A quarterly MDS assessment, dated 08/23/24, with Section N0415E coded yes for anticoagulant. 2. Review of Resident #31's medical record showed: - admission date of 02/21/23; - Diagnoses of repeated falls, chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow, making it difficult to breathe), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the resident's POS, dated 06/06/25, showed: - An order for clopidigrel (Plavix) 75 mg, one tablet by mouth one time a day, related to peripheral vascular disease, dated 02/21/23; - No orders for an anticoagulant. Review of the resident's MDS assessments showed: - A quarterly MDS assessment, dated 05/27/25, with Section N0415E coded yes for anticoagulant; - An annual MDS assessment, dated 02/24/25, with Section N0415E coded yes for anticoagulant. 3. Review of Resident #60's medical record showed: - admission date of 06/09/22; - Diagnoses of muscle weakness, history of pulmonary embolism (when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung), and atherosclerosis (buildup of fats, cholesterol and other substances in and on the artery walls). Review of the resident's POS, dated 06/06/25, showed: - An order for clopidigrel (Plavix), 75 mg, one tablet by mouth one time a day, related to presence of cerebrospinal fluid drainage device, dated 04/07/23; - No orders for an anticoagulant. Review of the resident's MDS assessments showed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A quarterly MDS assessment, dated 03/09/25, with Section N0415E coded yes for anticoagulant; - A quarterly MDS assessment, dated 12/07/25, with Section N0415E coded yes for anticoagulant. During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing (DON), and both Assistant Directors of Nursing said they would expect MDS assessments to be coded correctly to reflect the resident's current status and current condition. During an interview on 06/11/25 at 1:20 P.M., the MDS Coordinator said she was coding Plavix (clopidigrel) as an antiplatelet, and then she was told to code it as an anticoagulant. The person who trained her is not there anymore. The order in the electronic charting system says it is a hematological agent, so she just Googled the medication to find the drug class. When asked if she used the tool in their electronic charting system that provides a link to that particular section of the MDS assessment, she looked at Section N and said it showed clopidigrel as an antiplatelet and not an anticoagulant. She said she is going to have to go back and fix the MDS assessments where she had coded it wrong.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and revise care plans with specific interventions to meet individual needs for three residents (Resident #6, #48, and #85) out of 20 sampled residents. The facility's census was 97. Review of the facility's Comprehensive Person-Centered Care Plan policy, revised March 2022, showed: - A comprehensive, person-centered plan that includes measurable objectives and time tables to meet the resident's physical, psychosocial, and functional needs will be developed and implemented for each resident; - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; - The comprehensive, person-centered care plan is developed within seven days of completion of the required Minimum Data Set (MDS-a federally mandated assessment, completed by facility staff), and no more than 21 days after admission; - The care plan interventions are derived from a thorough analysis of information gathered as part of the comprehensive assessment; - Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his/her care plan; - The comprehensive, person-centered care plan includes measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, stated goals, and reflects currently recognized standards of practice for problem areas and conditions; - Assessment of residents are ongoing and care plans are revised as information about residents and residents' conditions change; - The IDT reviews and updates care plans when there has been a significant change in condition, when desired outcome is not met, when resident has been readmitted to facility from hospital stay and at least quarterly with the MDS assessment. 1. Review of Resident #6's medical record showed: - admission date of 05/26/22; (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of Alzheimer's disease (a brain disorder that affects memory and thinking skills), dementia (a brain disorder that interferes with daily life and activities and causes memory loss, confusion and difficulty doing daily tasks), schizophrenia (a severe mental disorder that affects a person's ability to think, feel and behave clearly), and unsteadiness on feet (difficulty in maintaining balance and coordination while walking or standing). Review of the resident's progress notes, dated 03/22/25, showed discharge from hospice. Review of the resident's MDS, dated [DATE], showed: - Section O0110K1-hospice care unmarked; - Section GG0170-walk 10 feet, coded a 9- not applicable - not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Review of the resident's care plan, date initiated 01/16/24, showed the resident is ambulatory; however, requires use of a wheelchair for locomotion on the unit at times. Review of the resident's care plan, date initiated 08/02/24, showed: -The resident has the potential for impairment to skin integrity, the resident has poor nutritional intake and is on hospice care. During an interview on 06/06/25 at 10:40 A.M., Certified Medication Technician (CMT) H said the resident does not walk and is dependent on staff for wheelchair mobility, and the resident hasn't been on hospice for some time. 2. Review of Resident #48's medical record showed: - admitted on [DATE]; - Diagnoses of chronic kidney disease (a longstanding disease in which the kidneys fail to remove waste from the body appropriately), renal osteodystrophy (a disease that weakens bones in patients with chronic kidney disease), Type II diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy) and chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe). Review of the resident's Physician's Order Sheet (POS), dated 06/06/25, showed: - On 01/31/25, an order that resident will require lunch to go for dialysis every Monday, Wednesday and Friday; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/10/25, an order to assess, monitor and report concerns to Primary Care Physician (PCP) and dialysis center for bruit (whoosh sound heard through a stethoscope), thrill (purring vibration at access site), collateral vein distention (veins in arm close to fistula-a surgically created connection between the artery and vein, typically in the arm and used for hemodialysis access, which is when a machine is used to filter waste from the body when the kidneys are no longer able to do so), bruising, hematomas (a localized pooling of blood under the skin and outside of the blood vessel), significant changes in the extremity, every shift, shunt location in left upper arm; - On 04/25/25, an order to monitor for signs and symptoms of steal syndrome (condition where the fistula is taking too much blood away from the hand, causing pain, numbness or tingling) every shift, report signs and symptoms to dialysis physician for possible transfer; - On 05/12/25, an order to assess and monitor weight, blood pressure, respirations, pulse, temperature, oxygen saturation and access site, prior to dialysis, and document on dialysis communication slip, ensure that dialysis receives copy. Review of the resident's care plan, last reviewed 05/20/25, showed: - Resident needs dialysis related to kidney failure; check and change dressing daily at access site; - Do not draw blood or take blood pressure in arm with graft (a synthetic tube surgically placed between an artery and a vein to create an access point for dialysis); - Monitor for signs and symptoms of infection at access site; - Monitor for signs and symptoms of steal syndrome; - Resident will receive lunch to go on following days (no days listed). During an interview on 06/03/25 at 1:30 P.M., Resident #48 said staff would weigh him/her and send the paper work with him/her to dialysis. He/she eats breakfast and lunch at the facility (leaves after breakfast and is back before lunch) and has a port under the skin in the upper left chest that the dialysis center takes care of. During an interview on 06/06/25 at 1:43 P.M., the Assistant Director of Nurses (ADON) G said Resident #48 has a left chest catheter and has had that since he/she had been here on 02/07/25. Whoever put the orders in had hit dialysis and did not unclick certain areas. The fistula could have been unclicked, but wasn't. There are port specific orders, such as with flushes, but the dialysis center flushes, not us. It is a terribly written order, and the nurses are checking the other things listed in the order (weight, blood pressure, respiration, heart rate, temperature and oxygen saturation), however, the order should have been specifically written for the resident and his/her port, not just the template. We would of course call the doctor if there were any issues. During an interview on 06/06/25 at 2:45 P.M., ADON G said Resident #48's port was placed on 04/18/24. The orders from dialysis were to not do anything at all and report anything that could be an issue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #85's medical record showed: - admission date of 06/07/24; - Diagnoses of metabolic encephalopathy (a condition where brain dysfunction occurs and causes mental status changes due to an underlying condition), senile degeneration of the brain (a brain disorder that leads to a decline in cognition, memory, reasoning and the ability to perform everyday activities), and dementia (a group of conditions that cause impairment to at least two brain functions, such as memory loss and judgment). Review of the resident's MDS, dated [DATE], showed: - Section GG Functional Abilities, GG0120. Mobility Devices, only marked for the use of a wheelchair, not marked for the use of a cane; Review of the resident's care plan, dated 06/19/24, showed: - The resident has a cane to maximize independence with transferring, but often forgets to use it; - The resident requires supervision/touching assistance by one staff to walk every two hours and as necessary; - The resident uses a cane for walking, clean weekly. Staff to remind him/her to use the cane. During an interview on 06/06/25 at 10:40 A.M., CMT H said that the resident does not use a cane and hasn't been ambulatory for some time, he/she is dependent on staff to push his/her wheelchair. During an interview on 06/06/25 at 10:45 A.M., the MDS Coordinator said there has been some new changes implemented over the last couple of months, the interdisciplinary team (IDT) updates care plans and care plans are updated weekly. He/She also said when a resident is discharged from hospice, then all things regarding hospice care should be removed from the care plan. During an interview on 06/06/25 at 7:35 P.M., the Administrator and Director of Nursing (DON) said they would expect care plans to be updated to reflect the current status, needs and/or issues of residents and care plans should be tailored to fit each individual.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and/or follow physician orders in a timely manner after the pharmacist made recommendations for specific medications for one resident (Resident #31) outside of the 20 sampled residents and failed to ensure a Certified Nursing Assistant (CNA) did not perform duties outside the scope of practice. The facility's census was 97. Review of the facility's Medication Regimen Reviews (MRR) policy, revised May 2019, showed: - The consultant pharmacist reviews the medication regimen of each resident, at least monthly; - The goal of MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication; - The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors, and other irregularities; - Within 24 hours of the MRR, the consultant pharmacist provides a written report to attending physicians for each resident identified as having a non-life threatening medication irregularity; - If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, the pharmacist contacts the medical director or Administrator; - The attending physician documents in the medical record that the irregularity has been reviewed and what, if any, action was taken to address it. The facility did not provide a policy regarding CNA scope of practice. 1. Review of Resident #31's medical record showed: - admitted on [DATE]; - Diagnoses of repeated falls, chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow, making it difficult to breathe), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs); - An order for bupropion ER 12 hour 150 mg tablet, give one tablet by mouth one time a day for other specified depressive episodes, with a start date of 02/22/23 and discontinued on 06/27/24; - An order for bupropion 75 mg tablet, give one tablet by mouth one time a day, with a start date of 06/28/24 and discontinued on 08/27/24; - An order for bupropion ER 24 hour tablet, give 100 mg by mouth one time a day, with a start date of 08/27/24 and discontinued on 08/29/24; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for bupropion 100 mg tablet, give one tablet by mouth one time a day, with a start date of 08/30/24 and discontinued on 03/21/25; - The resident received the incorrect dosage of bupropion 54 times from 06/28/24 to 08/27/24. Pharmacist review of the resident's bupropion (antidepressant medication) showed: - On 06/22/24, a recommendation to reduce bupropion ER (extended release) 12 hour 150 milligram (mg) daily to bupropion ER (extended release) 12 hour 100 mg daily; - On 07/29/24 and 08/26/24, documentation that an order was received on 06/28/24 per pharmacist request made on 06/22/24 to reduce bupropion ER (extended release) 12 hour 150 milligram (mg) daily to bupropion ER (extended release) 12 hour 100 mg daily. The new order was transcribed in the electronic charting system dated 06/28/24 as the immediate release formulation (bupropion 75 mg daily) instead of the extended release 12 hour formulation and also an incorrect dose (75 mg instead of 100 mg). Please clarify and update the order to reflect the correct dose and formulation: bupropion 100 mg ER 12 hour daily and notify the pharmacy of the changes. During an interview on 06/06/25 at 3:00 P.M., Assistant Director of Nursing (ADON) G said Resident #31's bupropion order was entered incorrectly. 2. Review of Resident #15's medical record showed: - admission date of 02/24/25; - Diagnoses of gastrostomy status (G-tube - a feeding tube inserted directly into the stomach through the skin and abdominal wall), tracheostomy status (a surgical procedure where an opening is created in the neck to directly access the trachea (windpipe) for breathing), and visual loss in both eyes. Observation on 06/05/25 at 10:14 A.M. of the resident showed: - Following the resident's shower, CNA P and CNA Q transferred the resident from the shower chair to the bed; - After transferring the resident to bed, CNA Q obtained the disconnected feeding tube from the IV pole (a medical device used to hold IV fluids or medications during administration), reattached the resident's feeding tube to the feeding tube port, turned the feeding pump on, and restarted the tube feed. During an interview on 06/06/25 at 4:41 P.M., the Director of Nursing (DON) said CNAs should not be hooking the tube feeding back up. They should tell the nurse and have them come do it. During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) said they would expect new orders to be added correctly.

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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 ensure proper tracheostomy (trach - incision in the windpipe to relieve an obstruction to breathing) care for one resident (Resident #15) out of one sampled resident. The facility's census was 97. Review of the facility's policy, Suctioning the Trachestomy Tube, revised October 2023, showed: - The purpose of this procedure is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract; - Preparation: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for suctioning; Review the resident's care plan to assess for any special needs of the resident; Obtain baseline vital signs and oxygen saturation; Obtain information about the resident's medical history, including date of tracheostomy, respiratory signs and symptoms, and risk factors for increased secretions, decreased airway clearance and/or airway obstruction (i.e., Chronic Obstructive Pulmonary Disease [COPD], chest trauma, abdominal surgery, and smoking); Determine the need for suctioning: Visible secretions in the artificial airway; or Respiratory sounds heard when auscultating over the trachea; Assemble the equipment and supplies as needed; Test equipment before use. Determine if suction equipment is generating appropriate negative pressure; Portable suction devices should have negative pressure set at -10 to -15 millimeters (mm) mercury (Hg); - Complications of suctioning the lower airway include trauma to the airway, infection, hypoxia (tissues and organs in the body do not receive enough oxygen to function properly), hypoxemia (abnormally low levels of oxygen in the blood), and cardiac dysrhythmias (resulting from hypoxemia). To minimize the risk of complications, apply the following guidelines: Suction only as needed, based on assessment of the resident's level of respiratory distress; Pre-oxygenate the resident by increasing the oxygen flow (as ordered) before the procedure and between suctioning; Suctioning of the lower airway is a sterile procedure; Set suction pressure as low as possible while effectively clearing secretions; Suction catheters should occlude less than 50% of the lumen for adults; Keep the suctioning procedure as brief as possible and no longer than 15 seconds; and Use a shallow suctioning technique; - Monitor the resident's pulse and oxygen saturation during suctioning. If pulse decreases more than 20 beats per minute (BPM) or increases more than 40 BPM, or oxygen saturation drops below 90 percent (or 5 percent from baseline) discontinue suctioning and re-oxygenate the resident; - The following equipment and supplies will be necessary when performing this procedure: Sterile suction catheter kit; or Sterile drape; Sterile cup; Sterile gloves; #10 to #16 French catheter (catheter outer diameter should not exceed one-half the internal diameter of the tube); Sterile gauze; Towel or Chux pad; 100 cc sterile saline or sterile water; Wall or portable suction unit; Tubing (approximately 6 feet); and Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed); - Identify the following risk factors for impaired airway clearance or aspiration: Impaired cough or gag reflex; Dysphagia; Weak respiratory muscles (from injury, abdominal surgery, etc.); COPD; Pulmonary infection; Presence of feeding tube; Smoking; and/or Decreased level of consciousness; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assess for the following signs and symptoms of respiratory distress/hypoxia/hypoxemia: Diminished breath sounds; Tachypnea; Dyspnea; Gurgling, crackling or wheezing upon inspiration; Cyanosis; Decreased oxygen saturation (SpO2); Restlessness; and/or Drooling, secretions or vomitus in mouth; - Steps in the Procedure: Provide for resident privacy. Explain the procedure to the resident. Perform hand hygiene. Put on gloves. Put on mask and protective eyewear (goggles or face shield), as indicated. Assist the resident to semi-Fowler's position with head turned toward you. Pre-oxygenate the resident by increasing supplemental oxygen flow for 30 seconds to one minute. Connect one end of suction tubing to suction unit and place the other end near the resident. Turn on suction unit and adjust to appropriate negative pressure (-100 to -120 mmHg for wall unit or -10 to -15 mmHg for portable unit). Remove gloves. Open suction catheter kit. Place sterile drape across the resident's chest. Remove sterile cup, touching only the outside. Fill cup with sterile saline or sterile water. Apply sterile gloves. The dominant hand will remain sterile. Holding the suction catheter in dominant hand and the suction tubing in the non-dominant hand, connect the catheter to the tubing. Suction a small amount of water from the cup to verify negative pressure. Rest catheter tip on sterile surface (e.g., sterile drape or open catheter kit). Remove oxygen or humidity delivery device using non-dominant hand. Insert the catheter into tracheostomy tube without applying suction. Advance the catheter until resistance is met and/or resident coughs (at the [NAME]). Pull back one to two cm. Apply intermittent suction and slowly withdraw catheter while rotating between thumb and forefinger. Limit suction time to no more than 15 seconds. Re-oxygenate the resident for 30 seconds to one minute between suctions. Dip catheter tip in sterile saline or sterile water and apply suction. Rinse catheter and tubing until clear. Assess cardio-pulmonary status. Repeat steps 19 through 23, if necessary. Limit suction passes to a maximum of three. Replace oxygen or humidity delivery device. If the resident's physical or medical condition permits, assist the resident to a position that promotes deep breathing and coughing. Turn off suction. Disconnect catheter from tubing. Wrap catheter around gloved hand. Pull the glove off and over the catheter. Discard in designated receptacle. Remove drape and discard in designated receptacle. Discard water or saline in commode. Dispose of cup in designated receptacle. Empty and rinse collection container if necessary or as indicated by facility protocol. Discard personal protective equipment in designated receptacles. Perform hand hygiene. Apply clean gloves and provide oral hygiene for the comfort of the resident, if indicated. Perform hand hygiene. Review of the facility's policy, Trachestomy Care, revised October 2023, showed: - Preparation and Assessment: Check physician order. Explain procedure to resident. Perform hand hygiene. Apply clean gloves. Remove supplemental oxygen from tracheostomy. Inspect skin and stoma site for signs or symptoms of infection, leakage, subcutaneous crepitus, or dislodged tube. Assess resident for respiratory distress. Measure resident's oxygen saturation with pulse oximeter. Listen to lung sounds with a stethoscope. Observe for asymmetrical chest expansion. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle. Perform hand hygiene; - Clean the Stoma and Surrounding Site: Apply clean gloves. Clean the stoma: With the moistened gauze starting at the 12 o'clock position of the stoma, wipe toward the three o'clock position. Begin again with a new gauze square at 12 o'clock and clean toward 9 o'clock. To clean the lower half of the site, start at the three o'clock position and clean toward six o'clock; then wipe from nine o'clock to six o'clock, using a clean moistened gauze square for each wipe. Continue this pattern on the surrounding skin and tube flange. Wipe with dry gauze. Apply a fenestrated gauze pad around the insertion site, touching only the outer edges; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Replace neck ties: A two-person technique is recommended, with one person holding the tracheostomy tube in place while the other person secures the ties. If the resident's condition is unstable, or if the stoma is less than two weeks old, apply new ties before removing old ones. Replace supplemental oxygen mask over tracheostomy. Remove gloves and discard into appropriate receptacle. Perform hand hygiene. The facility did not provide a policy regarding Certified Nursing Assistants' scope of practice. Review of Resident #15's medical record showed: - admission date of 02/24/25; - Diagnoses of respiratory failure with hypoxia (a condition where the lungs are unable to deliver adequate oxygen to the bloodstream, leading to low blood oxygen levels), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow, making it difficult to breathe), and trachestomy status. Review of the resident's Physician Order Sheet, dated June 2025, showed: - An order to change trach collar every Thursday day shift, dated 05/16/25; - An order for oxygen at five liters per minute via trach continuously. Humidified air at 28% via compressor. Obtain oxygen saturation and record every day and night shift, dated 05/16/25; - An order for trach care every day and night shift, dated 05/16/25; - No order to obtain baseline vital signs and oxygen saturation, pre-oxygenate, suction trach, or monitor vital signs and oxygen saturation during suctioning. Observation on 06/05/25 at 10:14 A.M. of Resident #15 showed: - Certified Nursing Assistant (CNA) P and CNA Q donned gloves, gown, and mask, and transferred the resident from the chair to bed; - CNA P then placed supplemental oxygen back on the resident's trach. Observation on 06/05/25 at 3:34 P.M. of Resident #15's trachestomy care showed: - Resident coughing and attempting to clear airway. He/She had copious amounts of thick yellow sputum in trach and on his/her neck area; - Licensed Practical Nurse (LPN) I donned a mask and gown, washed hands in the resident's bathroom sink, then donned clean gloves; - Without pre-oxygenating, obtaining vital signs or oxygen saturation, LPN I suctioned the resident's trach two passes with the suction catheter lying on the shelf in the opened packaging and already connected to the suction pump, rinsing the suction catheter in water container sitting on shelf to clean the catheter in between passes; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN I then disconnected the suction catheter and threw it in the trash with his/her gloves; - The resident continued to cough and attempt to clear his/her airway and had copious amounts of thick yellow sputum in trach and pooled on his/her neck area; - LPN I removed mask, gown, and gloves, and left the room to get another suction catheter; - LPN I donned a new mask and gown, washed hands, then donned clean gloves; - LPN I opened a trach kit and poured 1/2 hydrogen peroxide and 1/2 water in trach kit tray, dipped a 4 inch by 4 inch gauze in it and wiped the resident's secretions from his trach and neck; - LPN I removed gloves and, without performing hand hygiene, put on new clean gloves and unfastened the resident's trach collar, removed the gloves, then moved the trash can to the side of the bed with a bare hand; - LPN I washed hands, donned sterile gloves, removed the old trach collar and put the new one on; - LPN I removed sterile gloves and, without washing or sanitizing, put on clean gloves, and attached new suction catheter to pump; - Without pre-oxygenating, obtaining vital signs or oxygen saturation, LPN I suctioned the resident's trach, then suctioned secretions on the resident's chest, then suctioned the resident's trach again; - LPN I then rinsed out the suction catheter, curled it up and put it back in its opened package and laid it on the shelf; - LPN I washed hands, donned clean gloves, put split gauze dressing around the resident's trach and, without washing or sanitizing, changes gloves and gathered trash; - LPN I realized the oxygen concentrator wasn't running and turned on the concentrator. During an interview on 06/05/25 at 4:00 P.M., LPN I said they typically change suction catheter sets out daily, but he/she has worked other places and they change them after each suction, but they don't do that here. He/She doesn't know how long the oxygen concentrator had been off. He/She apologized that the care wasn't very good as he/she had a lot going on right now. During an interview on 06/06/25 at 4:41 P.M., the Director of Nursing (DON) said everyone who has a trach in the building has a Bivona (a specialized tracheostomy tube designed for long-term airway management), and they don't have an inner cannula that would need to be taken out. There should be an order to suction. A trach care order would mean cleaning. CNAs should not be placing the oxygen back on the resident's trach. They should tell the nurse and have them come do it. During an interview on 06/06/25 at 7:35 P.M., the Administrator, DON, and both Assistant Directors of Nursing (ADONs) said they would expect a resident with a trach to have orders to be suctioned and for staff to follow facility policy on suctioning. The suction catheter should only be used once and not reused.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain correct orders from the physician for dialysis (a process for removing waste and excess water from the blood) care, specifically for a port access (a medical device implanted for easy access to a vein), instead of a fistula (a surgically created connection between an artery and a vein, used for dialysis access) for one resident (Resident #48) out of one sampled resident. The facility's census was 97. Review of the facility's Care of a Resident With End-Stage Renal Disease (ESRD) policy, revised September 2010, showed: - Staff caring for residents with ESRD, including residents that receive dialysis care outside of the facility, shall be trained in the care and special needs of the resident; - Education and training of staff includes the nature and clinical management of ESRD, including infection prevention and nutritional needs, the type of assessment data that is to be gathered about resident's condition on a daily or per shift basis; - How to recognize and intervene in medical emergencies such as hemorrhage (uncontrolled bleeding) and septic infections (life-threatening complication of infection); - How to recognize and manage equipment failure or complications, timing and administration of medications, care for grafts and or fistulas and handling of waste; - Agreements between facility and contracted ESRD facility include all aspects of how the resident's care will be managed, including how the care plan will be developed and implemented and how information will be exchanged between facilities; - The resident's comprehensive care plan will reflect the resident's needs related to ESRD and dialysis care. 1. Review of Resident #48's medical record showed: - admitted on [DATE]; - Diagnoses of chronic kidney disease (a longstanding disease in which the kidneys fail to remove waste from the body appropriately), renal osteodystrophy (a disease that weakens bones in patients with chronic kidney disease), Type II diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe). Review of the resident's Physician's Order Sheet (POS), dated 06/06/25 showed: - On 01/31/25, an order that resident will require lunch to go for dialysis every Monday, Wednesday and Friday; - On 02/05/25, an order for a modified renal diet; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/10/25, an order to assess, monitor and report concerns to Primary Care Physician (PCP) and dialysis center for bruit (whoosh sound heard through a stethoscope), thrill (purring vibration at access site), collateral vein distention (veins in arm close to fistula-a surgically created connection between the artery and vein, typically in the arm and used for hemodialysis access, which is when a machine is used to filter waste from the body when the kidneys are no longer able to do so), bruising, hematomas (a localized pooling of blood under the skin and outside of the blood vessel), significant changes in the extremity, every shift, shunt location in left upper arm; - On 02/18/25, an order to obtain daily weights, for daily weight purposes only; - On 04/25/25, an order to monitor for signs and symptoms of steal syndrome (condition where the fistula is taking too much blood away from the hand, causing pain, numbness or tingling) every shift, report signs and symptoms to dialysis physician for possible transfer; - On 05/12/25, an order to assess and monitor weight, blood pressure, respirations, pulse, temperature, oxygen saturation and access site, prior to dialysis, and document on dialysis communication slip, ensure that dialysis receives copy. Review of the resident's care plan, last reviewed 05/20/25, showed: - Resident needs dialysis related to kidney failure; check and change dressing daily at access site; - Do not draw blood or take blood pressure in arm with graft (a synthetic tube surgically placed between an artery and a vein to create an access point for dialysis); - Monitor intake and output; - Monitor for signs and symptoms of infection at access site; - Monitor for signs and symptoms of steal syndrome; - Resident will receive lunch to go on following days (no days listed); During an interview on 06/03/25 at 1:30 P.M., the resident said staff would weigh him/her and send the paperwork with him/her to dialysis. He/She eats breakfast and lunch at the facility (leaves after breakfast and is back before lunch) and has a port under the skin in the upper left chest that the dialysis center takes care of. During an interview on 06/06/25 at 1:43 P.M., the Assistant Director of Nurses (ADON) G said the resident has a left chest catheter and has had that since he/she had been here on 02/07/25. Whoever put the orders in had hit dialysis and did not unclick certain areas. The fistula could have been unclicked, but wasn't. There are port specific orders, such as with flushes, but the dialysis facility flushes it, not us. It is a terribly written order, and the nurses are checking the other things listed in the order. However, the order should have been specifically written for the resident and his/her port, not just the template. We would of course call the doctor if there were any issues. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/25 at 2:45 P.M., ADON G said the port was placed on 04/18/24. The orders from dialysis were to not do anything at all and report anything that could be an issue. During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing (DON), and ADON G said they would expect orders to be accurate according to the resident's diagnoses and/or issues.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or less. There were four medication errors out of 30 opportunities for errors, resulting in an error rate of 13.33%. This practice affected resident (Resident #39) out of 20 sampled residents and one resident (Resident #91) outside the sample. The facility's census was 97. Review of the facility's policy, Administering Medications, revised April 2019, showed: - Medications are administered in accordance with prescriber orders, including any required time frame; - Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication, preventing potential medication or food interactions, and honoring resident choices and preferences, consistent with his or her care plan; - Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staff training. Review of the facility's policy, Administering Medications through an Enteral Tube (a feeding tube that allows liquid food to enter your stomach or intestine through a tube), revised November 2018, showed: - Purpose: to provide guidelines for the safe administration of medications through an enteral tube; - Steps: Wash your hands, retrieve medication(s), prepare the medication(s), prepare the resident, check compatibility with feeding tube formula, verify placement of the feeding tube, stop feeding and flush tubing with at least 15 ml (milliliters-a unit of volume, one-thousandth of a liter) warm purified water (or prescribed amount), remove syringe and clamp tubing, dilute medication(s): remove plunger from syringe, add medication and appropriate amount of water to dilute, dilute crushed medication with at least 30 ml purified water (or prescribed) amount, dilute liquid medication with 30 ml or more (depending on viscosity-a measure of a fluid's resistance to flow), purified water, administer each medication separately, reattach syringe (without the plunger) to the end of the tubing, administer medication by gravity flow, if administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications, when the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm purified water (or prescribed amount), quickly clamp the tubing when the flush is complete and remove the syringe, wash your hands. 1. Review of Resident #39's medical record showed: - admission date of 07/18/23; - Diagnoses of cerebral palsy (a group of conditions that affect movement and posture, cause by damage that occurs to the developing brain, most often before birth), depression (a persistent feeling of sadness and loss of interest, significantly impacts daily functioning), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician's Order Sheet (POS), dated 10/18/24, showed: - An order for clonazepam (medication to treat seizures, panic disorder, or anxiety) oral tablet, 0.5 milligram (mg-a unit of mass or weight, one thousandth of a gram), one tablet per g-tube (a feeding tube that provides direct access to the stomach for delivery of nutrition, fluids and medications) three times a day (TID), dated 02/18/25; - An order for trazodone (antidepressant medication) HCl oral tablet 50 mg, one tab per g-tube TID, dated 05/27/25; - An order for Depakene (anticonvulsant medication) oral solution 250mg/5ml, give 8 ml per g-tube TID, dated 04/01/25. Observation of the resident's medication pass on 06/05/25 at 2:15 P.M. showed: - Licensed Practical Nurse (LPN) J did not verify placement of the g-tube; - LPN J administered the crushed clonazepam 0.5 mg tab, mixed with water, and used a syringe to push the medication through the g-tube; - LPN J administered the crushed trazodone HCl 50 mg tab, mixed with water, and used a syringe to push the medication through the g-tube; - LPN J administered the Depakene oral solution, 8 ml mixed with water, and used a syringe to push the medication through the g-tube. 2. Review of Resident #91's medical record showed: - admission date of 03/25/25; - Diagnoses of cancer, diabetes mellitus (DM-a chronic disease characterized by high blood sugar, occurs when your body does not produce enough insulin, does not use insulin effectively, or both) with polyneuropathy (a common complication from DM, characterized by nerve damage, particularly in the feet and legs), low back pain, and artificial shoulder joint. Review of the resident's POS, dated 06/11/25, showed an order for diclofenac (anti-inflammatory medication) 75 mg, one tab by mouth twice daily (BID), dated 03/25/25. Observation of the resident's medication pass on 06/05/25 at 9:05 A.M. showed: - Certified Medication Technician (CMT) CMT K prepared fourteen medications for administration for Resident #91 and placed into a medication cup; - CMT K gave medications to the resident, and the resident dropped the diclofenac 75 mg pill on the floor; - CMT K picked up the medication up off the floor and threw it away; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CMT documented in the eMAR (electronic medication administration record) the pill was dropped in the floor; - CMT K closed out of the resident's eMAR and pulled up the next resident's name he/she had to administer medications to and started to move the medication cart; - CMT K, when questioned as to why he/she didn't give the resident a replacement pill for the one that was dropped, gave the resident a replacement pill, the last pill remaining in the card. During an interview on 06/05/25 at 9:10 A.M., CMT K said that usually when a pill is dropped, he/she will give a replacement pill, but it is cycle fill day (when the medication carts get stocked with medications) and typically there are no pills left on those days. During an interview on 06/06/25 at 7:35 P.M., the Administrator and Director of Nursing (DON) said they would expect the medication error rate to be less than five percent. During an interview on 06/11/25 at 12:08 P. M, the Director of Nursing (DON) said he/she would expect g-tube administered medications to be given using gravity. During an interview on 06/11/25 at 4:05 P.M., LPN J said she typically checks g-tube placement prior to administering medications, but he/she was nervous and forgot. Typically he/she would give g-tube medications per gravity flow, but Resident #39 likes to bear down and the medications won't go down unless pushed with a syringe.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Manor	783 Weber Road Farmington, MO 63640

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food under sanitary conditions, increasing the risk of food-borne illness. This had the potential to affect all residents. The facility's census was 97. Review of the facility's Food Receiving and Storage policy, revised November 2022, showed: - Food shall be received and stored in a manner that complies with safe food handling practices; - All foods stored in refrigerator or freezer are covered, labeled, and dated with a use by date; - Refrigerated foods are labeled, dated, and monitored so they are used by their use by date, frozen, or discarded. Review of the facility's Sanitation policy, revised November 2022, showed: - The food service area is maintained in a clean and sanitary manner; - All kitchens, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects; - All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions; - Kitchen wastes that are not disposed of by chemical means are kept in clean, leakproof, nonabsorbent, tightly closed containers and disposed of daily. Observation on 06/03/25 at 10:55 A.M. of the kitchen showed: - Two flies buzzed around the dish washing area; - The floor with a black, sticky substance in front of the condiment storage area, the rest of the kitchen floor was covered with debris; - [NAME] top area on stove with a greasy, black grime, and food crumbs on the surface; - Ten ounces (oz) of dill relish, with a best if used by date of 10/07/23; - Four, five pound bags of refrigerated shredded cheese with no dates; - Large container of refrigerated fat free Italian dressing with opened on lid, and a manufactured date of January 2025; - Five pounds of unopened refrigerated pasteurized processed cheese slices with no date; - One unopened refrigerated head of iceberg lettuce, with brown and mushy edges, and no date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the freezer on 06/03/25 at 11:15 A.M., showed: - One large bag of unopened, diced ham, no weight on package and no date; - Six four-pound bags of corn, carrot and green bean trio, with no dates; - Two two-pound bags of carrots, with no dates; - Ten two-pound bags of broccoli with no dates; - Eleven 32 oz bags of sugar snap peas, with an expiration date of October 2024; - Four bags of unopened, mixed vegetables, with no weight on bag, and no dates. Observation on 06/05/25 at 9:45 A.M. of the kitchen showed: - A soiled knife on the prep counter, along with a serving bowl and spoon with a light brown substance dried on it; - Two used cups left on the prep area, along with a partially consumed bottle of soda; - Large white towel with a brown substance in the floor under the convection oven; - Three large trays of cherry dessert in serving dishes on cart and not covered; - Trash can lid on the floor beside the trash can; - Floor with sticky areas and debris all over; - Two wadded paper towels on the floor in front of the small trash can next to the sink; - Two soiled towels with a brown substance on the floor under the condiment storage area; - [NAME] top area on stove with a greasy, black grime, and crumbs on the surface. During an interview on 06/05/25 at 9:45 A.M., the Dietary Manager (DM) said he rotates the food out when received. The dates are on the shipping labels, and he tries to keep the food in boxes. However, the packages should be dated when removed. The snap peas had been ordered, but should have been pitched because the residents didn't like them. Observation of the kitchen on 06/06/25 at 5:10 P.M. showed: - Two plastic drinking mugs on the floor next to the stove; - Food crumbs and debris all over the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/25 at 5:10 P.M., the DM said he would expect the floors, counters, and stove top to be clean and expired foods to be thrown out. He had been trying to get everyone to be better at cleaning up. During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing, and both Assistant Directors of Nursing said they would expect the the kitchen work/prep areas and floors to be clean, expired foods to be discarded, and packages to be dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during wound care and failed to keep a urinary catheter drainage bag off the floor for one resident (Resident #15) out of 20 sampled residents. The facility failed to use enhanced barrier precautions (EBP) for one resident (Resident #39) out of 20 sampled residents. The facility failed to maintain infection control practices to prevent the development and transmission of infection during peri (washing the genital and anal areas of the body) and urinary catheter (a flexible tube that is placed to drain urine from bladder) care for two residents (Resident #47 and #75) out of 20 sampled residents. The facility failed to maintain infection control practices to prevent the development and transmission of infection during medication administration for two residents outside the sample (Resident #91 and #246). The facility failed to maintain infection control practices to prevent the development and transmission of infection when obtaining fingerstick blood sugar (FSBS) for one resident (Resident #43) out of 20 sampled residents and when obtaining FSBS and during insulin administration for one resident (Resident #29) out of 20 sampled residents and two residents (Resident #38 and #52) outside the sample. The facility failed to maintain infection control practices to prevent the development and transmission of infection during medication administration via a gastrostomy tube (G-tube - a surgically placed tube that provides direct access to the stomach for feeding, fluids, or medications) for one resident (Resident #39) out of 20 sampled residents. The facility's census was 97. Review of the facility's Enhanced Barrier Precaution policy, reviewed March 2024, showed: - EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs-bacteria resistant to multiple antibiotics) to residents; - Gloves and gowns are applied prior to performing the high contact resident care activity; - PPE is changed before caring for another resident; - Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include dressing, bathing or showering, transferring, providing hygiene, changing linens, changing briefs or assisting to toilet, device care (urinary catheter, feeding tube, tracheostomy, etc) or wound care; - EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization; - EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of indwelling medical device; - Staff are trained prior to caring for residents on EBP; - PPE is available outside of resident rooms. Review of the facility's Personal Protective Equipment-Using Gloves policy, revised September 2010, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Gloves are used to prevent the spread of infection, protect wounds from contamination, protect hands from potentially infectious material and prevent exposure of viruses from blood or body fluids; - When gloves are indicated, use disposable, single-use gloves; - Discard used gloves into waste receptacle; - Wash hands after removing gloves as gloves do not replace handwashing. Review of the facility's Handwashing/Hand Hygiene policy, revised October 2023, showed: - All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; - All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections; - Hand hygiene is indicated immediately before touching a resident, before performing an aseptic task, after contact with body fluids, blood, or contaminated surfaces, after touching resident, before moving from work on soiled body site to clean-on same resident, immediately after glove removal; - Use an alcohol-based rub for most clinical situations; - Wash with soap and water when hands are visibly soiled and after contact with resident with infectious diarrhea; - The use of gloves does not replace hand washing/hand hygiene. 1. Observation on 06/03/25 at 11:43 A.M. of Resident #15 showed the resident lay in bed with his/her urinary catheter bag on the floor. 2. Observation on 06/05/25 at 10:14 A.M. of Resident #15's wound care showed: - Licensed Practical Nurse (LPN) I donned a mask and gown, then washed his/her hands in the resident's bathroom; - LPN I donned gloves, brought supplies in on a towel, placed on bedside table, moved the trash can with a gloved hand, then opened the supplies, including dressings, on the bedside table; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I repositioned the resident onto his/her side and, without performing hand hygiene, removed gloves and donned new gloves; - LPN I sprayed wound cleanser onto gauze and cleansed the upper wound on the resident's back; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN I tore off a small piece of calcium alginate (a highly absorbent wound dressing) with a gloved hand, then placed it on the upper wound on the resident's back, then covered it with gauze and a bordered gauze dressing; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I sprayed wound cleanser onto gauze and cleansed the lower wound on the resident's back; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I laid calcium alginate and gauze on a bordered gauze dressing, then placed it on the lower wound on the resident's back; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I peeled the backing off the tape and laid it on the towel on the bedside table; - LPN I sprayed wound cleanser onto gauze and cleansed the wound on the resident's buttock; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I opened collagen powder (a wound treatment to support tissue repair and regeneration), sprinkled on wound on the resident's buttock, then applied gauze and tape; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I repositioned the resident, then threw dressing wrappers away; - LPN I removed PPE and washed hands in the resident's bathroom, then left the room; - LPN I returned to the room with scissors, Gentian violet (an antiseptic dye), and sanitizer, donned a mask and gown, and sanitized hands; - LPN I sanitized hands and donned new gloves and poured Gentian violet into a cup; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I sprayed wound cleanser onto gauze and cleansed the wound on the resident's fourth and fifth left toes; - LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I again sprayed wound cleanser onto gauze and cleansed the wound on the resident's fourth and fifth left toes; - LPN I cut calcium alginate with scissors, then applied between the resident's fourth and fifth toes; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN I removed gloves and, without performing hand hygiene, donned new gloves; - LPN I sprayed wound cleanser onto gauze and cleansed the wound on the resident's lateral calf, then applied an abdominal pad to calf, wrapped with Kerlix (a bulky gauze bandage roll used for wound care and bandaging), then taped; - LPN I threw trash away, then gathered trash bag with bare hands and threw away in the resident's bathroom trash barrel, and washed hands; - LPN I obtained a germicidal wipe and donned gloves, then cleaned scissors and wrapped them in the wipe. During an interview on 06/05/25 at 10:45 A.M., LPN I said he/she washes his/her hands when she changes the system as in going from one body system to another. He/She washes when going from one task to another, like going from a g-tube to a trach. He/She doesn't wash or sanitize when doing, for example, the two wounds on the resident's back. The reason is because they're both in the same location on the resident's body (on the back). He/she would wash or sanitize when going from the back wounds to the buttock wound, but he/she didn't do that today. He/She normally cleans his/her scissors in between residents. 3. Observation on 06/06/25 at 9:45 A.M. of Resident #39's gastrostomy tube dressing change showed: - LPN L entered room, washed hands, donned gloves, but did not don a gown; - G-Tube supplies were located in the resident's room on a small stand; - LPN L sprayed wound cleanser into a small cup with clean gauze pads; - LPN L removed dressing, removed gloves and donned clean gloves; - LPN L cleaned area with moistened gauze pads, removed gloves and washed hands; - LPN L donned new gloves, placed split sponge dressing around site and taped into place; - LPN L removed gloves and washed hands. During an interview on 06/06/25 at 12:55 P.M., LPN L said he/she should have put a gown on prior to cleaning the G-Tube. The supplies were kept in the hallway. 4. Observation on 06/06/25 at 9:00 A.M. of Resident #47's peri and urinary catheter care showed: - Certified Nurse Aide (CNA) M already in room wearing a gown and gloves; - CNA F entered room, washed hands, and donned gown; - CNA M and CNA F donned gloves and transferred the resident from wheelchair to bed via mechanical lift; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA M changed gloves, but did not wash or sanitize hands; - CNA F emptied urinary catheter bag into container and took into bathroom to empty; - CNA F rinsed container, removed soiled gloves and donned new gloves without washing hands; - Resident rolled toward CNA M and mechanical lift pad removed; - CNA M removed the resident's pants and CNA F removed the resident's wet brief; - CNA F changed gloves without washing or sanitizing; - CNA F cleaned the resident's peri area, using a clean wipe per side, then with a clean wipe, cleaned catheter from peri area, down a few inches of the tube; - CNA F changed gloves, cleaned buttock area, noticed a small bowel movement, and removed gloves; - CNA F donned new gloves, but did not wash or sanitize hands; - CNA M placed a small amount of barrier cream onto CNA F's gloved hand; - CNA F applied cream to buttocks, removed soiled gloves, and donned clean gloves; - CNA F and CNA M placed clean brief on the resident; - CNA F changed gloves, then fastened brief; - CNA F and CNA M did not wash hands prior to leaving room, then sanitized in the hallway. During an interview on 06/06/25 at 9:35 A.M., CNA F said he/she washes hands before going into the room and when leaving. If he/she sanitized in between glove changes, he/she wouldn't be able to get gloves on. During an interview on 06/06/25 at 9:40 A.M., CNA M said staff are supposed to sanitize between glove changes or when going from dirty to clean and he/she also tries to sanitize when walking by the dispensers in the hallway. 5. Observation on 06/06/25 at 2:40 PM of Resident #75's peri and catheter care showed: - CNA O gathered a basin, washcloths, peri wash, and wipes and placed on the bedside table; - CNA E and CNA O washed their hands in the resident's room and donned gloves and gowns; - CNA O lowered the resident's blankets, loosened the soiled brief, removed gloves and did not sanitize or wash hands; - CNA E obtained warm water in the basin, handed to CNA O and he/she placed it on the bedside table; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA O donned gloves and used a wet washcloth with peri wash to clean down each side of the resident's legs while lying on his/her back; - CNA E obtained two plastic liners, one for soiled linens and one for trash; - CNA O rolled the resident to his/her left side, tucked the soiled brief under the resident and cleaned stool from the resident's buttocks using five wipes, each time reaching into the wipes container with his/her soiled glove; - CNA O removed gloves and washed hands; - CNA O donned gloves, tucked the soiled pad and brief farther under the resident, tucked the clean pad and brief under the resident and rolled the resident onto his/her right side; - CNA O then removed the soiled brief and pad from under the resident and placed them in separate plastic liners; - CNA E obtained the wipes from the container and handed them to CNA O, who wiped stool from the resident's buttocks three times; - CNA O removed gloves and donned clean gloves without washing or sanitizing his/her hands; - CNA O wiped each side of the peri area with a clean side of the washcloth and placed in a plastic liner; - CNA O obtained a clean washcloth and washed around the insertion site of the indwelling foley catheter; - CNA O obtained another washcloth and cleaned down the indwelling foley catheter tubing; - CNA O removed gloves and donned clean gloves, without sanitizing or washing his/her hands; - CNA O pulled the blanket up around the resident's shoulders; - CNA E placed the catheter drainage bag on the side of the bed, and bagged the dirty linens and trash; - CNA O emptied basin of water in the resident's sink; - CNA E and CNA O removed gowns and gloves; - CNA E and CNA O both washed their hands in the resident's room; - CNA E and CNA O carried bags of soiled linens and trash to the soiled utility room and sanitized their hands after exiting the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/25 at 2:50 P.M., CNA O said he/she should probably not have used a soiled glove to get wipes out of the wipes container. Each resident has their own wipes container in their room. He/She should sanitize his/her hands in between glove changes. 6. Observation on 06/05/25 from 9:05 A.M. to 9:25 A.M. of Resident #91 and #246's medication administration showed: - Certified Medication Technician (CMT) K administered medications to Resident #91 at 9:05 A.M.; - CMT K did not wash or sanitize his/her hands prior to medication preparation or administration; - Resident #91 dropped a pill on the floor. CMT K picked the pill up off the floor, threw the pill away and did not wash or sanitize his/her hands; - CMT K did not wash his/her hands after administering the medications; - CMT K administered medications to Resident #246 at 9:15 A.M.; - CMT K did not wash or sanitize his/her hands prior to medication preparation, during administration, or after administration. During an interview on 06/05/25 at 12:40 P.M., CMT K said he/she should sanitize his/her hands in between residents and before and after administering medications. 7. Observation on 06/05/25 at 11:45 A.M. of Resident #43's FSBS showed: - LPN J obtained glucometer (a device to measure the amount of glucose (sugar) in a person's blood), lancet (a sharp medical device to make a small puncture), test strip and alcohol wipe from the cart and laid supplies on top of the cart with a paper towel barrier; -LPN J donned gloves, entered the resident's room and obtained the resident's FSBS; -LPN J exited the resident's room, threw away the trash in the trash can on the side of the cart and removed gloves; -LPN J did not perform hand hygiene prior to or after the FSBS. 8. Observation on 06/05/25 at 12:10 P.M. of Resident #29's FSBS and insulin administration showed: - LPN J obtained a clean glucometer, lancet, and test strip from the cart and laid the supplies on top of the cart without a barrier; - LPN J washed his/her hands in the resident's room, then exited the resident's room and donned gloves; - LPN J removed plastic end piece from lancet, lifted trash can lid on the side of the cart, threw away plastic end piece, and did not remove gloves or sanitize hands; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN J obtained the resident's FSBS and exited the resident's room; - LPN J obtained a disinfectant wipe from the container on top of the cart with a soiled glove and wrapped the glucometer; - LPN J removed gloves and sanitized hands; - LPN J obtained the insulin vial, alcohol wipe, and syringe from the cart; - LPN J opened the alcohol wipe and lifted the lid of the trash can on the side of the cart to throw away trash; - LPN J did not sanitize his/her hands, donned gloves, administered insulin to the resident, removed gloves, and sanitized hands. During an interview on 06/05/25 at 11:50 A.M., LPN J said he/she should wash or sanitize his/her hands prior to performing a blood glucose check, and soon as he/she is done, and should wash his/her hands after every third person. 9. Observation on 06/05/25 at 12:18 P.M. of Resident #52's FSBS and insulin administration showed: - LPN N did not wash or sanitize his/her hands prior to performing the FSBS; - LPN N obtained clean glucometer, lancet, and test strip from the cart and laid it on top of the cart without a barrier; - LPN N donned gloves, obtained the resident's FSBS and exited the room; - LPN N threw away trash in the trash can on the side of the cart; - LPN N removed gloves and did not sanitize his/her hands; - LPN N obtained the insulin pen from the cart, primed the pen, and dialed up ordered amount of insulin; - LPN N donned gloves, dropped alcohol wipe on the floor, picked up alcohol wipe off the floor and did not change gloves or wash or sanitize his/her hands; - LPN N, wearing the same gloves administered insulin to the resident; - LPN N threw away trash, removed gloves, and did not sanitize or wash his/her hands. 10. Observation on 06/05/25 at 12:25 P.M. of Resident #38's FSBS and insulin administration showed: - LPN N obtained the glucometer, lancet, and test strip from the cart and laid the supplies on top of the nurse cart without a barrier; - LPN N donned gloves and obtained the resident's FSBS; (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN N removed gloves and did not wash or sanitize his/her hands; - LPN N obtained the insulin pen from the nurse cart, primed pen, dialed up ordered amount of insulin, donned gloves, and administered insulin to the resident; - LPN N removed gloves and did not sanitize or wash his/her hands. During an interview on 06/05/25 at 12:32 P.M., LPN N said he/she should sanitize his/her hands in between residents and in the beginning and after the fourth resident. 11. Observation on 06/05/25 at 2:15 P.M. of Resident #39's G-tube medication administration showed: - LPN J did not wash or sanitize his/her hands prior to medication preparation or administration; - LPN J obtained three small pill cups from the side of the nurse cart and touched the inside of the cups while pulling them apart; - LPN J obtained three medications from the nurse cart and placed each into the small medication cups; - LPN J obtained two pill pouches from the nurse cart and stuck his/her finger down in the pouch to open the pouches; - LPN J crushed each pill separately and then placed back into small medicine cups; - LPN J lifted the lid to the trash can on the side of the nurse cart to throw away pill pouches and sanitized his/her hands; - LPN J donned gloves and a gown; - LPN J entered the resident's room and administered each medication individually with flushes in between and at the end; - LPN J reconnected the tube feeding to the resident's G-tube; - LPN J removed his/her gown and gloves in the resident's room and washed his/her hands. During an interview on 06/05/25 at 2:30 P.M., LPN J said he/she should wash his/her hands before and after administering medications, that he/she should not touch the inside of medicine cups or pill pouches and should wash his/her hands after having contact with the trash can. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265798	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Manor	783 Weber Road Farmington, MO 63640

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing (DON), and both Assistant Directors of Nursing (ADON) said they would expect during medication pass for staff to sanitize and/or wash hands before administering medications, between residents, after picking up trash or pills off of floor, and when touching the trash can lid on the side of medication cart. They would expect staff to wear a clean glove when retrieving wipes from wipe container during peri care. Proper PPE, such as gowns and gloves, should be worn with residents on EBP. They would not expect a urinary catheter drainage bag to be on the floor. During wound care, staff should perform hand hygiene before starting, between each wound, when going from dirty to clean, and with glove changes. Staff should not be moving a trash can with a gloved hand that they then use to open up wound supplies. Surveyor: [NAME], April

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and functional environment for the residents by allowing items to be stored on top of overbed light fixtures for residents in five rooms. Storing items on the overbed light creates a hazard of the items falling on resident below and does not utilize the light fixture as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility's census was 97. The facility did not provide a policy regarding overbed light safety. Observation on 06/06/25 showed: - At 6:00 P.M., room W12 with a decorative Blessed sign stretching across the light fixture; - At 6:05 P.M., room W16 with a decorative Welcome sign and paper picture of a horse on top of the light fixture; - At 6:06 P.M., room W20 with a sound bar for the television on top of the light fixture; - At 6:08 P.M., room W22 with two small decorative Christmas trees, a stuffed animal, and another small decoration on the light fixture; - At 6:30 P.M., room E11 with eight small, decorative items on the light fixture. During an interview on 06/06/25 at 7:35 P.M., the Administrator, Director of Nursing, and both Assistant Directors of Nursing said they would expect light fixtures in rooms to be free from decorations and objects.