STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265825	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elsberry Missouri Health Care Center	1827 Hwy B Elsberry, MO 63343

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 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 observation, interview and record review, the facility failed to make appropriate updates and revisions to develop a plan of care consistent with residents' specific conditions, needs and risks for two residents (Resident #34 and #17) in a review of 17 sampled residents. The facility failed to revise Resident #34's care plan to provide staff direction for interventions related to the resident's auditory and visual hallucinations and confusion, did not update to address the resident's mechanically altered diet/loss of liquid/solids from his/her mouth when eating or drinking, holding food in his/her mouth/cheeks or residual food in mouth after meals, and did not address pain medications for pain and/or anxiety, and failed to revise Resident #17's care plan to include the resident's current oxygen therapy order. The facility census was 54. Review of the undated facility policy, Care Plan, showed the following:-A care plan is initiated upon admission (known as the baseline care plan) and is revised quarterly, with a significant change, and as needed. The MDS coordinator is the primary person responsible for updating the care plan, however the nursing staff, dietary manager, resident service coordinator, and restorative aide are responsible for updating the care plan as needed;-The comprehensive care plan will be initiated within 14 days of admission;-The care plan will be completed no later than 7 days after the comprehensive MDS is completed;-Care plan meetings are scheduled once a week and as needed to meet family/resident needs;-The MDS Coordinator chairs the meetings with input from the other department heads. 1. Review of Resident #34's undated medical diagnoses page showed the following:-Cerebrovascular disease (a group of disorders that affect blood vessels and blood supply to the brain, potentially leading to stroke, aneurysm, or other serious conditions);-Dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, language, and judgement that interferes with daily life and independence;-Dysphagia (a medical condition characterized by difficulty swallowing);-Hallucinations (a sensory experience that seems real but is not).-No diagnoses related to pain noted. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/01/25, showed the following:-Cognitively intact;-No behaviors;-Independent for eating;-No alternative or special diet;-No swallowing concerns;-The resident had pain that rarely interfered with his/her sleep and day-to-day activities. Review of the resident's significant change MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-No behaviors;-Independent for eating;-No alternative or special diet;-No swallowing concerns;-The resident had pain that rarely interfered with his/her sleep and day-to-day activities. Review of the resident's progress notes, dated 06/29/25, showed the following:-The resident refused to get out of bed for lunch, lunch tray taken to room and 0 percent (%) eaten;-40% of dinner consumed in room, being fed by staff. Resident refused to feed self, said hands didn't work. Review of the resident's Physician Order Summary Report showed the following:-Tylenol 650 mg every four hours PRN for pain; start date of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/01/25;-07/03/25, a physician ordered regular diet, mechanical soft texture, regular/thin consistency;-Morphine sulfate (medication for pain) 0.25 milliliters (ml) every three hours PRN (as needed) for pain; start date of 07/07/25. Review of the resident's progress notes showed staff documented the following:-On 07/03/25 at 10:33 A.M. the resident recently had a significant decline in condition, appetite was poor, but weight was stable;-On 07/03/25 at 3:34 P.M., the resident was on a mechanical soft diet with thin liquids;-On 07/07/25 at 5:16 A.M. the resident yelled out and talked in his/her sleep; -On 07/08/25 at 1:42 A.M. the resident was extremely confused Review of the resident's Physician Order Summary Report showed an order for lorazepam (medication for anxiety) 0.5 ml every four hours PRN; start date of 07/09/25. Review of the resident's progress notes showed staff documented the following:-On 07/17/25 at 2:10 P.M. behavior charting showed the resident called out from his/her room and dining room, saying help me. -On 07/18/25 at 2:29 P.M. behavior charting showed the resident was hollering out complaining of pain this shift and ate 25% to 50% of food at all meals; -On 07/19/25 at 6:11 A.M. behavior charting showed resident yelled off and on all shifts;-07/19/25 at 2:02 P.M. behavior charting showed the resident was restless and yelling out at breakfast; -07/20/25 at 2:02 P.M. behavior charting showed the resident was confused while talking throughout the day-07/24/25 at 10:22 A.M. notified resident's family of residents decline in condition, requiring total assist with eating, not eating well, ate less than 10% of breakfast, yelling out in pain, family notified and decided to proceed with hospice referral;-07/25/25 at 1:47 P.M. behavior charting showed the resident yelled out during lunch. Review of the resident's significant change MDS, dated [DATE], showed the following:-Severe cognitive impairment;-No behaviors;-Dependent for eating;-Loss of liquid/solids from mouth when eating or drinking and holding food in mouth/cheeks or residual food in mouth after meals;-On a mechanically altered diet;-The resident had pain that frequently interfered with his/her sleep and day-to-day activities. Observation on 07/29/25 at 12:47 P.M. and 1:02 P.M. showed the resident assisted by staff to eat a mechanical soft diet. The resident did not eat any of the mechanical soft meal, ate two ice creams and drank water and juice. Review of the resident's updated care plan, dated 07/29/25, showed the following:-He/She had auditory and visual hallucinations;-He/She had periods of confusion, encourage to drink fluids throughout the day;-He/She was on a regular diet, dependent on staff to eat;-He/She had chronic knee pain, takes scheduled pain medication, if increased pain offer a hot pack or offer to reposition;-The care plan was not updated to address the resident was on a mechanically altered diet, lost liquid/solids from his/her mouth when eating or drinking or pocketing food; -The care plan did not address interventions for when the resident was having auditory and visual hallucinations or when the resident was confused;-The care plan did not address as needed pain and anxiety medications available for pain and/or anxiety. Observation on 07/30/25 at 6:47 A.M. showed the resident in his/her room, yelling out and asking for someone to come to his/her room. Observation on 07/30/25 at 7:01 A.M. showed the resident continued to yell out from his/her room, asked for someone to come to his/her room, yelled for someone to untie him/her, had other mumbled conversations. Certified Nurses Aid (CNA) J knocked on the resident's door and told the resident he/she would be right back after he/she finished helping another resident. Observation on 07/30/25 at 7:18 A.M. showed the resident continued to yell out from his/her room. CNA J knocked and entered the resident's room and asked the resident if he/she was in pain. Resident stated yes, in his/her legs. CNA J said he/she would let the nurse know about his The resident was confused, yelling out and asking where he/she was and asked where [NAME] was. Observation on 07/31/25 at 8:52 A.M. showed the resident yelling out from his/her room, someone come down here, anyone help, I found her, hey come here please, come on nurse, and other inaudible comments. Observation on 07/31/25 at 9:01 A.M. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the resident continued to yell out from his/her room, please! Someone come down here. I need someone to come down here. Please!. An unidentified nurse aide exited the room next to the resident's, collected the dirty linen cart and walked away down the hall. During an interview on 07/31/25 at 9:36 A.M., Licensed Practical Nurse (LPN) K said the following:-The resident started declining quickly, within the last month;-The resident developed new behaviors of anxiety and yelling out during this time, and they have worsened over the last couple weeks;-The resident's diet changed from mechanical soft to pureed yesterday due to pocketing of food during meals;-Interventions for the resident's behaviors include regular checks, talking and communication, offering food and drink, adjusting temperature to ensure comfort, and asking about pain;-He/She knew the interventions from nursing report and being a smaller facility and familiar with the residents, it was not listed on the resident's care plan. 2. Review of Resident #17's care plan, dated 04/24/25, showed the resident with diagnosis of chronic obstructive pulmonary disease (COPD - disease of the lungs) and required him/her to be on oxygen at 2 liters (L) per nasal cannula (NC - flexible prongs placed in the nares that deliver oxygen) continuous. Review of the resident's physician orders, dated 05/30/25, showed an order for oxygen at 2L per NC as needed for shortness of breath. Review of the resident's care plan, on 07/30/25, showed it had not been updated to show the resident no longer required continuous oxygen therapy and only required it as needed as of 05/30/25.Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 07/17/25, showed the following:-Moderately impaired cognition;-Required oxygen therapy;-Oxygen therapy continuous not assessed;-Oxygen therapy as needed not assessed. Observation of the resident on 07/28/25 at 2:00 P.M. showed the resident sat in his/her wheelchair with a portable oxygen tank at 2L per nasal cannula. During an interview on 07/28/25 at 2:00 P.M., the resident said he/she wears his/her oxygen as needed and not continuously. Observation on 07/29/25 at 11:48 A.M. showed the resident taking off his/her nasal cannula. 4. During an interview on 07/31/25 at 2:50 P.M., CNA H said that he/she knows how to take care of a resident by looking at the care plan, getting the information in report or from the charge nurse. During an interview on 07/31/25 at 2:45 P.M., the Assistant Director of Nursing (ADON) said that she was responsible for care plans, but all nursing staff can update any changes to the care plan. The interdisciplinary team met weekly to discuss changes. During an interview on 07/31/25 at 5:01 P.M., the DON said that she would expect for the care plans and interventions to be up to date and accurate, and to reflect a resident's current needs. During an interview on 07/31/25 at 5:00 P.M., the Administrator said she would expect care plans and interventions to be accurate and up to date.

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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. Based on observation, interview and record review, the facility failed to follow physician's orders and facility policy when they did not notify the physician of blood glucose results (the amount of sugar in the blood outside of the parameter outlined in the physician's orders and facility policy for one resident, (Resident #2) in a sample of 17 residents. The facility also failed to adequately monitor pain for one resident (Resident #2) who had multiple diabetic wounds to his/her feet and arthritis. The facility census was 54. Review of the undated facility policy, Blood Glucose Test Procedure, showed the following:-Record test results in electronic medical record (EMR);-Report any values less than 50 or greater than 400 to the physician. Unless otherwise instructed by physician. Review of the undated facility policy, Notification of Changes, showed the facility will notify the resident, consult with the resident's physician and the resident's legal representative or an interested family member when a significant change in the resident's physical, mental or psychosocial status occurs, or a need to alter treatment significantly. Review of the Resident Assessment Instrument (RAI) manual, updated October 2025, showed the following:-Eschar tissue: Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scablike. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound;-Stage 1 Pressure injury: An observable, pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues;-Diabetic foot ulcers: Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful;-Unstageable: If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is unstageable. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable. During an interview on 07/31/25 at 2:30 P.M., the Director of Nurse said there was no specific policy on monitoring or premedicating a resident prior to treatments for pain. 1. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 05/22/25, showed the following:-Cognition intact;-Diagnosis of heart failure, kidney failure, diabetes mellitus (inability to regulate blood sugar) and restless leg syndrome;-Resident was not on a scheduled pain medication regimen;-Resident did not receive as needed pain medications in the last five days;-Occasionally has pain rated at a five;-Resident takes opioid medications;-Resident has two stage 1 pressure ulcers (intact skin with localized area of non-blanchable (when you press on the area of redness the redness does not go away) erythema (redness). Presence of blanchable erythema changes in sensation, temperature, or firmness may precede visual changes);-Is receiving pressure ulcer care. Review of the resident's July 2025 physician order sheets (POS) showed orders for the following:-Tramadol (medication for pain) 50 milligrams (mg), take one tablet every six hours as needed; order start date of 05/27/25;-Tylenol 8 Hour Arthritis Pain (medication for pain) 650 mg, take one tablet every eight hours PRN; start date of 05/27/25;-Hydrocodone-Acetaminophen (medication for pain) 5/325 milligrams (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(mg), take one tablet every four hours as needed (PRN), order date of 07/09/25;-Monitor pain every shift for one week related to a medication change from 07/11/25 to 07/18/25; order date of 07/11/25. Review of the resident's Medication Administration Record (MAR), dated 07/11/25 to 07/18/25, showed the order for pain monitoring entered and discontinued on 07/11/25; the MAR did not have the order entered where staff could monitor the order and would not prompt the staff to do a pain assessment because the order did not show it was due. Review of the resident's EMR, including the POS and nursing notes, showed no documentation staff obtained an order to discontinue monitoring for pain or to explain why the monitoring was not completed. Review of the resident's July 2025 POS showed an order, dated 07/14/25, for Accu checks (finger prick procedure to determine the amount of sugar in the blood) four times a day, call the physician with a blood glucose greater than 400. Review of the resident's MAR, dated 07/16/25, showed staff documented the resident's blood glucose at the mid-day check was 497, and the afternoon check (dinner time) was 409. There was no documentation staff reported the resident's blood glucose to the physician per the facility policy and the resident's physician's order. Review of the resident's EMR, including nursing notes, showed no documentation staff notified the physician on 07/16/25 of the resident's blood glucose results of 497 or 409. Review of the resident's MAR, dated 07/17/25, showed staff documented the resident's blood glucose at the mid-day check was 465, and the afternoon check (dinner time) was 482. There was no documentation staff reported the resident's blood glucose levels to the physician per the facility policy and the resident's physician's order. Review of the resident's EMR, including nursing notes, showed no documentation staff notified the physician on 07/17/25 of the resident's blood glucose results of 465 or 482. Review of the resident's care plan, dated 07/17/25, showed the following:-I have good communication skills and can make my needs known; I will let you know if I need something;-I am working with therapy on my ambulation;-I was admitted with three pressure wounds, including one to my heel. I have a diabetic ulcer to my left and right great toe and my left mid-foot;-I have pain to my back, shoulders and legs. I am on scheduled and have PRN pain medication to help with pain. If I am having more pain, please offer me a hot pack or offer to reposition me to allow for better pain control;-The care plan did not address how often staff should monitor for pain or if staff should be offering an intervention prior to therapy or wound treatments. Review of the resident's MAR, dated 07/18/25, showed staff documented the resident's blood glucose at the mid-day check was 461 and the afternoon check was 487. There was no documentation staff reported the resident's blood glucose levels to the physician per the facility policy and the resident's physician's order. Review of the resident's EMR, including nursing notes, showed no documentation staff notified the physician on 07/18/25 of the resident's blood glucose results of 461 or 487. Review of the resident's July 2025 POS showed orders for the following:-07/23/25, cleanse left ball of foot with wound cleanser and apply skin prep every shift (three times daily);-07/24/25, cleanse left heel with normal saline, pat dry with gauze, and apply skin prep to the peri-wound area, then apply Hydrofera (a type of wound dressing) blue ready to the wound bed, cover with foam dressing, check daily (day shift) and change every three days. Review of the resident's Medication Administration Record, dated 07/29/25, showed the resident received hydrocodone-acetaminophen 5-325 mg at 7:42 A.M. Review of the resident's EMR showed no documentation of Quarterly Pain Assessments completed for the resident. During an interview on 07/29/2025 10:43 A.M., the resident said nursing staff made him/her walk too much and his/her left foot hurt with pain rated nine out of ten, (with ten being the worst pain possible). His/Her heels and toes have wounds from his/her shoes. It hurt down his/her left leg, across the bottom of his/her foot, midfoot, joints and toes, and up the leg. Staff make him/her walk on it even though he/she doesn't want to. They changed the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing on the foot this morning. Observation on 07/30/25 at 10:45 A.M., showed the following:-Registered Nurse (RN) N and the Director of Nursing (DON) entered the resident's room to provide dressing changes;-The resident said that his/her pain was a seven. His/Her feet hurt and his/her shoulders, especially his right shoulder, and the pain went down his/her arm; RN N and the DON did not respond to the resident's reporting of pain at the time; -The resident had a diabetic ulcer on the tip of his/her right great toe that measured 1 centimeter (cm) in length and width;-The resident had an unstageable pressure ulcer on the right heel that measured 0.5 cm length and width, that had fragile new skin starting to cover; -The diabetic ulcer to the resident's left great toe showed red center that measured 1.5 cm in length x1.5 cm in width with a callus formed on the periwound; the center of the wound bed showed a 0.5 x 0.5 dark red spot;-The resident's ball of his/her left foot had a diabetic ulcer that measured 0.5 cm in length x 1 cm in width;-The resident's left heel had a pressure wound with eschar covering the wound bed that measured 1 cm in length x 2 cm in width; the RN N described the scab as weak;-The resident grimaced when the wounds were directly touched during the dressing changes. Review of the resident's Progress Notes/Medication Administration Note, dated 07/30/25, at 11:00 A.M., showed staff administered tramadol 50 mg. The resident complained of pain 7 /10 in bilateral (both) wrists and bilateral lower extremities and requested pain medication. During an interview 07/31/2025 2:53 P.M., the DON said the following: -If a resident has routine pain, the facility does pain documentation for a week; -The facility routinely does Quarterly Pain Assessments; -The facility uses the pain scale with faces (1-10 scale correlated with facial expressions) or PANAM (Pain Assessment in Advanced Dementia (PAINAD) scale, a specific tool used to assess pain in individuals with advanced dementia or other conditions affecting their ability to communicate verbally) or the 1-10 pain scale where resident's rate their pain 1-10 with 10 being the worst pain;-Staff are expected to ask and monitor residents about their pain; if they are having any signs or symptoms, restlessness, or physical outward signs of pain; -She does not know why the monitoring entered on 07/11/25 was entered and then looked like it was discontinued; -She expected staff to offer pain medication prior to completing wound dressings;-She nor RN N asked the resident about his/her pain prior to completing his/her wound care, but should have;-Staff are expected to report blood glucose results to the physician when they are over 400 or less than 50;-Those values (less than 50 or over 400) could be urgent to emergent depending on the resident and their situation, and need to be reported immediately for each time the resident has that value;-Staff are expected to follow the physician's orders, and document actions taken, if an order is not completed for any reason, staff are expected to document why and what actions were taken.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident, (Resident #49), with diagnosis of dementia, in a review of 17 sampled residents, received appropriate care to ensure his/her individualized dementia care needs were met. Resident #49 wandered in and out of other residents' rooms uninvited and went through other residents' belongings upsetting other residents. In response, the facility frequently moved the resident to different rooms. On 7/28/24, Resident #49 was looking through his/her roommate's (Resident #46) belongings. Resident #49 became verbally agitated with Resident #46 and in response Resident #46 punched Resident #49 in the arm multiple times resulting in a large bruise to the resident's arm and reinjury to an existing skin tear on the resident's hand. Further review showed Resident #49's care plan did not address dementia or interventions to address the resident's behaviors. The facility census was 54. During an interview on 07/31/25 at 12:04 P.M., the Director of Nursing (DON) said the facility did not have a policy for dementia care. The facility followed standards of practice. 1. Review of Resident #49's undated face sheet showed diagnoses of dementia (a condition characterized by a progressive decline in cognitive functions, such as memory, thinking, language, judgment, and behavior) and anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life.) Review of the resident's nurse's notes showed staff documented the following: -On 04/21/25 at 4:20 P.M., the resident came running out of his/her room shaking and yelling, I can't even go out of my room, I can't even touch my things, it's not supposed to be like this, this is supposed to be my room and it's not. I can't do nothing. I just wanted my clothes. This is supposed to be my room, too!. The resident was pointing to the curtain which separated the resident from his/her roommate. The resident said, He/She yells at me all the time, I can't do nothing. The resident was shaky and visibly upset. The nurse called the Director of Nursing (DON) and got permission to move the resident to another room for the night; -On 04/23/25 at 10:35 A.M., staff moved the resident to another room on 04/22/25 at 2:30 P.M. (the third room change since the resident's admission);-07/18/25 (a late entry) at 10:04 A.M., staff moved the resident to another room on 07/16/25 at 9:00 A.M. (a fourth room change since the resident's admission). Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 07/24/25, showed the following:-Severely impaired cognition;-No physical behavioral symptoms directed toward others;-No verbal behavioral symptoms directed toward others;-He/She was independent with walking;-He/She was independent with transfers. Review of the resident's nurse's notes showed staff documented on 07/28/25 at 9:51 P.M., the Certified Nurse Assistant (CNA) entered the resident's room, and the resident had his/her hand in his/her roommate's (Resident #46) face. Resident #49 said, you better watch yourself and the roommate grabbed the resident's left arm and started hitting Resident #49. Staff removed Resident #49 from the room and took him/her to the day room near the nurse's station. Review of Resident #49's care plan, revised 07/29/25, showed the following:-The resident can get confused on where to go and needs to be redirected on where to go when he/she was out of his/her room; -Independent with ambulation, but may need directions on where to go;-The resident had an altercation with his/her roommate on 07/28/25;-The care plan did not address the resident's diagnoses of dementia, behaviors of going through others' belongings or provide interventions for staff specific to the resident's individualized needs due to dementia. Observation on 07/29/25 at 12:40 P.M., showed the resident sat at the dining table with a foam dressing covering the top of his/her left hand, dated 07/29/25, and a large bruise on his/her left forearm near his/her left elbow. During an interview on (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	07/30/25 at 11:56 A.M. the resident's responsible party said the following:-The resident has anxiety and dementia;-On admission, the resident's first roommate screamed at the resident for getting into his/her belongings. Staff moved the resident to a room by himself/herself and the resident did well;-The resident then had a roommate again and this roommate watched TV a lot. If the resident walked in front of his/her roommate's TV, it irritated his/her roommate, and the roommate would yell or get upset at Resident #49; -The resident got in a fight the other night with his/her new roommate;-He/She was concerned about the most recent incident because it wasn't just verbal it was physical;-The resident gets confused because staff keep moving him/her. 2. Review of Resident #46's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;- He/She had no behaviors. During an interview on 07/30/25 at 10:19 A.M. and 10:29 A.M., the resident said the following:- His/Her roommate (Resident #49) was getting into his/her closet (on 07/28/25) and he/she said something to Resident #49r about those not being his/her belongings. Resident #49 came up to him/her, so he/she punched Resident #49 because the resident raised his/her hand and made a fist like he/she was going to hit him/her; -He/She punched Resident #49 on the arm a few times; -Two (unnamed) nurses were in the room with him/her and his/her roommate when this happened;-Resident #49 gets into his/her drawers and closet frequently and had even got into bed with him/her once; -He/She reported to staff before the incident occurred that he/she didn't think they would get along and he/she thought it was a bad fit because he/she didn't like someone getting into his/her things and Resident #49 didn't like people getting on to him/her for doing those things;-He/She only hit his/her roommate because he/she made a fist and threatened him/her;-He/She thinks his/her roommate was too confused and it was not fair to the other residents to put up with Resident #49 going through their belongings. 3. Review of Resident #2's admission MDS, dated [DATE], showed the resident was cognitively intact. During an interview on 07/30/25 at 10:30 A.M., the resident said a week ago Resident #49 was his/her roommate and had tried to crawl into bed with him/her. Resident #49 touched his/her bottom and his/her feet. He/She was able to get out of bed and went to the door and yelled for security. He/She did not feel safe, like Resident #49 was trying to do something to him/her. Staff did not move Resident #49 from the room that night. He/She was nervous and didn't know if something else would happen, so he/she didn't sleep well at all. 4. During an interview on 07/30/25 at 3:15 P.M., Certified Nurse Aide (CNA) B said the following:-(On 07/28/25) Resident #46 was yelling at Resident #49 and he/she went into the room;-Resident #46 said he/she was going to beat Resident #49 up;-Resident #49 was pointing in Resident #46's face and told him/her to behave himself/herself;-Resident #46 grabbed Resident #49's arm and hit him/her with a closed fist five times near the elbow on the lower part of his/her arm;-The resident had some previous small skin tears that opened back up from the punching and Licensed Practical Nurse (LPN) C cleaned them up;-Resident #49 likes getting into other resident's things;-Resident #49 had an incident with a former resident (in April) where Resident #49 was going through his/her roommates belongings and the roommate yelled at Resident #49;-Other residents will turn their call lights on when Resident #49 comes in their rooms or when he/she begins going through their things;-Resident #49 wandered and was more confused because he/she has been moved. Staff did their best to redirect the resident, but that was usually after an incident had occurred;-He/She felt it has been confusing for Resident #49 because he/she has been in so many rooms that is why he/she is always going in other resident's rooms. During an interview on 07/30/25 at 3:15 P.M., CNA D said the following: -It was difficult to keep up with Resident #49 on evening shift because he/she wandered into other residents rooms and upset the residents;-Resident #49 wandered more at night;-Resident #49 was more confused and trying to go into other resident's rooms because he/she has been moved to at least three different (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265825	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elsberry Missouri Health Care Center	1827 Hwy B Elsberry, MO 63343

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F 0744 Level of Harm - Actual harm Residents Affected - Few	rooms now. During an interview on 07/30/25 at 3:40 P.M., CNA E said the following:-Resident #49 wandered into other resident rooms;-Staff has been told in report to watch Resident #49 for wandering and to redirect the resident and monitor closely;-Something had to be triggering Resident #49 to wander. During an interview on 08/04/25 at 3:40 P.M., Licensed Practical Nurse (LPN) C said the following:-(On 07/25/25) Resident #46 was yelling and CNA B went into the room to see what was going on;-CNA B then started yelling for him/her to come in;-CNA B was taking Resident #49 to his/her recliner and said they needed to separate the residents, so they brought Resident #49 to the day room near the desk;-CNA B reported Resident #46 hit Resident #49 several times;-He/She called the on-call nurse (Assistant Director of Nursing/ADON) to report the altercation;-Resident #49 had areas with blood on his/her wrist and forearm that required wound cleanser (he/she believes it was the resident's left arm), but he/she could not see where the blood was coming from or where to even place a bandage;-Resident #46's responsible party informed him/her that Resident #49 had tried to get into Resident #46's bed previously, but he/she did not know about that at the time;-The facility tried to increase monitoring of the resident with 15 minute checks when the resident had behaviors; there were no other interventions to address the resident's behaviors. During an interview on 07/30/25 at 10:25 A.M. and 12:40 P.M. and 07/31/25 at 2:55 P.M. and 5:00 P.M., the Director of Nursing (DON) said the following:-Resident #46 said Resident #49 was in his/her closet and Resident #49 went over to him. Resident #46 hit Resident #49 on the left arm trying to get him/her away;-The nurse separated the residents and brought Resident #49 to the dayroom and called the on-call nurse, which was the ADON to report the incident;-She had heard about Resident #49 trying to get into Resident #46's bed and had told staff to increase monitoring;-Resident #49 got into Resident #46's closets and it upset Resident #46;-Resident #49 gets into other residents' closets, but she had not heard about any other resident incidents recently; -He/She believes Resident #49 does these things because he/she does not know where his/her stuff is;-Resident #49 did get into a former roommate's closet and that behavior really upset the former roommate resulting in the roommate yelling at Resident #49; -She would expect staff to redirect the resident and increase monitoring;-Resident #49 was in a room by himself/herself before he/she got his/her next roommate;- Increased monitoring and redirection were the only interventions that had been put in place to address the resident's wandering into other resident rooms;-She should redirect the resident when wandering, increase monitoring, offer an activity, anticipate the resident's needs, and determine why the resident was wandering;-Staff had not been directed specifically on these things.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food items were labeled, dated, and covered; failed to maintain the range hood to be free of an accumulation of grease and debris; failed to ensure staff wore beard restraints to prevent potential contamination; and failed to ensure the ice machine was free of a buildup of debris. The census was 54.Review of the undated facility policy, Food Storage-Refrigeration, showed foods shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labeled and dated with expiration dates. The manager and/or his/her designee shall check the refrigerators daily to ensure leftovers are discarded and all food is properly stored. 1. Observation on 7/28/25 at 10:51 A.M. of the reach-in refrigerator in the kitchen showed the following:-An opened five-pound bag of shredded cheddar cheese was open to air and was not sealed;-A small metal pan, labeled tomatoes, was partially covered with foil and was not dated. The pan was open to air and not sealed;-A plastic container held individually wrapped sandwiches. Neither the container nor the sandwiches were not labeled or dated;-A partial plastic bag of grated parmesan cheese was stored inside a zippered bag and was not dated. Observation on 7/28/25 at 12:25 P.M. showed a 20-ounce container of onion powder sat on a shelf over the preparation counter. The container lid was open to air and was not closed. During an interview on 7/30/25 at 10:50 A.M., the Dietary Manager said food items should be labeled, dated, and closed or sealed. The cooks checked food items when he wasn't working (on Thursdays and weekends). He checked for proper labeling, dating, etc. every other day. 2. Observation on 7/28/25 at 11:05 A.M. showed the range hood in the kitchen had a moderate buildup of dark colored debris and clear grease on the baffle filters. Yellow grease, drips and runs were visible on the interior of the range hood. During an interview on 7/29/25 at 4:20 P.M., the Maintenance Supervisor said he cleaned the range hood filters on 6/11/25. Kitchen staff wiped down the interior of the range hood, but he was unsure how often. During an interview on 7/30/25 at 10:50 A.M., the Dietary Manager said maintenance staff removed the filters from the range hood and ran them through the dish machine every other week. Dietary staff wiped down the inside of the range hood weekly. 3. Review of the facility policy, Personal Hygiene and Appearance, revised January 2016, showed hair nets or hair coverings shall be worn while in the kitchen or storage areas. Facial hair, except eyebrows, must be covered with a hair net or beard cover. Observation on 7/28/25 at 11:40 A.M. showed Dietary Aide A rolled clean silverware in napkins for the residents. Dietary Aide A had a beard and sideburns and did not wear a beard restraint. Observation on 7/28/25 at 11:58 A.M. showed Dietary Aide A filled plastic beverage glasses with a pitcher. Dietary Aide A had a beard and sideburns and did not wear a beard restraint. During an interview on 7/30/25 at 10:50 A.M., the Dietary Manager said staff should wear hair restraints when they entered the kitchen. If staff's beard hair was longer than 1/2-inch, the staff needed to wear a beard restraint. Dietary Aide A should wear a beard restraint when in the kitchen. He had trouble ordering beard restraints, but staff should use a hair restraint as a beard restraint if needed. 4. Observation on 7/29/25 at 12:55 P.M. showed the ice machine was located on the staff service hall inside the storage room labeled Compactor. [NAME] crusty debris and yellow-colored debris was visible inside the ice machine over the accumulated ice below on both sides of the unit. During an interview on 7/29/25 at 4:20 A.M., the Maintenance Supervisor said the ice machine was due to be cleaned last week. Kitchen staff empty the ice and wipe out the unit. He descaled the machine and cleaned it. He was unaware of the debris accumulation inside the ice machine. During an interview on 7/30/25 at 10:50 A.M., the Dietary Manager said dietary staff emptied the ice machine monthly into coolers and cleaned the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unit inside and outside monthly. The Maintenance Supervisor descaled the unit monthly.

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility policy to address Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease (a bacterial disease commonly associated with water-based aerosols) in persons at risk) control that included specific control parameters based on Center for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE)) standards. The administrator said the facility did not have a water management team, did not have a water flow map with the details of the water flow though the building and that include all of the elements the facility policy directed, and the facility had not been monitoring cold water temperatures. The Director of Nursing had not been trained to monitor residents with pneumonia for possible Legionnaire's Disease as directed by the facility policy. The facility census was 54. Review of the facility's Legionella and Water Management Policy, dated 9/26/19, showed the following:-As part of the infection prevention and control program, the facility had a water management team that includes the Administrator, Maintenance Supervisor, Director of Nursing (DON), and Medical Director;-The team is to identify areas in the water system where Legionella can grow and spread to reduce the risk of Legionnaire's disease;-A detailed description and diagram of the water system in the facility will include water intake-from the well, cold water delivery-chillers, hot water heating-boilers, hot water delivery and waste discharge;-Identification of areas in the water system that could encourage the growth and spread of Legionella include water heaters, filters, shower heads, hoses, personal humidifiers and medical machines such as Continuous Positive Airway Pressure (CPAP);-Situations that could arise and lead to Legionella include construction, water main breaks, changes in water sources, scale or sediment and stagnation, water pressure, inadequate disinfection and water temperatures;-Measures used to control the spread of Legionella include diagram of all applied control measures, monitor control limits and documentation of the program;-Review of the policy showed no direction of assessing hot and cold temperatures within the facility to ensure temperatures did not fall in the optimal growth range for Legionella and did not address how often the Water Management team was to meet. Review of the facility policy, Legionella Surveillance and Detection, dated 09/26/2019, showed the following:-The facility is committed to prevention, detection and control of water borne contaminants, including Legionella. Legionnaire's disease will be included as part of the facility infection control program;-Clinical staff will be trained on signs and symptoms associated with pneumonia and Legionnaire's and when to notify the physician in regard to testing. Symptoms can include cough, shortness of breath, fever, muscle aches, headache, diarrhea, nausea and confusion are also associated with Legionnaire's Disease;-If pneumonia or legionnaire's disease are suspected, the nurse will notify the physician immediately with an assessment of the resident's condition. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains;-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;-CMS expects Medicare certified healthcare facilities to have water (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Center for Disease Control (CDC) and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit;-Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system;-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens;-Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F. 1. The facility provided no documentation showing monitoring of cold water temperatures. During an interview on 08/14/25 at 3:25 P.M., the Maintenance Director said the following:-The facility had one water management team meeting since the last survey;-The water management team included himself, the Director of Nurses, administrator, and medical director;-He was not familiar with the ASHRAE standards;-He did not monitor the cold water temperatures;-He sent a monthly water sample and test for E. coli (bacteria), lead, and copper to the department of natural resources, but it does not test for legionella;-He did not know about cold and hot water ranges to prevent the growth of legionella;-He did not check for sediment, scaling, or biofilm. During an interview on 07/31/25 at 3:46 P.M., Registered Nurse (RN) M said the following:-He/She and the Administrator were both the infection preventionists in the facility;-He/She did not know what ASHRAE standards were;-He/She had not done any monitoring of any residents for legionellosis; she had not educated any staff on what to monitor for. During an interview on 07/31/25 at 3:46 P.M., the Director of Nursing (DON) said the following:-She did not know what ASHRAE standards were;-She had not attended a water management meeting;-She had not done any monitoring of any residents for legionellosis and did not have a plan to monitor future resident's with pneumonia; she had not educated any staff on what to monitor for. During an interview on 07/31/25 at 3:46 P.M., the Administrator said the following:-She and RN M were both the infection preventionists in the facility;-The facility staff do not know what ASHRAE standards are;-The facility does not have a water management team, but the Maintenance Supervisor checked temperatures on the tempering valves;-The facility had not had a water management meeting;-Staff should be monitoring residents for legionellosis per the facility policy;-The facility's water flow map had entry and exit points of water and water heaters, but no other areas in the building;-She thought the Maintenance Supervisor completed water temperature checks and thought that included cold water checks.