

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2024
NAME OF PROVIDER OR SUPPLIER  Moore-Few Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  901 South Adams Nevada, MO 64772	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31464</p> <p>Based on record review and interviews, the facility failed to ensure all residents were kept free from possible accident hazards when the facility staff did not fully secure one resident (Resident #1) in a wheelchair during transport in the facility's van. The facility census was 53.</p> <p>On 03/05/24, at 3:00 P.M., the Interim Administrator and the Acting Director of Nursing (DON) were notified of the Past Non-Compliance that occurred on 01/10/24. On 01/10/24, DON E notified the Department of Health and Senior Services (DHSS) of the incident, began an investigation, educated the employees involved, and initiated a new competency checklist for all transportation drivers. The noncompliance was corrected on 01/12/24.</p> <p>Review showed the facility did not have a policy and procedure specific to transporting residents in the facility van.</p> <p>1. Review of Resident #1's face sheet (general resident profile information) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included end stage renal disease (kidney failure), dependence on renal dialysis (manual filtering of waste products and excess fluid from the blood), stroke, congestive heart failure (CHF - decreased heart function caused by abnormality of the heart chamber walls), muscle weakness, history of left femur (upper leg bone), left humerus (upper arm bone), and left tibia (lower leg/shin bone) fractures, history of vertebral compression fracture, legal blindness, carpal tunnel syndrome (impairs wrist function, causes pain), and depression.</p> <p>Review of the resident's Physician Order Sheet (POS) showed an order, dated 06/27/23, for dialysis on Monday, Wednesday, and Friday each week.</p> <p>Review of the resident's care plan, dated 08/21/23, showed the resident needed dialysis related to renal failure. Encourage the resident to go for the scheduled dialysis appointments on Monday, Wednesday, and Friday.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 11/21/23, showed the following information:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Mild cognitive impairment;</p> <p>-Functional limitation in range of motion in upper and lower extremity on one side;</p> <p>-Mobilization utilizing a wheelchair usually propelled by others;</p> <p>-Dependent on staff for transfers from bed to chair/wheelchair;</p> <p>-Chronic pain.</p> <p>Review of a facility's Incident/Accident Report (Witnessed Fall) for the resident dated 01/10/24, at 9:10 A.M., showed during transport to dialysis, the resident slid out of his/her wheelchair while in the transportation van. The resident was assisted back into the wheelchair and taken to dialysis.</p> <p>Review of an intake report received by the State Agency on 01/10/24, at 11:28 A.M., showed the following information:</p> <p>-The resident was being transported to dialysis in facility van. At approximately 8:40 A.M., there were two vehicles in front of the transport van that slammed on their brakes. The transport van also hit their breaks to avoid a collision. The resident slid out of his/her wheelchair, landing on the van floor. Per the statement by the driver all safety straps were in place prior to leaving the facility;</p> <p>-The facility was investigating what happened and educating staff/updating policies to ensure the residents' safety.</p> <p>Review of the facility's internal event investigation file showed the following:</p> <p>-A signed statement by Staff A, dated 01/10/24, showed Staff A said he/she strapped the resident in his/her seat using all four straps, loaded another resident, and left the facility to take the residents to dialysis appointments.</p> <p>-Two cars ahead of the facility transport van slammed on their brakes, causing Staff A to also slam on the brakes. The resident slid out of his/her wheelchair.</p> <p>-Staff A pulled into a parking lot, got out of the van, and went to the back door. Staff A said the wheelchair remained where he/she had secured it with the four straps.</p> <p>During an interview on 03/01/24, at 3:43 P.M., Staff A said he/she was hired to be a transportation driver. Training was done by another transportation driver, who instructed him/her to strap down a wheelchair using two front and two back straps. Staff A said the trainer said they only needed to use the seatbelts if they were going out of town. Staff A said on 01/10/24, he/she secured the resident's wheelchair in the back of the van, but did not put the seatbelt on the resident. Staff A said while they were enroute to the dialysis center, a vehicle in front of them slammed on their brakes. Staff A had to also slam on the brakes. The resident slid from her wheelchair, but the wheelchair remained strapped in place to the van floor.</p> <p>Review of the facility's internal event investigation file showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A signed statement by Staff B , dated 01/10/24, showed Staff A called him/her due to the resident sliding out of his/her chair and Staff A needed help getting the resident up. Staff B reported the incident to the Director of Nursing (DON), who was also the acting Administrator at the time.</p> <p>Review of the facility interview with Resident #2's after the incident showed the following:</p> <p>-Staff A had to slammed on the brakes due to someone braking ahead of them;</p> <p>-Resident #2 heard Resident #1 moan and looked over to see him/her lying on the floor.</p> <p>During an interview on 03/01/24, at 3:42 P.M., Resident #2 said Resident #1 slid out of her chair when Staff A had to slam on the brakes. Resident #2 said the driver did not put a seatbelt on Resident #1.</p> <p>Review of the facility's interview with Resident #1 after the incident showed the following:</p> <p>-Resident #1 reported Staff A had to hit the brakes hard to avoid a collision with the driver ahead of them who braked hard. Resident #1 remembered sliding out of her chair and onto the floor of the van. He/she was unable to recall if he/she had a seatbelt across his/her lap, but stated I must not have, because I slid out of the chair.</p> <p>Review of the facility's Follow-Up Investigation Report to DHSS, undated, showed the following information:</p> <p>-Resident #1 said he/she knew the van made a sudden stop and he/she was thrown forward landing on the floor. He/she did not know if he/she had a lap belt on;</p> <p>-Resident #2 said the van had to stop suddenly, throwing residents forward. He/she looked over an saw Resident #1 on the van floor;</p> <p>-Staff A said he/she had to make a sudden stop. Safety straps were in place on Resident #1's wheelchair, but the resident slid out of the chair onto the floor;</p> <p>-Conclusion: Resident was not appropriately restrained. Implemented mandatory safety videos and competencies for drivers. Written warning to Staff A for failing to comply with Missouri laws regarding seat belts.</p> <p>Observation made of the facility van on 03/01/24, at 1:40 P.M., showed the van would accommodate two wheelchairs. There were four-point straps and shoulder/lap belts for each wheelchair position.</p> <p>During an interview on 03/01/24, at 2:51 P.M., Staff C said he/she received van transportation training quite a few years ago which included to latch the door open while loading residents, lock the wheels on the wheelchair, anchor wheelchairs with four corner straps (he/she crosses the back straps diagonally for better tightness), and secure the resident with the seatbelt, testing the straps and belt for any excess slack to be tightened. Staff C said he/she always secured Resident #1 in the back position of the van, with the seatbelt across the abdomen.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/01/24, at 3:05 P.M., Staff D said he/she received van transportation training which included instructions to use all four anchor straps, criss-crossing the two back straps for added strength and tightening effect. The resident should be secured with the seat belt across their lap. Staff D checks all straps and the seatbelt to ensure they are tight enough.</p> <p>During an interview on 03/05/24, at 3:00 P.M., with the Interim Administrator and the Interim DON, the Administrator said he/she was not working there at the time of the van incident on 01/10/24, and wasn't involved in the in-service education. The facility had initiated a new competency checklist that was utilized for all van drivers. The drivers should secure all wheelchairs with the four straps provided in the van, and they should put the seatbelt on the resident. The driver should also wear a seatbelt and cannot use their cell phone during transit. The Administrator said the facility did not have a specific policy regarding van transportation.</p> <p>MO00230479</p>		