STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09456 Based on observation, interviews, and record reviews, facility staff failed to provide reasonable accommodation of needs for one resident (Resident #53) to ensure the water cup was obtainable and in reach, so the resident could drink independently and failed to ensure acceptable table heights to encourage meal independence for two residents (Resident #68 and #37) out of 18 sampled residents. The facility census was 74. 1. Review of the facility's policies showed staff did not provide a policy for accommodation of needs. 2. Review of Resident #53's quarterly Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Independent with only set up help needed for meals; -Residents ability to stand or walk, not attempted due to medical condition or safety concern; -No impairment to upper extremity. Review of the residents care plan, last reviewed and updated 02/19/24, directed staff as follows: -Monitor oral intake of food and fluid; -Provide necessary assistance with food and fluids; -Evaluate hydration. Observation on 03/26/24 at 11:35 A.M., showed the resident in bed with his/her water cup on the bedside table across the room, out of reach of the resident. During an interview on 03/26/24 at 12:50 P.M., the resident's family member said Look where his/her water cup is, there's no way they could reach it, but if it was in reach he/she will drink. (continued on next page)

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
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/24 at 1:00 P.M., showed the resident was handed the water cup to him/her and the resident drank the water. Observation on 03/27/24 at 10:32 A.M., showed the resident in bed with their water cup on the top of the dresser across the room, out of reach of the resident. Observation on 03/27/24 at 11:28 A.M., showed Certified Nurse Assistant (CNA) K went into the residents room, and the resident asked for a drink of water. CNA K grabbed the water cup off the dresser and gave him/her a drink, then placed the cup back on dresser across the room. Observation on 03/27/24 at 4:45 P.M., showed showed the resident in bed with their water cup on the top of the dresser across the room, out of reach of the resident. Observation on 03/28/24 at 11:55 A.M., showed show the resident in their bed with their water cup on the bedside table up above the headboard, out of reach of the resident. During an interview on 03/28/24 at 1:00 P.M., CNA L said the resident is not able to get out of bed, or walk without assistance so they would not be able to get their water cup across the room. CNA L said the resident is able to drink with assistance. During an interview on 03/28/24 at 3:10 P.M., the Director of Nursing (DON) said she expects the resident's water cup to be in reach as the resident is not able to get up and get it herself. The DON said the resident is a one person assist, and would not be able to get the cup themselves. During an interview on 03/28/24 at 3:11 P.M., the administrator said she expects the residents' cup to be within reach, to accommodate him/her. 2. Review of Resident #68's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Upper and lower left extremity impairment; -Uses a wheelchair; -Required limited assist and supervision from staff to transfer. Review of the resident's care plan, dated 03/01/24, showed staff assessed the resident as at risk for an altered nutritional status. Observation on 03/25/24 at 12:39 P.M., showed the resident at a dining room table eating lunch in his/her wheelchair with the wheelchair arms prohibiting the resident from moving close to the table. Additional observation showed the resident sat at an angle to the table and reached across his/her chest to scoop his/her ice cream with his/her right hand. Further observation showed the resident dropped the food from his/her spoon onto his/her lap. Staff did not assist the resident to transfer to a regular chair or position him/her to better reach his/her food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/24 at 11:52 P.M., showed the resident at his/her dining room table in a wheelchair with the wheelchair arms against the table. Additional observation showed the resident sat at an angle and reached across his/her chest to pick up the food on his/her plate. Further observation showed the resident dropped the food from his/her spoon onto his/her lap. Staff did not assist the resident to transfer to a regular chair or position him/her to better reach his/her food. 3. Review of Resident #37's quarterly MDS dated [DATE], showed staff assessed the resident as follows: -Upper and lower left extremity impairment; -Uses a wheelchair; -Required extensive assistance from staff to transfer. Review of the resident's care plan dated, 12/24/23, showed staff assessed the resident as at risk for an altered nutritional status. Observation on 03/26/24 at 11:53 A.M., showed the resident sat at an angle to the dining room table in his/her wheelchair. Additional observation showed the table at the resident's chest and the resident reached across his/her chest to reach the food. Further observation showed the resident dropped his/her food into his/her lap. 4. During an interview on 03/28/24 at 3:07 P.M., Certified Medication Technician (CMT) U said staff do not transfer some residents from their wheelchair to a regular chair because some residents are hard to transfer, there is a lot going on at mealtime and some residents will get out of the chair. Additionally, the CMT said the facility is short staffed at times. During an interview on 03/28/24 at 3:15 P.M., Licensedn Practical Nurse (LPN) F said staff do not transfer residents from wheelchairs to regular chairs for safety reasons. He/She said staff have transferred residents before and the residents were falling trying to transfer themselves back to their wheelchairs. 39644

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50422 Based on observation, interview and record review, facility staff failed to ensure resident's personal privacy was protected, when they left the Medication Administration Records (MAR) open and unattended in a public hallway. Facility census was 74. 1. Review of facility's policies showed staff did not provide a policy for privacy during medication pass. 2. Observation on 03/25/2024 at 11:40 A.M., showed Licensed Practical Nurse (LPN) M left the MAR open and unattended with resident information exposed. Observation showed staff and residents walked past the cart. 3. Observation on 03/27/24 at 11:07 A.M., showed Registered Nurse (RN) E left the MAR open and unattended with resident information exposed. Observation showed staff and residents walked past the cart. During an interview on 03/27/24 at 12:03 P.M., RN E said that the computer screen should be shut off when walking away from the cart and not exposing resident information. 4. Observation on 03/27/24 at 11:33 A.M., showed Certified Medication Tech (CMT) D left the MAR open and unattended with resident information exposed. Observation showed staff and residents walked past the cart. During an interview on 03/27/24 at 11:33 A.M., CMT D said the MAR should have been closed when away from the cart. 5. During an interview on 03/28/24 at 2:42 P.M., the Director of Nursing said the computer screens should be minimized when walking away and carts should be locked. During interview on 03/28/24 at 3:02 P.M., the administrator said computer screens should be closed down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09456 Based on observation, interview and record review, facility staff failed to provide a clean, homelike and comfortable environment when staff failed to maintain resident rooms and the memory care unit common areas. Facility census was 74. 1. Review of the facility's policy titled, Maintenance Service, dated 12/19, showed staff were directed to do the following: -Maintenance services shall be provided to all areas of the building, grounds, and equipment; -Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times; -Functions of maintenance personnel include, but are not limited to maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines and maintaining the building in good repair and free from hazards; -Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 2. Observation on 03/25/24 at 3:07 P.M., showed resident occupied room [ROOM NUMBER] walls with gouge marks and missing and chipped paint by the bed, bathroom and door. Observation on 03/26/24 at 12:06 P.M., showed resident occupied room [ROOM NUMBER] walls with gouge marks and missing and chipped paint by the bed, bathroom and door. Observation on 03/27/24 at 10:47 A.M., showed resident occupied room [ROOM NUMBER] walls with gouge marks and missing and chipped paint by the bed, bathroom and door. Observation on 03/28/24 at 10:09 A.M., showed resident occupied room [ROOM NUMBER] walls with gouge marks and missing and chipped paint by the bed, bathroom and door. 3. Observation on 03/25/24 at 3:11 P.M., showed the memory care unit shower supply room soiled. Observation showed the clean utility room doors with black marks and missing and chipped paint. Observation showed the baseboard in the dining room had black marks and the entry into the dining room with missing and chipped paint and black marks. Observation on 03/28/24 at 10:21 A.M., showed the memory care unit shower supply room soiled. Observation showed the clean utility room doors with black marks and missing and chipped paint. Observation showed the baseboard in the dining room had black marks and the entry into the dining room with missing and chipped paint and black marks. Observation showed the ledge between the dining room and the hallway with debris and dirt. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on 03/25/24 through 03/28/24, showed resident occupied room [ROOM NUMBER] baseboard under the window torn from the wall and a small amount of crumbled plaster on the floor. Observation showed the resident's dressers fourth drawer torn from the sides and hanging over the drawer below it. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) F said he/she noticed room [ROOM NUMBER] and reported to the maintenance department. 5. During an interview on 03/28/24 at 10:46 A.M. Certified Nurse Aide (CNA) G said staff are directed to fill out a maintenance form and give it to the maintenance department when staff noticed environmental concerns. He/She had noticed issues with resident rooms and common areas and had reported it to the maintenance department During an interview on 03/28/24 at 11:11 A.M., the maintenance supervisor said rooms are checked monthly for any needed repairs. He/She said staff are directed to fill out a work order and put it in the maintenance mailbox, which was checked daily. He/She said he/she had noticed some resident's rooms that need rooms some repair. He/She said he/she believed it was important the room are in good repair, but have other obligations and had to prioritize his/her responsibilities. During an interview on 03/28/24 at 2:55 P.M., LPN F said staff are directed to inform the maintenance department of environmental concerns. He/She said staff are directed to document environmental concerns on a form and placed in the maintenance department mailbox, which was checked daily. He/She said had not noticed environmental concerns in the memory care unit. During an interview on 03/28/24 at 3:35 P.M., the administrator said staff are directed to document environmental concerns on a work order and place in the maintenance department mail box. He/She said staff should report emergency issues immediately to the maintenance department. He/She said the maintenance department checked the box multiple times a day. He/She said resident rooms are audited monthly. He/She said there are some rooms that need painting and patching. He/She said the maintenance department had been notified and are in the process of working on the concerns. He/She said there are only two maintenance workers working on the entire building, so it took time to complete the repairs. During an interview on 03/28/24 at 3:35 P.M. the Director of Nursing (DON) said staff are directed to document environmental concerns on a form and give to the maintenance department. He/She said the building is old and the maintenance staff are constantly working on it, but get pulled from one job to another. 42815

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47193 Based on interview and record review, facility staff failed to provide written notice to residents or the resident's representatives regarding resident transfers to the hospital for three (Resident #15, #54 and #73) out of three sampled residents. The facility census was 74. 1. Review of the facility's Discharge/Transfer Policy, undated, showed the written notice should include: -The reason for the transfer or discharge; -The effective date of transfer or discharge; -The resident's right to appeal the transfer or discharge to the director of the Department of Health and Senior Services hearing official withing thirty days of receipt of the notice; -The address to which the request for a hearing should be sent to Administrative Hearings Unit; -That filing an appeal will allow a resident to remain in the facility until the hearing is held unless a hearing official finds otherwise; -The location to which the resident is being transferred or discharged ; -The name, address, and telephone number of the designated regional long-term care ombudsman office. 2. Review of Resident #15's medical record showed staff documented as follows: -Transferred to the hospital on 04/25/23; -Returned to the facility on [DATE]; -Transferred to the hospital 05/08/23; -Returned to the facility on [DATE]; -Transferred to the hospital 05/20/23; -Returned to the facility on [DATE]; -Transferred to the hospital 05/30/23; -Returned to the facility on [DATE]; -Did not contain the transfer/discharge notice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #54's medical record showed staff documented as follows: -Transferred to the hospital on 01/14/24; -Returned to the facility on [DATE]; -Did not contain the discharge/transfer notice. 4. Review of Resident #73's medical record showed staff documented as follows: -Transferred to the hospital on 12/09/23; -Did not contain the discharge/transfer notice. 5. During an interview on 03/28/24 at 10:54 A.M., License Practical Nurse (LPN) F said he/she is unaware of a discharge/transfer sheet that is supposed to be filled out. During an interview on 03/28/24 at 2:42 P.M., the Director of Nursing said a discharge notice should be done with transfers/discharges. During interview on 03/28/24 at 3:02 P.M., the administrator said he/she is unsure about the discharge notices. He/She said the social worker is new and still in training to do his/her job. 50422

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815 Based on observation, interview and record review, facility staff failed to develop and implement a comprehensive person-centered care plan for four residents (Resident #38, #44, #63 and #78) out of 24 sampled residents. The facility census was 74. 1. Review of facility's policies showed staff did not provide a policy for comprehensive care plans. 2. Review of Resident #38's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/17/24, showed staff assessed the resident as: -Cognitively intact; -Somewhat important to have books, newspapers and magazines to read, to do things with groups of people, and do favorite activities; -Very important to listen to music he/she likes, to be around animals such as pets and get outside to get fresh air when the weather is good; -Not very important to keep up with the news or particpate in religious services or practices. Review of the resident's care plan, dated 01/23/24, showed the resident will take part in preferred activities pursuits through next review. The care plan did not contain direction for staff in regard to activity preferences. 3. Review of Resident #44's Annual MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Did not contain documentation of the preferences for customary routine and activities. Review of the resident's care plan, dated 03/05/24, showed staff are directed to provide a schedule of events to post in his/her room and encourage participation and positive feedback and praise. The care plan did not contain documentation of preferences for activities. 4. Review of Resident #63's Annual MDS, dated [DATE], showed staff assessed the resident as: -Did not contain documentation of a BIMS; -Did not contain documentation of the preferences for customary routine and activities. Review of the resident's care plan, dated 03/15/24, showed the resident will take part in preferred activities pursuits through next review. The care plan did not contain direction for staff in regard to activity preferences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #78's Admission MDS, dated [DATE], showed staff assessed the resident as: -Moderate cognitive impairment; -Not important at all to have books, newspapers and magazines to read; -Not very important to listen to music he/she likes, to keep on up news, to do things with groups of people, and to do his/her favorite activity; -Somewhat important to be around animals, such as pet, to go outside to get fresh air and to participate in religious services or practices. Review of the resident's care plan, dated 03/17/24, showed the care plan did not contain direction for staff for the activity preference. 6. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) F said the MDS coordinator was responsible to complete the care plan. He/She said the purpose of the care plan was to provide guidance to staff with person-centered care. He/She said the care plan was updated with changes or on a quarterly basis. He/She said the care plan should include activity preferences andthe type of assistance the resident required for activities of daily living. During an interview on 03/28/24 at 3:35 P.M., the Administrator said the care plans should include activity preferences and the type of assistance a resident required with activities of daily living. He/She said the MDS Coordinator was responsible for the care plans, but was recently terminated since he/she was not completing his/her responsibilities. During an interview on 03/28/24 at 3:35 P.M., the Director of Nursing (DON) said the care plans should include activity preferences and the type of assistance a resident required with activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 - Some	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** 39644 Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the resident's care needs for four residents (Residents #47, #56, #78, and #79) of 18 sampled residents. The facility census was 74. 1. Review of facility's policies showed staff did not provide a policy for comprehensive care plans. 2. Review of Resident #47's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/17/24, showed staff assessed the resident as: -Severe cognitive impairment; -Did not contain documentation of bed rail use; -Required supervison or touching assistance from staff with rolling left to right; -Required partial to moderate assistance from staff with moving from sitting on side of the bed to lying flat on the bed; move from a lying on the back to sitting on the side of the bed with feet flat on the floor and with no back support; and to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Review of the resident's care plan, dated 03/07/24, showed the record did not contain direction for the use of side rails. Observation on 03/27/24 10:50 A.M., showed the resident in bed with grab bars in an upright position on both sideds of the bed. 3. Review of Resident #56's QuarterlyMDS, dated [DATE] showed staff assessed the resident as: -Impaired Physical mobility; -Cognitive status is mildly/moderately impaired; -Independent for rolling left to right in bed, sit to lying position, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer; -Independent/supervision for toileting; sometimes mentally aware of toileting needs, but frequently incontinent due to stress or urgency; -No Restraints; -Diagnosis of dementia with psychosis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 - Some	Review of resident's care plan, dated 02/12/24, showed the record did not contain direction for the use of grab bars. Observation on 03/25/24 at 1:03 P.M., showed the resident in bed with grab bar in the upright position on right side of the bed. Observation on 03/28/24 at 10:35 A.M., showed the resident in bed with grab bar in the upright position on right side of the bed. 4.Review of Resident #78's Admission MDS, dated [DATE] showed staff assessed the resident as: -Moderate cognitive impairment; -Two or more non injury falls since admission. Review of the resident's care plan, dated 02/13/24, showed the resident was at risk for falls. The plan did not contain new interventions after the fall on 03/09/24. Review of the resident's medical record, dated 03/09/24, showed the resident sustained a fall with injury to his/her ear. 5. Review of Resident #79 Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively status: mildly/moderately impaired; -Supervision with bed mobility, ambulation, and transfers; -No restraints; -Occasionally incontinent of urine and bowel. Review of the resident's care plan, dated 03/19/24, showed the record did not contain direction for the use of side rails. Observation on 03/26/24 at 10:46 A.M., showed the resident in bed with bilateral bed rails in upright position. 6. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) F said the MDS coordinator was responsible to complete the care plan. He/She said the purpose of the care plan was to provide guidance to staff with person-centered care. He/She said the care plan was updated with changes or on a quarterly basis. He/She said the care plan should include side rails, activity preferences, the type of assistance the resident required for activities of daily living, diets, special treatments, a decline in condition, and after a new fall with a new interventions. During an interview on 03/28/24 at 3:35 P.M., the Director of Nursing (DON) said the care plans should include bed rails, activity preferences, the type of assistance a resident required with activities of daily living and a new interventions after each fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 - Some	During an interview on 03/28/24 at 3:35 P.M., the Administrator said the care plans should include bed rails, activity preferences, the type of assistance a resident required with activities of daily living and a new interventions after each fall. He/She said the MDS Coordinator was responsible for the care plans, but was recently terminated since he/she was not completing his/her responsibilities. 42815

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815 Based on observation, record review and interview, facility staff failed to ensure staff provided three dependent residents (Resident #44, #63 and #78) out of 24 sampled, that were unable to complete their own activities of daily living (ADL), the necessary care and services to maintain adequate grooming. The facility census was 74. 1. Review of the facility's policy titled, Activity of Daily Living (ADL), dated 08/17/17, showed it is the standard of the facility to promote the highest level of health and hygiene for the residents residing at the facility, while promoting the upmost independence. In order to adhere to this standard, it is the policy that any resident that is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review showed: -Assistance with ADLs cannot be performed independently by the resident. The level of assistance with ADLs provided by staff are based on the resident's ability to maintain highest level of health and hygiene, their clinical picture; -Residents are encouraged to perform and/or allow assistance with ADLs to, again, maintain the highest level of health and hygiene. The resident, or the resident's representative, have the right to refuse any care and treatment to restore or maintain functional abilities. Facility staff are responsible to attempt to identify the underlying cause of the refusal/declination of care. If this occurs, the facility will inform and education about the benefits/risks of the proposed care and treatment and offer alternatives. The decision to refuse must be documented with interventions identified on the care plan and in place to minimize or decrease functional loss were refused by the resident or the resident's representative; -The policy did not provide direction to staff of the procedure to carry out activities of daily living. 2. Review of Resident #44's Annual Minimum Data Set (MDS), a federally mandated assessment, dated 09/03/23, showed staff assesed the resident as follows: -Severe cognitive impairment; -Did not contain documentation of the type of assistance required from staff for personal hygiene. Review of the resident's care plan, dated, 03/05/24 showed staff are directed to provide assistance with self care as needed. Observation on 03/25/24 at 11:41 A.M., the resident finger nails long with debris under the nails and facial hair. Observation on 03/26/24 at 9:25 A.M., showed the resident wore the same shirt and pants from 03/25/24 and had debris on the front of his/her shirt and pants. Observation showed the resident fingernails long with debris under the nails and facial hair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/24 at 11:16 A.M., showed the resident pants with debris on the front. Observation showed the resident fingernails long with debris under the nails and facial hair. Observation on 03/28/24 at 10:08 A.M.,showed the resident pants with debris on the front. Observation showed the resident fingernails long with debris under the nails and facial hair. During an interview on 03/28/24 at 10:46 A,M., Certified Nurse Aide (CNA) G said the resident can be combative. He/She said he/she had seen the resident's nails and tried to clean them yesterday, but he/she refused. He/She said he/she tried to re-approach. He/She said the resident would allow staff to trim his/her nails, but not always his/her facial hair. He/She said they are understaffed, so the staff did not always attempt to re-approach or complete all the tasks. 3. Review of Resident #63's Quarterly MDS, dated [DATE], showed the following: -Did not contain documentation of the Brief Interview (BIMS); -Required substantial to maximum assistance from staff with personal hygiene. Review of the resident's care plan, dated 03/05/24, showed staff are directed to provide assistance with self care as needed. Observation on 03/26/24 at 11:02 A.M., showed the resident with facial hair. Observation on 03/27/24 at 10:56 A.M., showed the resident with facial hair and debris under his/her nails. Observation on 03/28/24 at 10:46 A.M., showed the resident with debris under his/her nails. During an interview on 03/28/24 at 10:46 A,M., CNA G said the resident was showered on 03/26/24. He/She said the resident was not shaved because he/she was upset during the shower, so that might be why the resident was not shaved. He/She said he/she believed the staff was overwhelmed and did not have time to go back and shave the resident, but he/she did shave the resident yesterday. He/She said he/she just noticed the debris under the resident's nails. He/She said there is a concern of getting bacteria in the resident's mouth if the resident had debris under their nails. 4. Review of Resident #78's Admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Required supervision or setup assistance from staff with personal hygiene. Review of the resident's care plan, dated 02/06/24, showed staff are directed to provide assistance with self care as needed and required total assistance from staff. Observation on 03/25/24 at 11:41 A.M., showed the resident's hair unbrushed and his/her nails were long and jagged with debris under the nails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/26/24 at 9:44 A.M., showed the resident's hair unbrushed and his/her nails were long and jagged with debris under the nails. Observation on 03/27/24 at 11:11 A.M., showed the resident's hair unbrushed and his/her nails were long and jagged with debris under the nails. Observation on 03/28/24 at 10:05 A.M., showed the resident's hair unbrushed and his/her nails were long and jagged with debris under the nails. During an interview on 03/28/24 at 10:46 A,M., CNA G said he/she did not know why the residents nails were not trimmed. He/She said the resident did not reject care. 5. During an interview on 03/28/24 at 10:46 A,M., CNA G said nail care and facial hair shaves are provided on shower days and as needed. He/She said if a resident refused care, staff are directed to re-approach. He/She said nails are cleaned on shower days and try to clean them after meals. He/She said the facility is short staff, so staff are not always able to clean the resident's nails when needed. He/She said they are understaffed, so the staff did not always attempt to re-approach or complete all the task. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) F said the aides provided shaves and nail care, unless the resident has diabeties, then the nurse or podiatrist trimmed the resident's nails. He/She said the aide provide nail care and facial hair shaved on showers and as needed. He/She had noticed some residents with unkempt facial hair and long fingernails. He/She said nails should be cleaned daily. He/She said there ws an infection control concern with debris under the residents nails. He/She said staff were directed to brush hair and change clothes when they get the resident's out of bed or as needed. He/She said there are some residents who refused care. He/She said staff are educated to reapproach and then notify a nurse. During an interview on 03/28/24 3:35 PM, the administrator said aides were responsible to trim and clean resident's nail as needed. He/She said aides are directed to provide shaves as needed and brush hair and change clothes daily or as needed. He/She said if a resident had jagged nails, it could skin tear. He/She said dirty nails carry bacteria. He/She said the facility try to staff two aide and a medication technician on the memory care unit and feels there is enough staff a majority of time. He/She said staff should call the other units to get assistance if there was not enough staff to assist with resident's needs. During an interview on 03/28/24 at 3:35 PM, the Director of Nursing (DON) said aides were responsible to trim and clean resident's nail as needed. He/She said aides are directed to provide shaves as needed and brush hair and change clothes daily or as needed. He/She said if a resident had jagged nails, it could skin tear. He/She said dirty nails carry bacteria. He/She said staff should call the other units to get assistance if there was not enough staff to assist with resident's needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 42815 Based on observation, interview and record review, facility staff failed to provide an ongoing program of activities designed to meet the residents' interest on the weekends and staff failed to provide an ongoing program of activities designed to meet the residents' interests for residents who reside on the memory care unit. This had the potential to affect all residents. The facility census was 74. 1. Review of the facility's policy titled, Activity Department, dated 08/17/21, showed staff were directed to do the following: -The facility takes a holistic approach to the care of all its residents. In order to have this approach, the facility maintains an Activity Department for it's residents. The facility provides, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community; -Activities refers to any endeavor, other than routine Activities of Daily Living (ADL) in which a resident participates that is intended to enhance her/his sense of well-being and to promote or exchange physical, cognitive, and emotional health. These includes, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence; -Activities will provide 1 on 1 to any resident that do not want to participate in group activities or are not able to attend group activities. Review of the facility's Activity Calendar, dated March, 2024, showed: -Saturday, 03/02/24; 10:00 A.M., Catholic Services and 10:30 A.M. Bible Study; -Sunday, 03/03/24; 10:00 A.M., 9:00 A.M. to 11:00 A.M., TV Church; -Saturday, 03/09/24; 10:00 A.M., Catholic Services; -Sunday, 03/10/24; 10:00 A.M., 9:00 A.M. to 11:00 A.M., TV Church; -Saturday, 03/16/24; 10:00 A.M., Catholic Services and 10:30 A.M. Bible Study; -Sunday, 03/17/24; 10:00 A.M., 9:00 A.M. to 11:00 A.M., TV Church; -Saturday, 03/23/24; 10:00 A.M., Catholic Services; -Sunday, 03/24/24; 10:00 A.M., 9:00 A.M. to 11:00 A.M., TV Church; -Saturday, 03/30/24; Catholic Services and 10:30 A.M. Bible Study; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday, 03/31/24; 9:00 A.M. to 11:00 A.M., TV Church. During an interview on 03/28/24 at 10:35 A.M., Nurse Aide (NA) J said there are no weekend activities for any resident, except church, and staff do not invite the residents on the memory care unit. During an interview on 03/28/24 at 2:47 P.M., the Activity Director (AD) said there are no weekend activities. He/She did not know why there are no weekend activities. He/She said he/she just started in October. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) D said said there are no scheduled weekend activities throughout the building. During an interview on 03/28/24 at 3:35 P.M., the administrator said there are no full time activity aide on the weekends to provide scheduled activities, but staff offer church and movie activities on the weekends. During an interview on 03/28/24 at 3:35 P.M., the Director of Nursing (DON) said there are no full time activity aides on the weekends to provide scheduled activities, but staff offered church and movies on the weekends. 3. Review of the Memory Care Unit Activity Calendar showed: -Monday, 03/25/24; Did not contain documentation of an activity; -Tuesday, 03/26/25; 3:00 P.M., Sing Along with Chuck; -Wednesday, 03/27/24; 10:00 A.M., Nails, 11:00 A.M., Activity Cart, and 1:30 P.M., Painting. Observation on 03/25/24 at 2:31 P.M., showed six residents in the dining room without a staff led activity. Observation on 03/25/24 at 3:15 P.M., showed six residents by the nurse station without a staff led activity. Observation on 03/26/24 at 3:43 P.M. showed eight residents by the nurse station without a staff led activity. Observation on 03/27/24 at 11:04 A.M., showed the AD brought colored pencils and paper into the dining area. Observation showed the AD walked by residents sitting by the nurse station and he/she entered the dining room to setup pencils and paper. Observation showed the AD did not did not ask resident's who not in the dining room if they would like to attend the activity. 9. During an interview on 03/28/24 at 10:35 A.M., Nurse Aide (NA) J said residents on the memory care unit are not getting daily activities. He/She said sometimes staff will bring in activities for the residents. He/She said sometimes the AD would take a couple of residents for music, but not all residents. He/She said the memory care residents did not get to attend the holiday activities, including being excluded from the food, gift exchange, and hired musicicans. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/24 at 2:47 P.M., the AD said he/she tried to visit the memory care unit twice a week, but it is only him/her providing activities, so he/she is not always able to provide staff led activities. He/She said he/she takes some of the residents to events outside the memory care unit. He/She said there are no scheduled activities in the memory care unit. He/She said he/she had an assistant who would go to the unit one hour a day, but quit a week ago. He/She said he/she used to keep an activities down on the unit, but did not know where they went. He/She said he/she did invite all residents to activities held on the unit, but was nervous, so he/she forgot to invite all the residents to the activities yesterday. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) D said there are no daily scheduled activities in the memory care unit and he/she did not know why. He/She said he/she did know the facility was attempting to hire another AD, since there is only one activity person. During an interview on 03/28/24 at 3:35 P.M., the Administrator said some of the memory care residents are invited to the activities outside the unit, but not all residents due to staff shortage. He/She said the aides have not told him/her there are no activities games back in the unit. He/She said he/she said the aides on the memory care unit are able to provide the resident's with a half hour of activity daily. During an interview on 03/28/24 at 3:35 P.M., the Director of Nursing (DON) said the aides on the memory care unit have not told them there are no activities games on the unit. He/She said he/she believed the memory care staff could provide a half hour activity daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815 Based on observation, interview, and record review, facility staff failed to ensure the resident environment remained as free of accident hazards four resident's (#37, #47, #54 and #66) out of eleven sampled resident's when staff failed to apply the residents foot pedals to prevent accidents and propelled the residents in his/her wheelchair. The facility census was 74. 1. Review of the facility's policy titled, Wheelchair Safety, undated, showed staff were directed as follows: -It is often the responsibility of the facility staff to assist a resident from point A to point B via wheelchair/[NAME]-walker/pedal broda throughout the facility. It is utmost importance that facility staff assist with propelling the resident in the safest manner possible; -At no time should a resident be propelled by anyone while their feet are dragging on the floor. Foot pedals should be added to the resident's wheelchair to allow their feet to be elevated during transport; -In the event a resident is fatigued or for any reason unable to lift their feet while being propelled, the leg rests will be placed on the wheelchair to allow the residents' feet to rest upon while being propelled. 2. Review of Resident 37's quarterly Minimum Data Set (MDS), a federally mandated assessment tool dated 12/24/23, showed staff assessed the resident as follows: -Upper and lower left extremity impairment on one side; -Used a wheelchair; -Required extensive assistance from staff to transfer. Observation on 03/25/24 at 12:08 P.M., showed an unknown staff propelled the resident to the dining room in his/her wheelchair without foot pedals. Observation showed the resident's right heel slid the floor. Observation showed the resident's wheelchair foot pedals hung on the back of his/her wheelchair. 3. Review of Resident #47's quarterly MDS, dated [DATE], showed facility staff assessed the resident as: -Severe cognitive impairment; -Used a wheelchair; -Required supervision or touching assistance once seated in a wheelchair/scooter and can wheel at least 50 feet and make two turns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/25/24 at 2:54 P.M., showed Certified Nurse Aide (CNA) I propelled the resident in a wheelchair without foot pedals from the nurse station to the shower room. Observation showed the residents feet slid on the floor. 4. Review of Resident #54's quarterly MDS, dated [DATE], showed facility staff assessed the resident as: -Did not contain documentation of Brief Interview for Mental Status (BIMS); -Did not contain documentation of wheelchair use; -Did not contain documentation of how far the resident can wheel in a corridor or similar space. Observation on 03/25/24 at 2:52 P.M., showed CNA I propelled the resident in a wheelchair without foot pedals from the hall to the nurse station. Observation showed the resident's feet slid on the floor. 5. Review of Resident #66's admission MDS, dated [DATE], showed facility staff assessed the resident as: -Did not contain documentation of a BIMS; -Used a wheelchair; -Required substantial to maximal assistance from staff to wheel 50 feet and make two turns. Observation on 03/25/24 at 1:09 P.M., showed CNA G propelled the resident in his/her wheelchair without foot pedals out of the dinning room. Observation showed the resident's feet could be heard dragging on the floor. Observation on 03/25/24 at 2:58 P.M., showed Nurse Aide (NA) J propelled the resident in a wheelchair without foot pedals down the hall and into the dining room. Observation showed the resident's feet slid on the floor. Observation on 03/25/24 at 3:21 P.M., showed CNA I propelled the resident in a wheelchair without foot pedals from the hallway to the nurse station. Observation showed the resident's feet slid on the floor. Observation on 03/26/24 at 11:11 A.M., showed the Activity Director (AD) propelled the resident in a wheelchair without foot pedals from the nurse station into the dining room. Observation showed the resident's feet slid on the floor. Observation on 03/26/24 at 11:35 A.M., showed CNA I propelled the resident in a wheelchair without foot pedals from the dining room, to the hall, then back to the shower room. Observation showed the resident's feet slid on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/26/24 at 12:03 P.M., CNA I said staff were directed to use foot pedals when propelling a resident in a wheelchair. He/She said some of the residents had a difficult time using foot pedals because they are not able to propel themselves with their arms, but able to use their feet, so he/she did not always use foot pedals for those residents. He/She said the concern with propelling a resident without foot pedals was the potential the resident will stop the chair with their feet and fall forward. 6. During an interview on 03/28/24 at 2:55 P.M. Licensed Practical Nurse (LPN) F said staff are educated to use foot pedals when propelling a resident in a wheelchair. He/She said if staff did not use foot pedals, there is a concern the resident could hurt themselves by falling out of the chair if they put their foot down when being pushed. He/She said there was an in-service within the past month. During an interview on 03/28/24 at 2:40 P.M., the Director of Nursing (DON) said all residents who are being pushed in wheelchair should have foot pedals on the wheelchair, if they do not have foot pedals on wheelchair then the staff should get them or not push the resident. During an interview on 03/28/24 at 3:02 P.M., the administrator said residents should not be propelled in wheelchair without foot pedals. He/She said if the resident does not have foot pedals on wheelchair, the resident should be able to propel themselves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09456 42815 Based on observation, interview and record review, facility staff failed to complete entrapment assessments, review risk and benefits, side rail assessment and/or obtain consent for the use of bed rails for four (Resident #37 #47, #56, and #79) out of four sampled residents. The facility census was 74. 1. Review of the facility's Bed Safety and Bed Rails policy, dated June 2018, showed: -Assess the residents for risk of entrapment from bed rails prior to installation; -Review the risks and benefits of bed rails with the resident or resident's representative and obtain informed consent prior to installation; -Ensure that the beds dimensions are appropriate for the resident's size and weight; -Following the manufacturers recommendations and specifications for installing and maintaining bed rails; -With installation, confirm bed rails are appropriate for the size and weight of resident, regularly check for areas of possible entrapment, and check beds regularly to make sure they are installed correctly as rails may shift or loosen over time. 2. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/24/23, showed staff assessed the resident as follows: -Upper and lower left extremity impairment; -Used a wheelchair; -Required extensive assistance from staff to transfer; -Bedrails not used. Review of the resident's care plan, dated 12/24/23, showed staff assessed the resident with left sided paralysis and uses a grab bar to assist with positioning. Review of the resident's medical record, showed the record did not contain documentation staff reviewed the risk and benefits, completed side rail assessment, obtained a consent or completed a entrapment assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/24 at 11:38 A.M., showed the resident used the grab bars on his/her bed to assist with rolling from side to side during personal care. 2. Review of Resident #47's quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Did not contain documentation of bed rail use; -Required partial to moderate assistance from staff with moving from sitting on side of the bed to lying flat on the bed; move from a lying on the back to sitting on the side of the bed with feet flat on the floor and with no back support; and to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Review of the resident's medical record, showed the record did not contain documentation staff reviewed the risk and benefits, a completed side rail assessment, obtained a consent or completed a entrapment assessment. Observation on 03/27/24 10:50 A.M., showed the resident in bed with grab bars in an upright position on both sides of the bed. 3. Review of Resident #56's quarterly MDS, dated [DATE] showed staff assessed the resident as: -Impaired Physical mobility; -Cognitive status is mildly/moderately impaired; -Independent for rolling left to right in bed, sit to lying position, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer; -Independent/supervision for toileting; sometimes mentally aware of toileting needs, but frequently incontinent due to stress or urgency; -Did not use restraints. Review of the resident's medical record showed the record did not contain documentation staff reviewed the risk and benefits, obtained a consent or completed a entrapment assessment. Observation on 03/25/24 at 1:03 P.M., showed the resident in bed with the grab bar in the upright position on right side of the bed. Observation on 03/28/24 at 10:35 A.M., showed the resident in bed with the grab bar in the upright position on right side of the bed. 4. Review of Resident #79 quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively status: mildly/moderately impaired; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Supervision with bed mobility, ambulation, and transfers; -No restraints; -Occasionally incontinent of urine and bowel. Review of the resident's medical record, showed the record did not contain documentation staff reviewed the risk and benefits, a completed side rail assessment, obtained a consent or completed a entrapment assessment. Observation on 03/26/24 at 10:46 A.M., showed the resident in bed with bilateral bed rails in upright position. During an interview on 03/26/24 at 10:46 A.M., the resident said he/she didn't ask for the bed rails they were just there on bed when he/she came to this room. He/She said he/she does not use them. During an interview on 03/28/24 at 10:40 A.M., Certified Nursing assistant (CNA) G said he/she does not see the resident use his/her grab bar but said he/she may use it in the morning to sit up in bed. CNA said he/she does not know about any assessments done for grab bars. During an interview on 03/28/24 at 10:53 A.M., License Practical Nurse (LPN) F said the resident uses the grab bar for repositioning in bed. He/She said the side rail assessment is done upon admission or change of condition. He/She said a doctor's order is required for side rails, but not grab bars. 5. During interview on 03/28/24 at 2:42 P.M., the Director of Nursing (DON) said the side rail assessments are done. He/She said side rails are to help the residents turn and move in bed. During interview on 03/28/24 at 3:02 P.M., the administrator said he/she did not know there is a document for entrapment and he/she has never seen an entrapment assessment in this facility. 50422

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 39644 Based on interview and record review, facility staff failed to ensure three Nurse Aide's ((NA) NA A, NA B and NA C) completed the nurse aide training program within four months of his/her employment in the facility. The census was 74. 1. Review of the facility's Nursing Assistant Facility Requirements policy, undated, showed individuals must successfully complete a nursing assistant training program approved by the department or shall enroll in and begin the first available approved training program which is scheduled to commence within (90) days of the date of the CNAs employment and which shall be completed within four (4) months of employment. 2. Review of NA A's Certified Nurse Aide (CNA) training report, showed a hire date of 09/06/23. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program. During an interview on 3/28/24 at 1:37 P.M., the Director of nursing (DON) said he/she was told the NA had not started the program yet due to a conflict with his/her school schedule. During an interview on 3/28/24 at 3:10 P.M., the Corporate Human Resource said the NA was signed up for the March 6th class. During an interview on 3/28/24 at 3:30 P.M., the Director of Human Resource said the NA did not start the program until recently. He/She said the NA is in school and the facility had issues working with his/her schedule. 3. Review of NA B's CNA training report, showed a hire date of 11/8/23. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program. During an interview on 3/28/24 at 1:37 P.M., the DON said the NA is waiting on taking the skilled portion of the program. During an interview on 3/28/24 at 3:30 P.M., the Director of Human Resource said the NA is waiting on taking the skilled portion of the program, but he/she is unsure when the NA plans to take it. During an interview on 3/28/24 at 3:30 P.M., the Director of Human Resource said the NA started late to the program because he/she worked nights at the facility, and they struggled with the schedule. He/She said the NA needs to get the skilled portion of the program completed and is enrolled for the May session. 4. Review of NA C's CNA training report showed, hire date of 11/14/23. Review showed the NA's file did not contain documentation the NA completed a nurse aide training program. During an interview on 3/28/24 at 1:37 P.M., the DON said the NA just started the program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24 at 3:10 P.M., the Corporate Human Resource said the NA was signed up for the March 6th class. During an interview on 3/28/24 at 3:30 P.M., the Director of Human Resource said the NA was having a hard time grasping the NA position at the facility, so they were waiting to enroll him/her in the program. He/She said the NA is currently in the program. 5. During an interview on 3/28/24 at 1:37 P.M., the DON said he/she was not aware that the NA's needed to complete the training program within the four months of hire. He/She said he/she thought they just needed to be enrolled in the program within the four months. During an interview on 3/28/24 at 3:30 P.M., the Director of Human Resources said he/she was aware that the NA's needed to complete the program within four months of hire. He/She said his/her job is just to enroll the staff in the program once he/she is notified. He/She said it is the responsibility of the facility HR to make sure he/she is notified and the NAs complete the program timely. During an interview on 3/28/24 at 3:30 P.M., the Director of Human Resource said he/she is responsible for helping with the hiring process and sending all the paperwork where is needs to go, including notifying the corporate human resource to set up NA training. He/She said they try and enroll the staff in the first available training. He/She said the trainings are every four to six weeks. He/She said he/she is aware staff need to be certified within four months of hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815 Based on observation, interview, and record review, facility staff failed to store and label medications in a safe an effective manner when staff did not date the opened medication in the medication cart and staff placed nonmedication in medication strorage room refrigerator. This had the potential to affect all residents. The facility census was 74. 1. Review of the facility's policy titled, Storage of Medication, dated 2022, showed staff were directed to do the following: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner; -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean safe, and sanitary manner; -The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location; -Medications must be stored separately from food and must be labeled accordingly; -The policy did not contain direction for staff for labeling medication with the date opened. 2. Observation on [DATE] at 11:26 A.M., showed the 200 hall medication cart contained: -Four opened and undated bottle of flucticason (used to relieve symptoms of nonallergic rhinitis); -One opened and undated bottle of artificial tears (used to lubricate dry eyes); -One opened and undated bottle of eye itch relief. During an interview on [DATE] at 11:26 A.M., Certified Nurse Aide (CMT) D said staff are directed to check for an open date on opened medications. He/She said eye drops should be disposed of 30 days after being opened. He/She said the opened and unlabeled medications should have been removed from the medication cart and destroyed. He/She said he/she did not normally work on the 200 hall, so he/she did not know why the bottles were not labeled. During an interview on [DATE] at 2:55 P.M., Licensed Practical Nurse (LPN) F said the medication carts are checked daily for a dates labeled on open medications. He/She said the purpose of labeling the medications with the date opened was to ensure the medications are not administered after the expiration date. He/She said some medication are only good for a certain period of time once opened because of the concern of the medication losing it's effectiveness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:35 P.M., the Administrator said the medication carts are checked monthly by staff and the pharmacy. He/She said staff are directed to label the medication with the date opened and the expiration date. He/She said if the medication was not labeled with the date it was opened, staff are directed to bring the medication to him/her or the Director of Nursing (DON) for proper disposal. He/She said the medication technicians are educated to check to verify if it is labeled with the open date when dispensing the medications. He/She said the medication could be expired if the medication was not labeled with the date it was opened. He/She said there was an in-service on medication sometime last month. During an interview on [DATE] at 3:35 P.M., DON said the medication carts are checked monthly by staff and the pharmacy. He/She said staff are directed to label the medication with the date opened and the expiration date. He/She said if the medication was not labeled with the date it was opened, staff are directed to bring the medication to him/her for proper disposal. He/She said the medication technicians are educated to check to verify if it is labeled with the open date when dispensing the medications. He/She said there was an in-service on medication sometime last month. 3. Observation on [DATE] at 12:33 P.M. showed the medication storage room refrigerator contained: -Two bottles of soda; -Chocolate; -Butter; -Three insulin pens (an injection device to deliver preloaded insulin); -Four 32 fluid ounce containers of Med Pass 2.0 (used to add additional dietary calories and protein). During an interview on [DATE] at 12:33 P.M., CMT D said the refrigerator in the medication room is for medications only. He/She said he/she had told staff not to store their food or drinks in the medication refrigerator. During an interview on [DATE] at 2:55 P.M., LPN F said insulin pens should be stored, dated and labeled in the cart. He/She said the insulin pens should not be stored in the refrigerator with food because of the potential of cross contamination. He/She said he/she removed the pens after being told by a medication technician they were stored with food. During an interview on [DATE] at 3:35 P.M., the Administrator said there was a designated refrigerator for medications in each medication room. He/She said medications should not be stored with food, since there was a potential for contamination. He/She said there was an in-service on medication sometime last month. During an interview on [DATE] at 3:35 P.M., DON said there was a designated refrigerator for medications in each medication room. He/She said medications should not be stored with food, since there was a potential for contamination. He/She said there was an in-service on medication sometime last month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 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. 33477 Based on observation, interview and record review, the facility staff failed to allow sanitized dishes to air dry prior to stacking in storage and use to prevent the growth of food-borne pathogens. This failure has the potential to affect all residents. The facility census was 74. 1. Review of the facility's Warewashing and Storage policy dated January 2019, showed the policy directed staff to allow all washed and sanitized dinnerware, utensils, preparation and service supplies to air dry prior to storage. Observation on 03/27/24 at 9:18 A.M., showed Dietary Aide (DA) V pulled a rack of sanitized plastic cups from the mechanical dishwasher, stacked the cups together while wet and then placed the cups on a service tray on a utility cart. Observation on 03/27/24 from 9:23 A.M. to 9:32 A.M., showed DA W removed two racks of sanitized insulated plate covers from the mechanical dishwasher, stacked the covers together while wet and then placed the covers on the service. Observation showed the DA then removed a rack of sanitized glasses from the dishwasher, stacked the glasses together while wet and then placed the glasses on a tray on a utility cart. Observation showed the DA continued to remove sanitized dishes from the dishwasher, stack the dishes together while wet and then put the dishes away multiple times. During an interview on 03/27/24 at 9:32 A.M., DA V said the dishes stored on the utility cart are to be put away in the dining room service station for use at meals. The DA said dishes should be dry before they are put away and he/she just got in a hurry. During an interview on 03/27/24 at 9:34 A.M., DA W said dishes should be dry before they are put away, but he/she did not have enough room or time to let the dishes air dry before he/she put them away. During an interview on 03/27/24 at 10:05 A.M., the Dietary Manager (DM) said staff should allow sanitized dishes to air dry before they are stacked together and put away and staff are trained on this requirement. Observation on 03/27/24 at 10:40 A.M., showed eight metal food preparation and service pans stacked together wet under the counter in the cook's station. During an interview on 03/27/24 at 10:43 A.M., Cook X said the cooks are responsible to wash the pots and pans and they should be air dried before they are stacked and put away. The cook said he/she did not wash those pans that morning, but they should not be stacked together wet. Observation on 03/27/24 at 12:07 P.M., showed showed staff used wet stacked glasses and plate covers for service of food items during the lunch meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/27/24 at 1:25 P.M., the administrator said staff should allow all dishes to dry before they are put away, staff are trained on this requirement and he/she would expect the DM to monitor dish washing and storage daily when on duty as part of his/her management duties. The administrator said the DM is not expected to documented those inspections.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 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** 42815 Based on observation, interview, and record review, facility staff failed to perform appropriate hand hygiene, and glove changes during incontinence care for three (Resident #48, #65, and #37) out of three sampled residents. Facility staff failed to appropriately sanitize a multi-use glucometer (a device for monitoring blood sugars) between use for two residents (Resident #67 and #30) out of three sampled residents to prevent the spread of infection causing contaminants. The facility census was 74. 1. Review of the facility's policy titled, Hand Washing/Use of Gloves Policy and Procedure, undated, showed the purpose of this procedure is to provide guideline to employees for proper and appropriate hand washing techniques that will aid in the prevention of transmission of infections.To prevent the spread of infectious disease, when to wash/sanitize hands: -After handling used dressings, specimen containers, contaminated tissues, linen, etc.; -After contact with blood, body fluids, secretions, mucous membranes, or broken skin; -After handling items potentially contaminated with a resident's blood body fluids, excretions or secretions; -After removing gloves; -Upon completion of duty; -Gloves do not place of hand washing; however once gloves are soiled you must not touch anything clean. This includes, dressing residents, fluffing pillows, covering them with blankets, utilizing items such as transferring equipment, or wheelchairs. 2. Review of Resident #48's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/06/24, showed the following: -Severe cognitive impairment; -Required partial to moderate assistance with toileting hygiene. Observation on 03/26/24 at 9:06 A.M., showed Nurse Aide (NA) H entered the resident's room to provide care. He/She gathered supplies without performing hand hygiene and then put on gloves. Observation showed NA H left the resident's room to get perineal care wash, came back in the room, applied gloves without hand hygiene. The NA provided perineal care and with the same soiled gloves, touched the resident's side, removed the soiled brief, provided perineal care to buttocks area, touched a new brief and applied under the resident. Observation showed NA H removed the resident's soiled pants, removed his/her gloves, touched and applied the resident's clean pants, adjusted the blanket. He/She picked up the trash bags, sat them down, then touched the drawers, closets door, and lowered the resident's bed, touched the door without performing hand hygiene prior to leaving the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/09/24 at 12:45 P.M., NA H said staff are directed to perform hand hygiene and glove change when entering, exiting a residents room and when moving from a dirty to a clean task. He/She said he/she had anxiety when being watched and realized he/she missed a hand hygiene and glove change opportunity. 3. Review of Resident #65's admonition MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Required substantial to maximal assistance with toileting hygiene. Observation on 03/26/24 at 10:15 A.M., showed CNA O and CNA N entered the resident's room to provide care. CNA O and CNA N gathered supplies, did not perform hand hygiene and put on gloves. CNA O removed wash clothes from the resident's sink, squeezed them out and placed them in the dirty bag, with the same soiled gloves, CNA O placed clean washclothes into the sink and turned the water on. CNA N then used the wash clothes and provided perineal care on the genital area, he/she wiped the front area and did not clean between the residents legs. CNA N and CNA O positioned the resident to his/her side and CNA O cleaned the residents buttock area. CNA N left the room to get barrier cream and did not perform hand hygiene when he/she returned, placed gloves on and applied barrier cream to the residents buttock. With the same gloves, CNA N removed the soiled linens from the bed, placed the residents clean brief on, and assisted the resident with putting on their clothes. During an interview on 03/26/24 at 12:50 P.M., Certified Nursing Assistant (CNA) N said he/she should have washed their hands when they entered the room. CNA N said the resident legs should have been spread apart to clean front area better. He/She said they should have changed their gloves more times than they did, such as between clean and dirty task. 4. Review of Resident #37's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Upper and lower left extremity impairment; -Required extensive assistance from staff to maintain toileting hygiene. Observation on 03/26/24 at 11:38 A.M., showed CNA O and CNA N entered the resident's room to provide care. CNA N put on gloves and rolled the soiled brief under the resident, took a washcloth and washed the resident's peri-area, picked up a clean washcloth and with the same soiled gloves, washed the resident's bottom. CNA N used his/her soiled glove to dip into the balm container and placed the balm on the resident's bottom. The CNA did not change his/her gloves before he/she placed a clean brief and assisted the resident to pull up his/her pants. 5. During an interview on 03/28/24 at 2:55 P.M., Licensed Practical Nurse (LPN) F said staff are directed to perform hand hygiene before, during, and after care and between glove changes. He/She said staff should perform hand hygiene and glove change anytime moving from a dirty to a clean task. He/She said if staff did not change gloves and perform hand hygiene between task, there is an infection control issue. He/She said staff fattened an in-service on glove change and hand hygiene within the past month. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/28/24 at 3:10 P.M., the Director of Nursing (DON) said staff are expected to wash hands between glove changes, and to change gloves between clean and dirty tasks. The DON said they do not use wipes, they use wash cloths, however staff are to hold the rags under the water to allow them to get wet or place them in a basin. The DON said there is no policy on the use of wash cloths for care, but staff are not to place then in the sink due to infection control concerns and bacteria. During an interview on 03/28/24 at 3:11 P.M., the administrator said she would expect the facility staff to follow policy with hand hygiene and glove changes, and wash clothes being used for resident care should not go into the sink. 6. Review of the facility Glucometer Cleaning Policy, undated, showed staff are directed as follows: -Sanitize the glucometer with an approved germicidal or bleach wipe; -Wipe the surface on the glucometer including the test strip and USB port; -Wipe the glucometer thoroughly; the treated surface should remain visible wet for a full two minutes for it to be properly cleaned; -Let the Glucometer completely air dry prior to its next use. 7. Observation on 03/27/24 at 11:07 A.M., showed Registered Nurse (RN) E obtained Resident #67's blood sugar with the multi-use glucometer. Observation showed the RN wiped the multi-use glucometer but did not allow the surface of the glucometer to remain wet for two minutes as instructed after he/she obtained the residents blood sugar check. Observation on 03/27/24 at 11:23 A.M., showed RN E did not sanitize the multi-use glucometer with a wipe after he/she obtained Resident #45's blood sugar or before he/she entered Resident #30's room to obtain a blood sample for glucose testing. During an interview on 03/27/24, at 11:24 A.M., with RN E said he/she should have wiped off the multi-use glucometer and it should be wiped down between residents and let air dry. During an interview on 03/28/24 at 2:40 P.M., the Director of Nursing (DON) said alcohol wipes should be used to clean the multi-use glucometer between residents, lay on towel on cart to air dry for about 45 seconds to one minute. During an interview on 03/28/24 at 3:02 P.M., the administrator said the multi-use glucometer should be wiped with an alcohol-based wipe between each use. He/She said he/she was unsure if wipes are on the carts and he/she is unsure of the process for cleaning the meters. 50422

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 47193 Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor antibiotic use. This deficient practice had the potential to affect all residents in the facility. The facility census was 74. 1. Review of the facility's policy titled, Antibiotic Stewardship, undated,showed as a facility, the facility will do the following to improve antibiotic use: -Review and monitor for trending during weekly risk meeting; -Commit resources for monitoring antibiotic use and providing feedback to staff; -Develop facility-specific standards for empiric antibiotic use, based on data from the facility; -Review antibiotic appropriateness and resistance patterns on a regular basis. Review of the facility's antibiotic stewardship program showed facility staff did not track antibiotic trends. During an interview on 03/28/24 at 10:45 A.M., the Assistant Director of Nursing (ADON) said they track antibiotics through a report generated by their electronic medical record (EMR). He/She said he/she looks at the information sometimes weekly to every few weeks but was not tracking or trending the antibiotic use in the facility. He/She said the facility staff were recording the antibiotic use but did not perform any follow up with the information. During an interview on 03/28/24 at 10:52 A.M., the Director of nursing (DON) said they do a risk assessment meeting, and he/she takes notes over who is on antibiotics and why, but they do not go over trends. During an interview on 03/28/24 at 12:34 P.M., the administrator said he/she does not know any information on antibiotic stewardship. He/She said all he/she knows if they go over antibiotic use in their morning meetings, but do not go over any trends.