

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER West Vue Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Davis Drive West Plains, MO 65775	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47445</p> <p>Based on observation, interview, and record review, the facility failed to follow physician's orders by not obtaining the segmental pressures (the measurement of blood pressures at different points along the leg to assess for potential blockages in the arteries) as ordered and for not obtaining the arterial duplex (a non-invasive imaging procedure that uses ultrasound technology to examine the blood flow in the main arteries of both legs) in a timely manner for one resident (Resident #28) out of one sampled resident. The census was 115.</p> <p>The facility did not provide a policy on following physician orders.</p> <p>1. Review of Resident #28's Physician's Order Sheet (POS), dated 11/14/24, showed:</p> <ul style="list-style-type: none"> - Diagnosis of hypertension (HTN - high blood pressure); - An order for segmental pressures bilateral (both) lower extremities, dated 11/14/24. <p>Review of the resident's Provider Progress Notes, dated 11/14/24, showed:</p> <ul style="list-style-type: none"> - Order for arterial duplex bilateral lower extremities. <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> - No documentation the segmental pressures bilateral lower extremities, ordered on 11/14/24, was completed; - No documentation of a segmental pressures bilateral lower extremities findings report. <p>Review of the resident's Arterial Duplex report, completed on 01/23/23 and dated 01/24/25, showed:</p> <ul style="list-style-type: none"> - Findings consistent with mild peripheral vascular disease (a circulatory condition that occurs when blood vessels narrow, spasm, or become blocked outside of the heart and brain) without occlusion, right lower extremity; - Findings consistent with moderate peripheral vascular disease without occlusion, left lower extremity; <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Moderate stenosis (abnormal narrowing of a passageway in the body, such as a blood vessel, canal, or organ) between the left mid superficial femoral artery (SFA - major artery in the lower extremity) and the distal (far) SFA; - Moderate stenosis (50-75%) of the left mid SFA; - Mild plaque (a buildup of cholesterol, fat, and other substances that can narrow or block arteries) was noted within the visualized arteries, right; - Moderate plaque was noted within visualized arteries, left. <p>Observations on 01/23/25 at 1:36 P.M., showed Resident #28 lay in bed with his/her bilateral legs and feet with no discoloration and dry, flaky skin. The resident complained of pain when LPN E touched his/her feet. He/She said the top and bottom of his/her left toes hurt. The resident had facial grimacing and said the pain was in the bottom of the foot, mostly at the arch.</p> <p>During an interview on 01/23/24 at 11:00 A.M., the Director of Nursing (DON) said the order for the segmental pressure bilateral lower extremities related to discoloring and increased pain was not followed up on, clarified, or completed due to the order not being put in the system. No one followed up on the NP Progress Note, dated 11/14/24, to check for an order which was where the arterial duplex bilateral lower extremities order was located.</p> <p>During an interview on 01/23/25 at 1:36 P.M., CNA C said the resident had been complaining about his/her feet hurting, especially when his/her shoes were put on. CNA C said he/she reported the discoloration, swelling, pain, and if there were any spots on the feet, like pressure spots, to the nurse.</p> <p>During an interview on 01/23/25 at 1:36 P.M., LPN E said Resident #28 had pain in his/her legs and feet, and they were doing the arterial duplex today. The resident had pain when the NP was here on 11/14/24. The left foot was cooler to the touch currently but he/she could feel the pulse on the top of the foot.</p> <p>During an observation and interview on 01/24/25 at 10:40 A.M., Resident #28 said sometimes he/she told the staff his/her feet hurt. The nurse would provide Tylenol, but it didn't always help. The bottom of his/her feet hurt now. The resident sat up in a recliner with the bilateral lower extremities resting on a pillow on the footrest and had non-slip socks on his/her feet.</p> <p>During an interview on 11/24/25 at 12:02 P.M., the DON said If tests or labs were ordered, she usually checked daily for results to let the physician know. She expected physician orders to be followed. She was not aware there was a new order for imaging for Resident #28 on 11/14/24.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>37575</p> <p>Based on interview and record review, the facility failed to ensure an appropriate diagnosis for the use of an antipsychotic (a medication used to treat symptoms of psychosis, such as hallucinations and delusions) medication for one resident (Resident #16) and to limit the use of an as needed (PRN) order for psychotropic (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviors) medication to 14 days for two residents (Residents #71 and #267) out of six sampled residents. The facility census was 115.</p> <p>The facility did not provide a policy for an appropriate diagnosis for antipsychotic medication and PRN psychotropic medication use.</p> <p>1. Review of Resident #16's January 2025 Physicians Order Sheet (POS) showed:</p> <ul style="list-style-type: none"> - Diagnoses of unspecified dementia (a condition characterized by progressive loss of memory and thinking, sometimes resulting in personality change, resulting from disease of the brain), unspecified severity, with other behavior weakness (specific type of dementia is unknown, the severity is not clearly defined, and the patient exhibits behavioral disturbances beyond just memory loss, potentially including things like agitation, mood swings, social disinhibition, or unusual behaviors), anxiety disorder a mental health disorder characterized by feelings of worry, or fear that can be strong enough to interfere with daily activities), and epilepsy (a chronic neurological condition characterized by recurrent seizures, which are brief episodes of abnormal brain activity); - An order for Abilify (an antipsychotic medication) 10 milligram (mg) by mouth every day for unspecified dementia, unspecified severity, with other behavior weakness, dated 10/04/23; - Specific behaviors were not identified or addressed; - The facility failed to provide an appropriate diagnosis for the Abilify medication use. <p>Observations of the resident on 01/21/25, showed:</p> <ul style="list-style-type: none"> - At 11:18 A.M., the resident sat in a wheelchair at the dining room table waiting for lunch and with nonsensical speech; - At 12:25 P.M., the resident sat quietly in a wheelchair at the dining room table feeding self with assistance of staff; - At 3:15 P.M., the resident sat quietly in a wheelchair at the dining room table holding a doll. <p>Observations of the resident on 01/22/25, showed:</p> <ul style="list-style-type: none"> - At 9:30 A.M., the resident sat in a wheelchair at the dining room table yelling with nonsensical speech; <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 12:40 P.M., the resident sat in a wheelchair quietly feeding self and consumed 90% of lunch with assistance from staff;</p> <p>- At 2:45 P.M., the resident sat quietly in a wheelchair at the dining room table holding a doll.</p> <p>Observations of the resident on 01/23/25, showed:</p> <p>- At 11:30 A.M., the resident sat in a wheelchair quietly at the dining room table;</p> <p>- At 3:50 A.M., the resident lay quietly in bed.</p> <p>Observations of the resident on 01/24/25, showed:</p> <p>- At 8:38 A.M., the resident sat in a wheelchair at the dining room table holding a doll and laughing;</p> <p>- At 2:45 P.M., the resident sat quietly in a wheelchair at the dining room table during an activity.</p> <p>During an interview on 01/24/25 at 11:35 A.M., Licensed Practical Nurse (LPN) B said Resident #16 did yell out with nonsensical speech at times in the dining room when aggravated. The resident had been taking Abilify 10 mg for at least a year.</p> <p>2. Review of Resident #71's January 2025 POS showed:</p> <p>- Diagnoses of dementia, anxiety disorder and insomnia (difficulty sleeping);</p> <p>- An order for hydroxyzine (an antianxiety medication) 25 mg three times a day PRN for agitation for anxiety, dated 11/11/24, with no stop date;</p> <p>- The facility failed to provide a 14 day stop date order for the hydroxyzine PRN order.</p> <p>3. Review of Resident #267's January 2025 POS showed:</p> <p>- Diagnosis of depression (a serious medical illness that negatively affects how you feel, the way you think and how you act);</p> <p>- An order for lorazepam (an antianxiety medication) 2 mg/milliliter (ml) concentrate 0.25 ml to 1 ml sublingual (applied under the tongue) every one hour PRN for anxiety/restlessness, dated 01/15/25, with no stop date;</p> <p>- The facility failed to provide a 14 day stop date order for the lorazepam PRN order.</p> <p>During an interview on 01/22/25 at 1:24 P.M., Registered Nurse (RN) A said he/she was unaware PRN psychotropic medications required a stop date.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/24/25 at 10:52 A.M., the Director of Nursing (DON) said she would expect PRN psychotropic medications to have a 14 day stop date, or the physician would need reevaluate the resident for an extended period stop date.</p> <p>During an interview on 01/24/25 at 10:57 A.M., the Administrator said she would expect PRN psychotropic medications to have a stop date. If not for 14 days, then the order should be written for an extended period with a stop date, and the physician would have to reevaluate the resident before reordering.</p> <p>During an interview on 01/24/25 10:30 A.M., the DON said she would expect all antipsychotic medications to have a proper diagnosis when prescribed and for her staff to be knowledgeable of this.</p> <p>During interview on 01/24/25 10:55 A.M., the Administrator said she would expect a proper diagnosis for antipsychotics to be in place when a physician orders the medications.</p> <p>46521</p> <p>49150</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46521</p> <p>Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 115.</p> <p>Review of the facility's policy titled, Sanitation, revised April 2014, showed:</p> <ul style="list-style-type: none"> - The food service area shall be maintained in a clean and sanitary manner; - All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects; - All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seams, and cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair; - If a sink is used for washing utensils, cooking equipment, or dishes, and also used to wash produce or thaw food, it will be cleaned between uses with an approved cleaning and sanitizing agent; - Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime (dirt ingrained on the surface of something); - Food Service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. <p>1. Observations on 01/21/25 at 11:12 A.M., and 01/24/25 at 10:13 A.M., of the kitchen showed:</p> <ul style="list-style-type: none"> - One partially full five-gallon clear plastic storage bin with powdered milk undated and unlabeled near the walk-in freezer; - The floor area behind the tilt skillet fryer with a glue trap, five attached bugs, and an electrical connection box with an oily film build up and brown grime; - Ice machine with white build up on the exterior surfaces; - The commercial style can opener with an oily film and white substance on the blade; - The walk-in refrigerator with scattered food debris and a pooled white liquid on the floor approximately 1 inch (in.) deep, below the left side food shelves with white grime build up; - The floor below the reach-in freezer, reach-in refrigerator, range, deep fryer, and ice machine, with scattered debris and an oily film; - The microwave oven interior with food debris build-up along the top surface; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - The dishwasher with white build up on the exterior surfaces; - The floor below the dishwashing area counters with white build up; - A 10 foot (ft.) section of approximately 1 in. deep pooled water in the dishwasher and disposal sink area; - The sink disposal drain area with yellow food debris and white grime build up in the sink basin; - The air curtain (a device used to prevent air, contaminants or flying insects from moving from one space to another) above the back exterior door near the dry food storage room with a brown build up along the ventilation louvers; - The circular fan near the supply closet with a brown build up on the front and back guard; - One 6 ounce (oz.) red plastic drink cup, scattered food debris, and a glue trap with six bugs below a food shelf with drink supplements near the dry food storage room. <p>2. Observation on 01/21/25 at 11:15 A.M., of the walk-in freezer showed:</p> <ul style="list-style-type: none"> - The floor near the door with approximately a 3 ft. diameter (dia.) area with ice build up; - Ice build up on most of the food shelving, ventilation louvers, and the ceiling area near the ventilation louvers approximately 1 in. thick; - One 5 pound (lb.) bag of fried okra dated, October 2025, covered with ice build up one-half in. thick; - One 4 lb. bag of mixed vegetables dated, November 2026, covered with ice build up one-half in thick; - Six 3 lb. packages of country ribs dated, October 2025, covered with ice build up one-half in. thick; - One 3 lb. bag of hash brown potatoes undated, covered with ice build up one-half in. thick. <p>3. Observations on 01/21/25 at 11:22 A.M., and 01/24/25 at 10:23 A.M., of the dry food storage area showed:</p> <ul style="list-style-type: none"> - Two 6 lb. 12 oz. tapioca pudding cans undated, with a brown substance; - Scattered food debris and three individually wrapped cookies lay in the floor along the walls below the food shelves; - A 55.115 lb. brown sack of dried buttermilk mix lay on the floor beside a large 4 in. metal pipe; <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- A cardboard box with 72 individual containers of 4 oz applesauce cups lay on the floor beside the metal food racks.</p> <p>During an interview on 01/21/25 at 11:22 A.M., Dietary Aide (DA) F said he/she normally rinsed the food waste down the sink but must have missed a spot this morning. Water splashed out of the sink when rinsing dishes off and created a large pool of water in the floor in front of the dishwashing area and it had to be swept toward the floor drain.</p> <p>During an interview on 01/21/25 at 11:32 A.M., the Dietary Manager (DM) said the order for lime scale remover that removed the white build up from the ice machine had been ordered over a month ago but had been delayed. The air curtain and fan in the dishwashing area should not have dust build up on the louvers and will need to be cleaned by maintenance. An outside service company checked on the freezer about three months ago, but the ice build up occurred since the last service and should not be there. The Maintenance Director had been made aware of the frost build up in the walk-in freezer. The ice was normally scooped out when it was serviced. There were cleaning logs, and it was on the list to clean under the shelving, but those areas would need more work. Food containers should not have been placed on the floor in the dry storage area.</p> <p>4. Observation on 01/24/25 at 8:12 A.M., of the Whispering Pines kitchen showed:</p> <p>- One 12 in. x 12 in. ceiling diffuser (one of the few visible parts of an air conditioning system) with dust build up and a brown substance on the front exterior surfaces near the food shelves.</p> <p>5. Observation on 01/24/25 at 8:27 A.M., of the Flowering Dogwood kitchen showed:</p> <p>- The ice machine and refrigerator dispenser with a white substance along the outer surfaces and a brown substance on the ice machine ventilation louvers near the floor.</p> <p>6. Observation on 01/24/25 at 8:35 A.M., of the Sleepy Oaks kitchen showed:</p> <p>- The dry food storage area floor with food debris below the shelves;</p> <p>- The top refrigerator shelf with a 2 in. dia. area of a red substance and black debris inside the door shelves;</p> <p>- The oven interior with a 1 in. diameter dried yellow substance near the door seal;</p> <p>- 12 recessed lighting canisters with a brown build up along the interior surface.</p> <p>During an interview on 01/24/25 at 8:47 A.M., DA G said the floors were normally swept after breakfast and should not have food debris near the shelves. The oven and refrigerator would have to be cleaned and should not have signs of grime or food debris.</p> <p>During an interview on 01/24/25 at 8:55 A.M., the DM said the recessed lighting housings should be clean and the maintenance department would have to be contacted and asked to clean. The floor should have been cleaned in the dry foods area. The refrigerator shelves with a dried red substance on the shelves and the door shelves should have already been cleaned. The oven should be clean inside and not have any grime build up.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 01/24/25 at 10:13 A.M., the Administrator said the dishwashing sink sprayer may need to be adjusted or replaced to prevent water from splashing in the floor. The freezer and some food items should not have frost and ice build up and the gasket had been replaced. The freezer would need to be checked to see what caused the issue. The ceiling vents and lighting should be kept clean. Food should not be stored on the floor and should be labeled and dated. Floor areas below the appliances should be clean and the refrigerator spills should not be left to dry.</p> <p>During an interview on 01/24/25 at 12:47 P.M., the Maintenance Director said he/she oversaw the cleaning and servicing for the walk-in freezer. Some of the ice build-up had been removed and it should not be there. The ceiling ventilation louvers and light fixtures in the kitchens with brown build up would need to be cleaned.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, homelike environment. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 115.</p> <p>The facility did not provide a policy for a homelike environment.</p> <p>1. Observation on 01/24/25 at 8:05 A.M., of room [ROOM NUMBER] showed:</p> <p>-13 figurines from 1 inch (in.) to 3 in. tall on the light fixture beside the chair.</p> <p>2. Observation on 01/24/25 at 8:10 A.M., of room [ROOM NUMBER] showed:</p> <p>- Eight figurines from 1 in. to 4 in. tall on the light fixture above the right side of the bed.</p> <p>3. Observation on 01/24/25 at 8:15 A.M., of room [ROOM NUMBER] showed:</p> <p>- One 8 in. by 10 in. picture frame, one 8 in. by 5 in. picture frame, six stuff animals 4 in. tall, and one 12 in. gnome on the light fixture beside the chair.</p> <p>4. Observation on 01/24/25 at 8:20 A.M., of room [ROOM NUMBER] showed:</p> <p>- One figurine approximately 5 in. tall and one plaque 8 in. by 5 in. on the light fixture above the bed.</p> <p>5. Observation on 01/24/25 at 8:35 A.M., of room [ROOM NUMBER] showed:</p> <p>- Two decorative objects approximately 5 in. tall and three 5 in. by 7 in. picture frames on the light fixture above the bed.</p> <p>6. Observation on 01/24/25 at 8:39 A.M., of room [ROOM NUMBER] showed:</p> <p>- Two angel figurines and a cross figurine from 6 in. to 8 in. tall on the top of the light fixture and one 6 in. snowman stuck to the front of the light fixture beside the bed.</p> <p>7. Observation on 01/24/25 at 8:43 A.M., of room [ROOM NUMBER] showed:</p> <p>- One ball cap hung on the corner of the light fixture beside the bed.</p> <p>During an interview on 01/24/25 at 8:58 A.M., the Maintenance Supervisor said some residents did have items on their lights. The facility didn't recommend that being done.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/24/25 at 11:50 A.M., the Director of Nursing (DON) said it was not recommended but it happened. The residents usually had to purchase the shelves themselves and then the shelves were put up.</p> <p>During an interview on 01/24/25 at 12:05 P.M., the Administrator said items should not be on top of light fixtures in resident rooms. She would expect staff to inform maintenance and shelves be put up for the residents' belongings.</p> <p>47445</p>		