STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265182	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Nursing Center	1700 South Hudson Avenue Aurora, MO 65605

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** 41787 Based on observation and interview, the facility failed to maintain a facility temperature range of 71 to 81 degrees Fahrenheit (F) and at a comfortable level of the residents in resident rooms and common areas accessible to residents affecting ten residents (Residents #160, #14, #52, #25, #50, #32, #31, #41 ,#35, and #45) out of a sample of 26 residents. The facility census was 60. Review showed the facility did not provide a policy regarding facility heating and cooling system or monitoring of facility temperature for resident comfort. 1. Review of the National Weather Service (website weather.gov) showed on 04/07/24 the high temperature measured 71.6 degrees F. 2. Review of Resident #160's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by the facility), dated 04/08/24, showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included multiple sclerosis (MS - a long-lasting (chronic) disease of the central nervous system, that impacts the brain and spinal cord, which make up the central nervous system and controls everything one does). Observation and interview on 04/07/24, at 5:21 P.M., showed the following: -The temperature of the dining area measured 81.6 degrees F; -The resident said the building was often hot which caused his/her MS symptoms to be worse. 3. Observation on 04/07/24, at 5:35 P.M., showed the following: -The thermostat on the wall at the beginning of the 500 hall showed a temperature of 78 degrees F with a thermostat setting at 70 degrees F; -The temperature on the hall in the common area by the nurses' desk measured 84 degrees F; (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The temperature on the 200 hall measured 82 degrees F. 4. Observation on 04/7/24, at 6:12 P.M., of the thermostat on the 400 hall (unit) showed the temperature measured 79 degrees F with two windows open in the dining room. 5. Review of the National Weather Service (website weather.gov) showed on 04/08/24, the high outside temperature measured 78 degrees F. 6. Review of Resident #14's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease the causes obstructed airflow from the lungs) and congestive heart failure (CHF - a long-term condition in which the heart can't pump blood well enough to meet the body's needs). Review of the resident's admission MDS, dated [DATE], showed moderate cognitive impairment. During an observation and interview on 04/08/24, at 12:15 P.M., the resident called the surveyor into his/her room and said it was warm and requested the fan turned on. The resident sat in his/her recliner with a short-sleeved shirt and shorts on. Registered Nurse (RN) F entered the room and reported the air conditioner comes on in May due to the building being old. He/she said the building had only heat or air at one time possibly due to a boiler system. During an observation on 04/08/24, at 3:51 P.M., the resident sat in his/her room in a recliner with the curtains closed and a fan on. The temperature of the room measured as 82.2 degrees F based on thermometer reading. 7. Review of Resident #52's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included pneumonia and respiratory failure (condition in which the blood doesn't have enough oxygen or has too much carbon dioxide) Review of Resident #25's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included COPD with acute exacerbation (episode of symptom worsening). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/08/24, at 3:37 P.M., of Resident #52's and Resident #25's room showed the room had a fan on and the room temperature measured 82.8 degrees F. The residents said their room was always hot and the only time it was cool was in the winter. Resident #52 said that when he/she laid down, his/her back sweat and caused the sheets to be wet due to being too warm in the room. 8. Review of Resident #50's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included end-stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own). Observation and interview on 04/08/24, at 3:46 P.M., showed the resident's room temperature measured 82. 4 degrees F. The resident said it was too hot most of the time in his/her room. There was no fan in the resident's room. 9. Review of Resident #32's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included diabetes. Observation and interview on 04/08/24, at 3:52 P.M., showed the room temperature measured 81.6 degrees F with the window open. The resident said that his/her room was too warm and caused him/her to sweat. 10. Review of Resident #31's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included respiratory failure and heart failure. Review of Resident #41's quarterly MDS, 03/20/24, showed the following: -admitted [DATE]; -Severe cognitive impairment; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Observation on 04/08/24, at 4:00 P.M., showed the residents' room temperature measured 81.9 degrees F with the window open and fan on. The residents said it was warm in the room. 11. Review of Resident #35's annual MDS, dated [DATE], showed the following: -admitted [DATE]; -Severe cognitive impairment; -Diagnoses included hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side and dementia. Review of Resident #45 quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; -Cognitively intact; -Diagnoses included hip fracture and dementia. Observation on 04/08/24, at 4:10 P.M., showed the residents' room temperature measured 81.2 degrees F. 12. During an interview on 04/7/24, at 6:12 P.M., Certified Nurse Aide (CNA) GG said the following: -It was constantly hot on the unit since the weather started getting nice outside; --He/she tells the charge nurse when the unit is uncomfortable because of the temperature; -One resident complained yesterday that it was hot on the unit; -He/she opened the windows in the dining room, because it was very warm. During an interview on 04/7/24, at 6:15 P.M., CNA HH said the following: -The temperature on the unit is pretty warm; -The unit stays hot even when the air conditioning is on; -The residents have complained in the past about the unit being too warm; -He/she was told the heat to the facility could not be turned off until a certain date; -The windows in the dining room were open because it was too hot; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One resident's family member opened the resident's window and brought in a fan for the resident, because his/her room is too warm. During an interview on 04/08/24, at 4:32 P.M., the Maintenance Director said the facility heating and cooling system was either hot or cold. It is a boiler and chiller system and it is either off or on. Usually, the facility changes from heat to air conditioner on April 15th of each year. This was the first day he was made aware that residents complained of being hot. He would be contacting the contractor for the system to schedule the switch to cool for the following Friday. He had not been monitoring the facility or resident room temperatures unless someone complained. If it was too hot, the facility would provide fans and open windows. The facility also had a portable AC cooler/heater that could be taken to rooms if a resident was too uncomfortable. During an interview on 04/11/24, at 12:03 P.M., the Assistant Director of Nursing (ADON) said if any residents complained of being too hot or too cold, staff could adjust the thermostat on the wall or on the unit in the resident room. Staff could open a window or provide a fan. If that did not resolve the issue staff could notify the Director of Nursing (DON), Administrator, and/or maintenance staff. During an interview on 04/12/24, at 1:53 P.M., with the Administrator and the Corporate Director of Clinical Operations, the Administrator said staff should monitor building temperatures. Staff should be going around with temperature gauge. The facility does not have an actual policy on that, but it should be done any time it is perceived that someone is uncomfortable. The Maintenance Director would be responsible, but it ultimately falls on the administrator. 48534 49585 34871

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25513 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #48), who is non-verbal and dependent on staff for all personal needs and mobility, was free from mental abuse by staff when one staff member, Certified Nurse Aide (CNA) S, purposely made comments to the resident to upset him/her. The resident was visually upset when discussing the CNA and the comments made to him/her, including becoming red faced, teary eyed, reaching out his/her arm and grunting. A sample of 26 residents was reviewed in a facility with a census of 60. On 2/8/24, SLCR completed a complaint investigation at the facility regarding an allegation of the resident not being treated with dignity and was unable to verify deficient practice occurred. A reinvestigation began during the recertification survey. As a result of the findings of the investigation, the Administrator was notified on 04/10/24, at 6:26 P.M., of an Immediate Jeopardy (IJ). The IJ was removed on 04/11/2024, as confirmed by surveyor onsite verification. Review of the facility's Abuse Prevention Policy, dated 2021, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. -Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain or mental anguish. It includes verbal abuse, and mental abuse. Willful, as used in this definition of abuse, means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Mental abuse includes but is not limited to, humiliation, harassment, and threats of punishment or deprivation. -Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are limited to threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. 1. Review of Resident #48's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included stroke, aphasia (a language disorder that affects how one speaks and understands language), reduced mobility, and weakness. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff), dated 02/01/24, showed the following: -Unclear speech-slurred or mumbled words; -Sometimes makes self understood-responds adequately to simple, direct communication only; -Sometimes able to understand others - responds adequately to simple, direct communication only; -Severely impaired cognitive skills; -Felt or appeared down, depressed or hopeless nearly every day; -Upper extremity (shoulder, elbow, wrist, hand) functional limitation in range of motion, impaired on one side; -Used a wheelchair for mobility; -Dependent on staff for personal, oral and toileting hygiene, lower extremity dressing, bathing, and all modes of mobility. Review of the resident's current care plan, revised on 02/02/24, showed the following information: -The resident had a communication problem; -Staff to monitor for and record confounding problems decline in cognitive status, mood, and decline in activities of daily living (ADLs); -Staff to monitor and document frustration level. Staff should wait 30 seconds before providing resident with word; -Use communication techniques which enhance interaction; allow adequate time to respond, repeat as necessary, do not rush, request feedback and clarification from the resident to ensure understanding, face when speaking and make eye contact, reduce environmental noise, and ask yes/no questions if appropriate. Use simple, brief, consistent words/cues, use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs and pictures; -Validate the resident's message by repeating aloud; -The resident has impaired cognitive function and dementia or impaired thought processes; -Communicate with the resident, family, caregivers regarding resident's capabilities and needs; -Use preferred name and identify yourself with each interaction. The resident understands consistent, simple directive sentences. Provide the resident with necessary cues-stop and return if the resident becomes agitated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNA Q's handwritten statement, dated 01/07/24 and provided to the State Agency on 04/10/24 by CNA Q, showed the following: -On more than one occasion he/she heard and witnessed comments being made to the resident, saying I hope you dream of [descriptor] people, because they (CNA S and CNA V) heard the resident was a racist. They did not want to help the resident at any time. During interviews conducted on 04/09/24, at 12:08 P.M., and on 04/10/24, at 10:02 A.M., CNA Q said the following: -He/she worked the night shift in December 2023 with CNA S; -CNA S made statements in the past about how he/she did not want to assist the resident and how he/she could not stand the resident because he/she heard stories the resident was racist; -The resident was nonverbal, but could make noises and sounds, shake his/her head yes or no, and scream; -The resident's roommate did not get along with CNA S so when CNA Q worked, he/she often assisted the resident's roommate; -On 12/30/23, CNA Q worked the night shift with CNA S and CNA V. That night, when CNA Q assisted the resident's roommate. He/she heard CNA S tell the resident, he/she hoped he/she (the resident) dreamed of [descriptor] people. CNA Q heard CNA S say this to the resident two times on 12/30/23 and one time on 12/31/23. CNA Q did not tell the night nurse because she did not trust him/her. He/she did not tell the day shift nurses because at the time, he/she did not know them; -On 01/07/24, CNA Q worked the day shift and assisted the resident up the hall towards the nurses' station. When the resident saw CNA S, he/she planted his/her feet onto the ground and grunted, screamed, and pointed at CNA S. After the incident, CNA Q tried to console the resident and wheeled him/her to his/her room. The resident was upset and had tears in his/her eyes; -Licensed Practical Nurse (LPN) D and Registered Nurse (RN) F saw the resident's response to CNA S and wondered what happened. CNA Q told LPN D and RN F about the incidents that occurred the weekend before; -RN F interviewed the resident about the incident and he/she became tearful; -The facility hired a new Administrator who started last Friday (04/05/24). CNA Q told the new Administrator about the incident regarding the resident because he/she did not want her blindsided. Review of a CNA CC's handwritten statement, dated 01/07/24 and provided to the State Agency on 04/10/24 by LPN D (the nurse who collected the statement and sent to the ADON), showed CNA CC documented there was a day when CNA S was giving him/her report and he/she made a comment about how the resident was completely racist and he/she sometimes told him/her Good night, hope you dream of [descriptor] people. During an interview on 04/10/24, at 3:25 P.M., CNA CC said the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews conducted on 04/09/24, at 12:30 P.M., and on 04/10/24, at 12:17 P.M., LPN D said the following: -He/she did not remember the date, but one morning, during shift report, he/she heard a noise and looked up to find the source. The resident sat in his/her wheelchair, near the nurses' station, with his/her feet planted firmly on the floor seemingly to prevent CNA Q from pushing him/her further down the hall. The resident pointed his/her finger at CNA S's face, yelling angrily. CNA Q saw the resident's reaction to CNA S and asked the resident if he/she was okay and if he/she was hurt. The resident grunted and indicated he/she was not hurt; -CMT DD asked CNA S why the resident responded that way and CNA S said I guess he/she's mad at me; -LPN D said he/she could tell the resident was frustrated and scared all at the same time; -CNA Q and CNA W then told LPN D and RN F that CNA S and CNA V whispered to the resident at night, I hope you dream about [descriptor] people. That was significant because there were rumors the resident was racist. LPN D considered what the CNAs said to be verbal abuse. The nurse did not document this incident because RN F took responsibility for the hall; -Anytime CNA S was on shift, the resident's demeanor changed. It was difficult to describe how it changed but LPN D noticed a change. During an interview on 04/11/24, at 1:15 P.M., CMT DD said the following: -A few months ago in the early morning, the resident sat in his/her wheelchair in the hall. The resident saw CNA S and pointed, shook and grunted at CNA S. The resident tried to back up in his/her wheelchair like he/she was trying to get away from CNA S. The look on the resident's face was fear. The resident never acted like that before; -CNA CC told CMT DD said that CNA S told him/her that he/she tells the resident he/she hoped the resident dreamed of [descriptor] people tonight. CMT DD thought this was a significant statement because he/she did not think the resident cared for [descriptor] people. During an interview on 04/10/24, at 9:18 A.M., CNA R said the following: -The resident did not talk and communicated with actions such as putting his/her feet down if he/she did not want to go somewhere; -He/she wrote a statement about the incident that occurred on 01/07/24 between the resident and CNA S, and slid it under the former DON's office door. Review of the resident's January 2024, February 2024, and March 2024 progress notes showed staff did not document the incident that occurred on 01/07/24 or of the information obtained regarding CNA S's statements. During an interview on 04/10/24, at 12:39 P.M., the ADON said the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-If staff told her or she heard an allegation of abuse, she obtained statements from staff and completed an assessment of the resident. She then reported the allegation to the DON, who contacted the Administrator. The Administrator then contacted the Regional Clinical Director (RCD). The DON or Administrator investigated the allegation. The DON or Administrator consulted with the RCD, and if she agreed, the Administrator would call in a self-report to the state agency; -The nurses should document the allegation in a progress note. The nurses also complete an incident report and the DON or Administrator would review it; -She did not know the entire story regarding the resident, but thought it occurred a couple months ago. A staff member told her that another staff member told the resident he/she hoped the resident dreamed of [descriptor] people. The ADON did not know who told her or who said this to the resident. The ADON was on call around that time, but nobody sent her any pictures of statements related to CNA S or the resident; -The former DON and former Administrator already knew about the incident when she reported it to them. -She considered the statement about dreaming about [descriptor] people as verbal abuse. During an interview on 4/10/24, at 4:02 P.M., the former DON said the following: -On 01/07/24, the ADON sent the former DON, via phone, employee statements that alleged when CNA S and CNA V assisted the resident to bed, they would say they hoped he/she dreamed about [descriptor] people. The former DON did not know why the staff would say this to the resident. She did not know anything about the resident's past; -The former Administrator told the former DON, that even though the CNA's comments were not considered abusive statements, corporate staff told her (the former Administrator) they needed to investigate or talk to other residents to ensure there was not something else going on with CNA S. The former DON talked with other residents regarding staff treatment of them with no identified problems. During an interview conducted on 04/11/24, at 12:17 P.M., the former Administrator said the following: -On 01/07/24, CNA S assisted the resident and the resident became upset with him/her in the hallway on his/her way to breakfast. That behavior was not abnormal for the resident because sometimes he/she did not want to go to breakfast; -On Monday morning (01/08/24) the former DON brought her paper statements from CNA Q and CMT DD. which accused CNA S of telling the resident that he/she hoped he/she (the resident) dreamed of [descriptor] people; -The former Administrator thought the statement about dreaming of [descriptor] people was borderline abuse. Observation and interview on 4/10/24, at 5:05 P.M., showed the following: (continued on next page)

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	265182	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Nursing Center	1700 South Hudson Avenue Aurora, MO 65605

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident laid in bed with his/her eyes closed. RN F entered the resident's room and lightly touched his/her shoulder. The resident opened his/her eyes. The RN asked the resident if he/she remembered talking about CNA S? The resident grunted in reply. The RN asked the resident if CNA S was ever mean to him/her and he/she grunted. RN F asked the resident if she ever whispered in his/her ear I hope you dream of [descriptor] people. The resident grimaced then loudly grunted. He/she tried to sit up and raised his/her left arm. The resident was clearly upset and tried to communicate by angrily grunting/yelling, and firmly shutting his/her eyes. RN F placed his/her right hand in the resident's hand and the resident calmed. After speaking with the resident briefly ensuring he/she was calm, the RN left the room. -RN F said the resident was having an off day. He/she usually communicated more verbally with the RN. He/she said the resident expressed anger by attempting to sit up and by raising his/her arm in the air. In a statement written by RN F, dated 5/10/24, she wrote that during the interview with the surveyor she asked the resident if he/she remembered when she asked him questions awhile back about CNA S and he/she grunted his reply as in yes. When asked if CNA S was ever mean to him/her, the resident grunted yes. When asked if when she put him/her to bed at night if she ever whispered in his/her ear I hope you dream of [descriptor] people, the resident got red faced, teary eyed, and started reaching his/her left arm out and grunting, trying to speak with his/her stroke, he/she is unable to verbally communicate. RN F wrote she is able to tell he/she is upset and really wants to speak when he/she grunts more than usual, reaching his/her left arm out trying to talk and when his/her face turns red and becomes teary eyed. RN F wrote the resident usually only turns red faced and grimaces when in pain. During an interview conducted on 04/11/24, at 1:35 P.M., the resident's physician said the following: -She did not know about CNA S telling the resident who he/she hoped he/she dreamed of [descriptor] people. She would consider the comment an allegation of psychological abuse; -The resident's actions on 01/07/24 were not typical for him/her and neither was his/her response to RN F's questions about CNA S. She had only seen the resident become slightly frustrated with her if she asked him/her too many questions. During an interview on 04/10/24, at 3:04 P.M., the RCD said the following: -If administration wrote up a staff member, they placed the write up in the employee's personnel file; -She expected staff to suspend an employee if named in an allegation of abuse and for staff to complete an abuse investigation; -The RCD did not know anything about comments made to the resident by CNA S. During an interview on 04/10/24, at 3:04 P.M., the Administrator said the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA Q told her about something that happened in the past, no date, regarding a night shift aide, CNA S who said something about [descriptor] people to the resident; -CNA Q said he/she told the former Administrator of the allegation; -At first, she did not know the context or reason for the comment; -She should investigate the possible allegation to find out the context; -The Administrator did not find an investigation into the comment I hope you dream about [descriptor] people conducted by the previous Administration. NOTE: At the time of the annual survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). 34871 49585

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48534 Based on interview and record review, the facility failed to follow their abuse prevention policy of screening all staff at hire when the facility failed to request a Criminal Background Checks (CBC) or Family Care Safety Register (FCSR - a database that can provide CBC along with other background checks) check prior to one staff member's (Licensed Practical Nurse (LPN) D) contact with residents. A sample of 10 hired employees was reviewed in a facility with a census of 60. Review of the facility's Abuse Prevention Policy, dated 2021, showed the following: -The facility's abuse prohibition program includes the following seven components: screening, training, prevention, identification, investigation, protection and reporting/response; -Screening: The facility will not knowingly employ individuals who have been found guilty of abusing, neglecting or mistreating residents or misappropriating their properties; -All employees will have criminal background checks, state and federal required checks, employment reference checks (previous and current), and license/certification confirmation. The facility will make reasonable efforts to uncover information about any past criminal prosecutions. 1. Review of LPN D's personnel file showed the following: -Hire date of 12/20/22 and start date of 01/06/23; -Staff did not document a CBC request; -Staff did not complete a FCSR inquiry for the employee until 08/25/23. During an interview on 04/11/24, at 4:03 P.M., the payroll/human resource (HR) staff said the following: -The hiring process included an inquiry to the FCSR/CBC for all employees; -Staff should not have contact with residents prior to the FCSR/CBC check being completed. During an interview on 04/12/24, at 7:47 A.M., the Administrator said the following: -Payroll/HR staff were responsible for completing the FCSR/CBC inquiry for all new hire employees; -No employee should have contact with residents until the FCSR/CBC inquiry was completed. 34871

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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** 41787 Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for the transfer, for two residents (Resident #21 and #160), out of a sample of 26 residents. The facility census was 60. Review of the facility's document titled, Notification of Transfer or Discharge, undated, showed the following fields to be completed by facility staff: -Date of transfer, date of notice, resident name, and representative name; -Missouri Ombudsman office, address, and phone number; -You are hereby notified of our intent to transfer or discharge the above named resident for the following reason; -Name and address of location which resident will be transferred or discharged to; -Notice to resident regarding right to appeal transfer or discharge; -Person completing transfer/discharge notice; -Person delivering written notice of transfer/discharge and method of delivery. 1. Review of Resident #160's face sheet showed the following information: -admitted [DATE]; -Diagnoses included multiple sclerosis (MS - a long-lasting (chronic) disease of the central nervous system, that impacts the brain and spinal cord, which make up the central nervous system and controls everything we do). Review of the resident's progress notes showed the following: -On 04/03/24, at 12:57 P.M., staff documented the registered nurse (RN) was called to the resident's room at 12:19 P.M. by a CNA who observed the resident to be having seizure like activity. Upon entering the room at 12:24 P.M., the RN observed the resident with severe muscle rigidity, and uncontrollable tremors throughout his/her body. At 2:00 P.M., valium (medication that treats anxiety, seizures, muscle spasms or twitches) was given. Staff placed call to the physician with observations and obtained an order to send the resident to emergency room for evaluation and treatment. Resident left with Emergency Medical Services (EMS) at 12:43 P.M. Review of the resident's medical record showed staff did not have documentation of a written notice of transfer provided to the resident or resident's representative at transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #21 face sheet showed the following: -admitted [DATE]; -Diagnoses included hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting unspecified side, congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), schizoaffective disorder (mental health condition including schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and mood disorder symptoms), bipolar type (disorder associated with episodes of mood swings ranging from depressive lows to manic high), and dementia (group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, Review of the resident's progress notes showed the following: -On 02/25/24, at 3:22 A.M., staff documented the resident complained of sharp chest pain rating an 8 out of 10. The resident at first was not wanting to go to emergency room (ER). Nursing staff did education with resident then he/she agreed to go to ER. Called resident's responsible party. The resident left with EMS at 3:20 A.M. Review of the resident's medical record showed staff did not have documentation of a written notice of transfer to the resident or resident's representative at transfer. 3. During an interview on 04/10/24, at 6:28 P.M., RN F said the nursing staff send a transfer/discharge sheet with the ambulance staff, that includes all the resident's pertinent information, and a current physician order sheet. They notify the family by phone of the hospital transfer. He/she did not send anything to the family. During an interview on 04/10/24, at 7:05 P.M., RN E said nursing staff send a face sheet, physician orders, labs or results with the resident to the hospital. He/she did not send a transfer notice. During an interview on 04/11/24, at 12:03 P.M., the Assistant Director of Nursing (ADON) said staff send the physician orders, face sheet, and discharge/transfer paper with the resident to the hospital. Nursing staff notify the family and the Administration by mediprocity (secure form of messaging) of resident sent out. During an interview on 04/11/24, at 4:15 P.M., Social Services said she sends a notice at the end of every month to the ombudsman of discharged and transferred residents. She did not send a discharge letter to families or resident representatives. She was unsure if the nurses might be sending the information. During an interview on 04/12/24, at 1:53 P.M., with the Administrator and Corporate Nurse, the Administrator said staff should send a transfer letter when sending a resident to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on interview and record review, the facility failed to give information to the resident and/or resident's representative of the facility's bed hold policy when two residents (Residents #21 and #160) were transferred to the hospital, out of a sample of 26 residents. The facility census was 60. Review of the facility provided policy, dated February 2014, Bed Hold Policy & Agreement Form, showed the following: -To establish policy and procedure for facility to notify the resident and/or responsible party of the Bed Hold Policy and Agreement to Pay Charges for Bed Hold; -The bed hold agreement is to be obtained for each occurrence - hospital or therapeutic leave; -When hospital or therapeutic leave is reported on the midnight census, the business office will notify the resident and/or responsible party to sign the bed hold agreement; -The business office will address weekend or holiday transfer on the next business day; -When the resident goes to the hospital or out of the facility for overnight visitation the bed may be held by paying the rate as identified in the bed hold agreement; -A telephone call may be documented as notification on bed hold agreement; -If the resident or representative does not want the bed held then the bed will be released. Any personal belongings must be picked up in 24 hours; -If the bed is not held and the resident wants to be readmitted to the facility, the resident's name will be placed on the waiting list for the first available bed; -Medicaid residents may be charged based on the applicable laws in the state and shall be governed by the state bed hold policy. 1. Review of Resident #160's face sheet showed the following information: -admitted [DATE]; -Diagnoses included multiple sclerosis (MS - a long-lasting (chronic) disease of the central nervous system, that impacts the brain and spinal cord, which make up the central nervous system and controls everything we do). Review of the resident's progress notes showed the following: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/03/24, at 12:57 P.M., staff documented the registered nurse (RN) was called to the resident's room at 12:19 P.M., by a CNA who observed resident to be having seizure like activity. Upon entering the room at 12:24 P.M., the RN observed the resident with severe muscle rigidity, and uncontrollable tremors throughout his/her body. At 2:00 P.M., valium (medication that treats anxiety, seizures, muscle spasms or twitches) was given. Call placed to physician with observations, order obtained to send resident to emergency room (ER) for evaluation and treatment. Resident left with Emergency Medical Services at 12:43 P.M. Review of the resident's medical record showed staff did not document providing notice of a bed hold agreement to the resident or resident's representative at transfer. 2. Review of Resident #21 face sheet showed the following: -admitted [DATE]; -Diagnoses included hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting unspecified side, congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), schizoaffective disorder (mental health condition including schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and mood disorder symptoms), bipolar type (disorder associated with episodes of mood swings ranging from depressive lows to manic high), and dementia (group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, Review of the resident's progress notes showed the following: -On 02/25/24, at 3:22 A.M., staff documented the resident complained of sharp chest pain rating an 8 out of 10. The resident at first was not wanting to go to ER. Nursing staff did education with resident then he/she agreed to go to ER. Called resident's responsible party. The resident left with EMS at 3:20 A.M. Review of the resident's medical record showed staff did not document providing notice of a bed hold agreement to the resident or resident's representative at transfer. 3. During an interview on 04/10/24, at 6:28 P.M., RN F said they do not send a bed hold notice to the resident or the family. They notify the family by phone of the hospital transfer. During an interview on 04/10/24, at 7:05 P.M., RN E said they used to send a bed hold policy, but had not done that for about one year. He/she did not know why the facility stopped sending that information. During an interview on 04/11/24, at 12:03 P.M., the Assistant Director of Nursing (ADON) said she had not ever sent a bed hold with the resident or to family. During an interview on 04/11/24, at 4:15 P.M., Social Services said she did not send a bed hold to families or resident representatives. She was unsure if the nurses might be sending the information. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24, at 1:53 P.M., with the Administrator and Corporate Nurse, they said staff should send a bed hold when sending a resident to the hospital.

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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** 41787 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for all residents when staff failed to care plan oxygen use for one resident (Resident #2), failed to care plan smoking safety for one resident (Resident #160), and failed to care plan wound care for one resident (Residents #259). A sample of 26 residents was reviewed in a facility with a census of 60. Review of facility's policy titled, Care Planning - Interdisciplinary Team, dated 02/2021, showed the following: -To assess each resident's strengths, weaknesses, and care needs using the Minimum Date Set (MDS - a federally mandated assessment instrument completed by facility staff); -To use this assessment data to develop a comprehensive plan of care for each resident that will assist resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible; -The comprehensive plan of care must address all care issues that are relevant to the individual. 1. Review of Resident #2's face sheet showed the following information: -admitted [DATE]; -Diagnoses included pneumonia (lung inflammation caused by bacterial or viral infection) and congestive heart failure (CHF - long-term condition in which the heart can't pump blood well enough to meet the body's needs). Review of the resident's care plan, last updated 12/06/23, showed the following information: -The resident had CHF; -Staff should administer cardiac medications as ordered. Review of the resident's Physician's Order Sheet (POS), current as of 04/12/24, showed the following: -An order, dated 01/29/24, for oxygen at two to four liters per minute (LPM - flow of oxygen received from delivery device) via nasal cannula (device that delivers extra oxygen through a tube and into your nose) as needed (PRN) to keep oxygen saturation about 90% for shortness of breath related to CHF; -An order, dated 01/29/24, to clean oxygen concentrator filter weekly; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 02/05/24, to change oxygen tubing, humidifier bottle, and plastic holding bag for oxygen tubing every Monday. Review of the resident's care plan, last updated 12/06/23, showed staff did not add oxygen use or care of oxygen equipment to the resident's care plan. Review of the resident's annual MDS, dated [DATE], showed use of oxygen. Review of the resident's care plan, last updated 12/06/23, showed staff did not add oxygen use to the resident's care plan. Review of the resident's April 2024 Medication Administration Record (MAR), current as of 04/12/24, showed the following: -Staff documented change of oxygen tubing, humidifier bottle, and plastic holding completed on 04/01/24 and 04/08/24. Observation on 04/11/24, at 10:13 A.M., showed the oxygen tubing, humidifier bottle, and plastic bag on the oxygen concentrator in the resident's room. During an interview on 04/12/24, at 9:37 A.M., Certified Nurse Assistant (CNA) O said oxygen use should be on the resident's care plan. During an interview on 04/12/24, at 9:50 A.M., Certified Medication Technician (CMT) P said information about oxygen should be included on the care plan so staff know how to care for resident. During an interview on 04/12/24, at 10:30 A.M., Registered Nurse (RN) E said oxygen use should be included on the care plan. During an interview on 04/11/24, at 4:15 P.M., the Social Service Director (SSD) said care plans should include oxygen usage. During an interview on 04/12/24, at 12:09 P.M., the Assistant Director of Nursing (ADON) said oxygen use should be included on the care plan. During an interview on 04/12/24, at 12:14 P.M., the MDS Coordinator said oxygen use should be included on the care plan. Interventions for oxygen use included change tubing, give medications as ordered, monitor blood oxygen saturation, and oxygen settings. During an interview on 04/12/24, at 1:53 P.M., with the Administrator and Corporate Nurse, the Administrator said care plans should include oxygen usage. 2. Review of Resident #160's face sheet showed the following information: -admitted [DATE]; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included multiple sclerosis (MS - a long-lasting (chronic) disease of the central nervous system, that impacts the brain and spinal cord, which make up the central nervous system and controls everything we do), muscle wasting and atrophy (decrease in size) right and left lower leg, and muscle spasm. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/08/24, showed the following: -Cognitively intact; -Use of wheelchair for locomotion; -Required set up or clean up assistance for eating, oral hygiene, toileting hygiene, personal hygiene, upper body dressing, and lower body dressing. Review of resident's smoking assessment, dated 03/27/24, showed the following: -The resident was not a current smoker; -All residents must be supervised when smoking; -Vaping and use of electronic cigarettes was not permitted. Interviews and observation, at the following dates and times, showed the following: -On 04/07/24, at 4:52 P.M., the resident said that his/her family was bringing a new vape this night. He/she said the staff keep the vape in the locked box and he/she went outside at smoke breaks to use the vape; -On 04/08/24, at 1:30 P.M., the resident was in line to go outside for smoke break with staff; -On 04/10/24, at 9:39 A.M., the resident was on the outside smoking patio with staff. The staff handed the resident a vape from the locked box of cigarettes and supplies. Review of the resident's care plan, dated 03/27/24, showed staff did not care plan related to the resident's smoking preference. During an interview on 04/11/24, at 9:40 A.M., the MDS Coordinator said residents should be assessed for safe smoking on admission and routinely throughout the year to ensure no changes. The resident should have been re-assessed once it was determined he/she used a vape during smoke breaks and this information should also be in resident care plans. During an interview on 04/11/24, at 4:15 P.M., the SSD said that resident care plans should include any special information about the resident. This would include if they were a smoker and any interventions needed when out for smoke break. (continued on next page)

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	265182	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Nursing Center	1700 South Hudson Avenue Aurora, MO 65605

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/12/24, at 1:53 P.M., with the Administrator and Corporate Nurse, the Administrator said residents should be assessed for safe smoking, and if initially the resident was assessed as non-smoker, but was then participating in smoke breaks, the staff should then re-assess the resident and the information should be on the care plan. 49585 3. Review of the Resident #259's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease the causes obstructed airflow from the lungs), congestive heart failure (CHF - a long-term condition in which the heart can't pump blood well enough to meet the body's needs), morbid obesity, and diabetes mellitus (disorder in which amount of sugar in the blood is elevated). Review of the resident's admission MDS, dated [DATE], showed the following information: -Cognitively intact; -Dependent on staff for bathing, dressing, and personal hygiene; -Dependent for transfers and mobility; -Resident is at risk for pressure ulcers; -Resident had no pressure ulcers. Review of the resident's care plan, revised on 04/12/24, showed the following: -Required assistance of one staff for bathing and hygiene; -Required assistance of two with transfers and mobility; -Used a wheelchair for mobility. Review of the resident's March 2024 and April 2024 Physician Order Sheets (POS) showed the following orders: -An order, dated 03/18/24, for dermaseptin 0.5%-20.65% topical ointment (skin cream) two times a day for shearing. Apply after incontinent episodes; -An order, dated 03/18/24, wound gel (wound dressing) applied to right lower leg topically one time a day for clotting formation for abrasion; -An order, dated 04/05/24, to cleanse open area to right inner upper thigh with wound cleaner and pat dry, cover with a foam dressing, change every three days and as needed; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 04/10/24, to cleanse open area to left buttock with wound cleaner and pat dry, cover with a foam dressing, change every three days and as needed. Review of the resident's March 2024 and April 2024 Treatment Administrator Record (TAR) showed staff provided care to skin and wounds as ordered. Review of the resident's care plan, revised on 04/12/24, showed staff did not address impaired skin integrity or related interventions prior to 04/12/24. During an interview on 04/12/24, at 9:50 A.M., CMT P said the information about skin conditions should be included on the care plan, so staff know how to care for resident. During an interview on 04/12/24, at 10:30 A.M., RN E said wound care should be included on the care plan. During an interview on 04/12/24, at 12:09 P.M., the ADON said wound care should be included on the care plan. During an interview on 04/12/24, at 12:14 P.M., MDS Coordinator said wounds should be on the care plan. During an interview on 04/11/24, at 4:15 P.M., the SSD said care plans should include wounds. During an interview on 04/12/24, at 1:53 P.M., with the Administrator and Corporate Nurse, the Administrator said care plans should include skin conditions. 4. During an interview on 04/09/24, at 12:00 P.M., CNA G said that he/she can find resident care needs on the care plan at the nurses' desk or in the electronic medical record. He/she can also ask the nurse for resident care needs. During an interview on 04/12/24, at 9:37 A.M., CNA O said care plans provide information about the resident. Care plans are on the computer, or he/she can ask a nurse where to find them. During an interview on 04/12/24, at 9:50 A.M., CMT P said care plans are in a binder at the nurse station or in the computer. During interviews on 04/10/24, at 7:05 P.M., and on 04/12/24, at 10:30 A.M., RN E said the following: -The MDS Coordinator completes and updates care plans; -Care plans can be found on the computer; -Staff utilize care plans for resident daily care needs; -The care plan should include all special care needs for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 04/11/24, at 12:03 P.M., and on 04/12/24, at 12:09 P.M., the ADON said care plans are updated by Social Services and MDS staff. They should be accurate to each resident needs. During interviews on 04/12/24, at 10:02 A.M. and 12:14 P.M., the MDS Coordinator said the following: -Care plan information is obtained from hospital documents, TARs, MARs, interviews, and nursing assessments; -Care plans are updated quarterly and as needed for changes; -Social Services also updates care plans as needed; -Care plan meetings are held every three months to review the care plan and to add any new information needed for resident care. During an interview on 04/11/24, at 4:15 P.M., the SSD said care plans are reviewed quarterly and should also be updated as needed. During interviews on 04/12/24, at 12:14 P.M. and 1:53 P.M., the Administrator said care plans should be reviewed in the morning clinical meeting. Care plans should contain information that is relevant to the resident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility failed to ensure all dialysis residents received services consistent with professional standards of practice when staff failed to routinely communicate and collaborate with the dialysis (a process of filtering and removing waste products from the bloodstream when the kidneys can no longer sufficiently do so) center after appointments for one resident (Resident #47) out of a sample of two residents. The facility census was 60. Review of the facility's policy titled Dialysis Communication, dated 02/2021, showed the following: -It is the policy of the facility to communicate openly and effectively with any provider of dialysis for a resident of the facility; -The Director of Nursing (DON) or designee will contact dialysis unit to establish the communication and explain the facility will be sending a communication form that will facilitate the sharing of resident information surrounding dialysis; -A dialysis communication form will be used to send information to and from the facility to the dialysis center and back; -The nurse in charge of the care of the resident on the days of scheduled dialysis shall initiate the dialysis communication form and will ensure the form is sent with the resident; -Upon return of the resident from the dialysis center, the nurse in charge of the resident will review the communication form and will obtain necessary post dialysis information; -If there are any questions regarding the completion of the form or needs of the resident, the nurse will call the dialysis center for a telephone report of any significant information needed; -The nurse will complete post dialysis information on the dialysis communication form. the completed form will be scanned into the electronic health record. 1. Review of Resident #47's face sheet (a general information sheet) showed the following: -admitted [DATE]; -Diagnoses included end stage renal disease (ESRD-a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis, and diabetes. Review of the resident's Physician Order Sheet (POS) showed the following information: -An order, dated 12/27/23, for hemodialysis (process of filtering the blood of a person whose kidneys are not working normally) every Monday, Wednesday, and Friday. Review of the resident's care plan, revised 04/10/24, showed the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident needed dialysis related to ESRD; -Encourage resident to go for the scheduled dialysis appointments; -Resident receives dialysis on Monday, Wednesday, and Friday. During interviews on 04/12/24, at 10:39 A.M., and on 04/16/24, at 1:42 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff)/Care Plan Coordinator said the following: -The resident had appointments on Monday,Wednesday, and Friday when he/she was first admitted to the facility; -The resident's dialysis appointment days changed to Tuesday, Thursday, and Saturday after admission; -Nurses should have changed the physician orders to Tuesday, Thursday, and Saturday for the resident's dialysis appointments; -He/she should have updated the resident's care plan for Tuesday, Thursday, and Saturday for his/her dialysis appointments. Review of the resident's dialysis communication forms and nurses' notes, dated 02/24/24 to 04/09/24, showed nursing staff did not have communication forms for the following dates: -Saturday, 02/24/24; -Tuesday, 02/27/24; -Thursday, 02/29/24; -Tuesday, 03/05/24; -Thursday, 03/07/24; -Saturday, 03/09/24; -Thursday, 03/14/24; -Thursday, 03/21/24; -Tuesday, 03/26/24; -Thursday, 03/28/24; -Saturday, 03/30/24; -Tuesday, 04/02/24; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Thursday, 04/04/24; -Tuesday, 04/09/24. -Staff did not document the dialysis communication being received or follow-up contact with the dialysis center. During an interview on 04/08/24, at 3:57 P.M., Registered Nurse (RN) F said the following: -Nursing staff send the communication form with the resident to dialysis on Tuesday, Thursday, and Saturday: -The dialysis center should send the resident's communication form back with the resident; -Nurses should call the dialysis center if the resident did not return to the facility with the communication form; -The resident takes the communication form and the dialysis center never sends it back; -He/she did not call the dialysis center when the resident does not return with the form; -He/she tells the resident to remember to ask the center for the communication form to return; -The communication form shows any changes for the resident before and after the dialysis appointment. During an interview on 04/11/24, at 4:15 P.M., the Assistant Director of Nursing (ADON) said the following: -The nurse completes the communication form the day before the resident goes to the appointment; -Nurses should call the dialysis center if the resident did not return from the appointment with the form. During interviews on 04/12/24, at 10:39 A.M., and on 04/16/24, at 01:42 P.M., the MDS/Care Plan Coordinator said the following: -Nurses should send the communication form with the resident for the dialysis appointment; -Nurses should call the dialysis center if the form is not sent back and document in the nurses' notes; -The communication form is important to know the results and how the resident did during the appointment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24, at 2:15 P.M., the Administrator said she expects staff to send the communication form with the resident and it should be returned with the resident. She expects nursing staff to call the dialysis center and document in the resident's chart if the dialysis center did not return the form to the facility.

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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** 48534 Based on observation, interview, and record review, the facility failed to care plan use of side rails and failed to obtain informed consent for use of side rails for two residents (Resident #6 and #12), and failed to complete gap measurements for installed side rails for three residents (Resident #6, #12, and #23) of a sample of four residents. The facility census was 60. Review of the facility's policy titled, Proper Use of Side Rails, revised December 2016, showed the following: -The purpose of these guidelines is to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms; -Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of resident's; -An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility; ability to change positions; transfer to and from bed or chair, and to stand and toilet; risk of entrapment from the use of side rails; and that the bed's dimensions are appropriate for the resident's size and weight; -The use of side rails as an assistive device will be addressed in the resident care plan; -Consent for using restrictive devices will be obtained for the resident or legal representative per facility protocol; -Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails; -The risk and benefits of side rails will be considered for each resident; -Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks; -The resident will be checked periodically for safety relative to side rail use; -When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment; -Facility staff, in conjunction with the attending physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of document provided by the facility, titled Rails. dated March 2024, showed the following: -No resident names; -List of room number with yes or no marked; -Staff did not document measurements. Review of the facility's document titled, Rails, dated April 2024, showed the following: -No resident names; -List of room numbers only, with yes or no marked next to the number; -Staff did not document measurements. 2. Review of Resident #6's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses include senile degeneration of the brain (older individuals who suffered from cognitive decline, particularly memory loss) and insomnia. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 01/18/24, showed the following: -The resident had severe cognitive impairment; -The resident required supervision from staff to roll left and right and moderate assistance from staff to move from sitting to lying and from lying to sitting. -The resident was dependent on staff for all transfers. Observations on 04/07/24, at 03:17 P.M., on 04/08/24, at 09:10 A.M., and on 04/10/24, at 05:10 P.M. showed the resident's bed had a horseshoe side rail on both sides of his/her bed. The rails were in the upright position. Review of the resident's current care plan, revised 12/29/23, showed the following: -Resident at risk for falls due to his/her current disease process; -Resident required supervision for all transfers. He/she was able to reposition himself/herself in bed. (Staff did not care plan regarding the use of side rails.) (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review showed the facility did not provide or document a side rail assessment, gap measurements, or informed consent for use of the resident's side rails. During an interview on 04/10/24, at 5:10 P.M., Restorative Nursing Aide (RNA) C said the following: -The resident had a new bed that came with side rails; -The bed the resident was using came with two options for side rail placement; -The position of the side rails on the resident's bed did not meet the measurement requirements; -The RNA said the gap between the side rails and the head of the bed was to large. During an interview on 04/11/24, at 11:58 A.M., Certified Nursing Assistant (CNA) A said the resident used his/her side rails for bed mobility. During an interview on 04/11/24, at 12:11 P.M., Certified Medical Technician (CMT) B said the resident had side rails to help him/her reposition in bed. 3. Review of Resident #12's face sheet showed the following: -admitted [DATE]; -Diagnoses included muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Resident had a severe cognitive impairment; -Dependent on staff for bed mobility and transfers. Observations on 04/07/24, at 3:42 P.M., on 04/08/24, at 11:20 A.M., on 04/09/24, at 11:27 A.M., and on 04/10/24, at 5:25 P.M., showed the resident rested in bed with half side rails up on both sides of bed. Review of the resident's current care plan, revised on 03/28/24, showed the following: -Required assistance of one staff for transfers, toileting, mobility, and dressing; (Staff did not care plan the use of side rails.) Review showed the facility did not provide or document a side rail assessment, gap measurements, or informed consent for the resident's side rails. 4. Review of Resident #23's face sheet showed the following: -admitted [DATE]; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included congestive heart failure (CHF - a long-term condition in which the heart can't pump blood well enough to meet the body's needs) and muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate moderate cognitive impairment; -Dependent on staff for bed mobility and transfers. Review of the resident's care plan, revised on 04/05/24, showed the following: -Required assistance of two staff for transfers, toileting, and dressing; -Mobility bars used as enabler; -Resident had impaired thought processes; -Risk for falls. Review of the resident's Resident Side Rail Usage and Screen, dated 05/23/23, showed resident's responsible party consented to use of side rails. Observations on 04/07/24, at 5:08 P.M., and on 04/09/24, at 11:30 P.M. showed the resident's bed had half side rails in the upright position on both sides of the bed. Review showed the facility did not provide or document gap measurements or assessment of side rails. 5. During interviews on 04/10/24, at 2:59 P.M. and 5:10 P.M., RNA C said the following: -He/she was responsible for monitoring the bed rails on admission and when the nurses tell him/her; -He/she checks the bed rails every month to ensure bed rails are not loose on the bed; -He/she did not have the measurements on the bed rails; -He/she did not have the January 2024 or February 2024 monitoring because it was given to the previous Administrator and he/she had not located the forms for those months; -He/she did not know who was responsible for completing the side rail assessment, getting the consent for side rails signed, who was responsible for measuring the side rails or who was responsible for maintaining the side rails. During an interview on 04/10/24, at 6:20 P.M., Registered Nurse (RN) F said on admission the nursing staff completes a bed rail assessment for safety with use a positioning aide only. He/she did not complete any measurements or apply bed rails to the bed frame. During an interview on 04/11/24, at 11:58 A.M., CNA A said the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Side rails helped residents navigate and reposition while in bed; -Maintenance staff was responsible for installing the side rails and maintaining them. During an interview on 04/11/24, at 12:11 P.M., Certified Medical Technician (CMT) B said the following: -Maintenance was responsible for putting side rails on the residents' beds; -The RNA is responsible for measuring the side rails and maintaining them. During an interview on 04/11/24, at 3:03 P.M., the Maintenance Supervisor said he was not responsible for maintenance of side rails, but did help tighten the side rails if staff asked him/her. During an interview on 04/11/24, at 3:23 P.M., the Therapy Director said the following: -Side rails are used for mobility and repositioning; -The resident or nurse, on behalf of a resident, request an evaluation from occupational or physical therapy (OT/PT), for side rails; -Therapy contacted the physician for an order to evaluate and the physician approved the order and OT/PT completed the evaluation; -When the resident was approved for side rails, staff notified the RNA or nursing staff for the side rails to be installed. During an interview on 04/12/24, at 1:53 P.M., the Administrator said residents should have a side rail assessment completed, they should be evaluated for the need for positioning, and have permission from family. The staff should measure to ensure appropriate fit to bed. The resident should have education about risks and benefits and the information should be on the care plan. 41787 49585

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34871 Based on record review and interview, the facility failed to designate a registered nurse (RN) to serve as the Director of Nursing (DON) on a full time basis. The facility census was 60. Review of the facility's document titled, Director of Nursing Services job description showed the following: -The primary purpose of the job position is to plan, organize, develop and direct the overall operation of the nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director to ensure that the highest degree of quality care is maintained at all times; -The Director of Nursing Services (DON) is delegated the administrative authority, responsibility, and accountability necessary for carrying out the assigned duties. In the absence of the Medical Director, the DON is charged with carrying out the resident care policies established by the facility; -Duties and responsibilities include administrative functions, committee functions, personnel functions, nursing care functions, staff development, safety and sanitation, equipment and supply functions, care plan and assessment functions, budget and planning functions, and resident rights. Review of the facility's assessment, dated 2020, showed the following: -Nursing management includes a DON for 40 plus hours a week and on call; -The DON is responsible for continuity of care, bathing scheduling, wound and skin risk management, resident weights, and various human resources duties regarding job performance of all nursing staff. 1. During an interview on on 04/07/24, at 4:02 P.M., the Administrator said the facility did not have a DON or interim DON. During an interview on 04/09/24, at 1:17 P.M., Registered Nurse (RN) F said the following: -The DON left in February 2024; -The facility had not had a DON since February 2024. During an interview on 04/11/24, at 10:11 A.M., RN E said the following: -Staff report to the Assistant Director of Nursing (ADON) or Regional Corporate Clinical; -The facility did not have an acting DON. (continued on next page)

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Aurora Nursing Center	1700 South Hudson Avenue Aurora, MO 65605

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/11/24, at 10:50 A.M., the Minimum Data Set (MDS - a federally mandated assessment completed by facility staff)/Care Plan Coordinator said the following: -The facility has not had a DON since the middle of February 2024; -The facility did not have applicants for a DON. During an interview on 04/07/24, at 4:02 P.M., the Regional Director of Clinical said the following: -The facility had not had a DON or interim DON since the middle of February 2024; -The former DON quit without notice on 02/17/24; -She had set up three interviews and no one showed up; -The DON position provides oversight on the nursing staff, assists the Administrator with guidance and questions and oversees medications.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to ensure all residents received behavioral health care and services to maintain the highest practical psychosocial well-being when the facility failed to care plan and implement resident specific interventions for one resident (Resident #259) who exhibited signs and symptoms of depression. The facility failed to have social services follow-up with the resident when the resident expressed signs of possible depression. The facility census was 60. Review showed the facility did not provide a behavioral health policy. 1. Review of Resident #259's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease the causes obstructed airflow from the lungs), congestive heart failure (CHF - a long-term condition in which the heart can't pump blood well enough to meet the body's needs), and encounter for palliative care. Review of a preadmission hospice visit narrative notes, dated 03/15/24 and located in the facility's medical record, showed the nurse discussed pending transfer to skilled nursing facility with resident and resident became very tearful. Review of resident's Physicians' Order Summary Report, dated 04/12/24, showed the following: -An order, dated 03/18/24, for sertraline (an antidepressant) tablet 100 milligrams (mg), give one tablet by mouth one time a day for depression. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 03/20/24, showed the following information: -Cognitively intact; -Felt down, depressed or hopeless, symptom occurred nearly every day; -Trouble falling asleep or staying asleep, or sleeping too much, symptom occurred several days; -Felt tired or had little energy, symptom occurred nearly every day; -Total resident mood score equaled 7, which indicated mild depression; -Always socially isolates; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent with all activities of daily living (ADL - skills required to care for oneself) except eating and oral hygiene; -Received antidepressant medication. Review of the resident's Social Services Assessment and History, dated 03/20/24, showed the following: -Lived with spouse in own home prior to entering the facility; -Resident reported admittance to skilled nursing facility as a very stressful event; -Had trouble falling or staying asleep, or sleeping too much two to six days out of last two weeks; -Feeling tired or little energy twelve to fourteen days out of the last two weeks; -Feeling down, depressed, or hopeless twelve to fourteen days out of the last two weeks; -Resident suffered a significant loss due to not living in own home; -Resident required emotional support. Review of the resident's care plan, initiated 03/20/24, showed the following information: -Hospice services related to COPD; -Hospice provided psychosocial support; -Staff will work with hospice to ensure resident's emotional needs are met. (Staff did not care plan related to the resident's depression or antidepressant use.) Review of the resident's medical record showed social services did not document follow-up visits with the resident regarding his/her depression. Review of the resident's medical record showed staff did not document regarding activity attendance. Interview and observation on 04/08/24, at 2:14 P.M., showed the resident awake sitting in recliner in room with no television on. Resident became tearful and said he/she feels sad to be in the nursing facility and wants to go home. He/she would like to talk to someone about his feelings. During an interview on 04/11/24, at 11:00 A.M., Registered Nurse (RN) E said the following: -The resident is pleasant at times, but other days grumpy and uncooperative with care; -A psychologist visits the facility at times; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would notify the physician for a resident that appeared depressed; -The physician would provide a referral to the psychologist and then he/she would advise medical records to schedule an appointment. During an interview on 04/11/24, at 11:40 A.M., RN N (the resident's hospice nurse) said the following: -The resident had a lot of psychosocial issues in his/her family; -He/she had not observed the resident tearful; -If a resident appeared depressed, he/she would get a social worker involved and some counseling; -Signs and symptoms of depression would be tearfulness, appearing withdrawn, or a change in usual activities. During interviews on 04/12/24, at 12:14 P.M. and 1:25 P.M., the MDS Coordinator said the following: -Social services conducted mood screening for the MDS; -Social services would notify nursing if an MDS screening indicated depression; -Th nurse contacts the physician for signs and symptoms of depression; -He/she does not recall social services notification regarding the resident being depressed; -He/she would notify the physician if the MDS indicated depression symptoms. During an interview on 04/12/24, at 12:36 P.M., Social Services said the following: -He/she obtained information about a resident's mood from the resident, family, or the staff; -The MDS is completed quarterly and for any changes; -Counseling services are available for residents through a contracted provider; -If a resident appeared depressed upon assessment,the MDS Coordinator would be notified and he/she notified physician; -He/she does not remember what happened with the resident's information obtained during the assessment regarding depression; -If screening results indicate depression, like the resident's did, he/she usually reported the information to MDS Coordinator. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/24, at 12:09 P.M., the Assistant Director of Nursing (ADON) said if a resident had an MDS assessment that indicated depression, the physician should be notified and the resident monitored. The physician should have been notified of the resident's depression screening results. During an interview on 04/12/24, at 2:17 P.M., the Administrator said the social worker is responsible for the resident's mood and behavior assessment. If a resident has indicators for depression, the social worker should share information with the department heads and nursing, so they are able to follow up.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on interview and record review, the facility failed to ensure as needed (PRN) orders for psychotropic medications were limited to 14 days when one resident (Resident #9) had an ongoing order for a psychotropic medication with no physician review and justification. The facility census was 60 residents. Review of the facility's policy Psychotropic Medication Use, dated 02/2021, showed the following: -Residents will only receive psychotropic medications when necessary to treat specific conditions which they are indicated and effective; -Gradual dose reductions of psychotropic medications will be done as outlined per federal regulations. (The policy did not address requirements for psychotropic PRN orders.) 1. Review of Resident #9's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included anxiety disorder and major depressive disorder. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 03/04/24, showed the following: -Cognitively intact; -Diagnosis of anxiety and depression; -Received anti-anxiety and antidepressant medications. Review of the resident's Care Plan, dated 03/07/24, showed the following: -Resident had a communication problem and staff should monitor and document frustration level; -Resident is taking anti-anxiety medication which is associated with increased risk of confusion, amnesia, loss of balance, cognitive impairment, and falls. Monitor resident for safety; -Anti-anxiety medications are given as ordered; -Monitor and document anti-anxiety medication side effects and effectiveness; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Consult with pharmacy and physician to consider dosage reduction when clinically appropriate. Review of the resident's Physician's Orders Sheet (POS), dated 04/12/24, showed the following: -An order, dated 02/21/24, for alprazolam (psychotropic medication used to treat anxiety disorders) tablet 0. 25 milligrams (mg), give one tablet by mouth every six hours as needed for anxiousness. Review of the resident's February 2024 Medication Administration Record (MAR) showed staff administered the resident's as needed alprazolam three times on 02/21/24, 02/23/24, and 02/25/24. Review of the resident's March 2024 and April 2024 MAR showed staff did not administer the resident's as needed alprazolam. Review of resident's progress notes showed staff did not document a re-evaluation and justification to continue the order for alprazolam beyond the original fourteen days. During an interview on 04/12/24, at 10:30 A.M., Registered Nurse (RN) E said he/she was not aware of a 14 day limit on as needed psychotropic medications. Medications are tracked through the pharmacy and they will generally send recommendations for medications to be discontinued or reduced. During an interview on 04/12/24, at 12:09 P.M., the Assistant Director of Nursing (ADON) said psychotropic as needed medications should be dated with a 14 day expiration date. Pharmacy monitors medications and will update physician for orders that should be discontinued or should be made routine. He/she did not know why this resident's order was still active. During an interview on 04/11/24, at 1:27 P.M., the Medical Director said psychotropic medications are re-evaluated after 14 days. The pharmacy conducts monthly reviews on medications and sends a report. The medication would then be discontinued or made into a routine order after report is received. He/she did not recall why this particular order was missed during pharmacy review. During an interview on 04/12/24, at 2:17 P.M., the Administrator said as needed psychotropic medications should have an end date of fourteen days.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility failed to ensure residents remained free of significant medication errors when staff administered a fentanyl patch (a narcotic patch placed on the skin to treat moderate to severe pain) and hydrocodone-APAP (narcotic that is used for relief of severe pain) to one resident (Resident #162) without orders, resulting in significant side effects and hospitalization . A sample of 26 residents was reviewed in a facility with a census of 60. The Administrator was notified on [DATE], at 2:28 P.M., of an Immediate Jeopardy (IJ) which began on [DATE]. The resident went to the hospital and did not readmit to the facility. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's policy titled Medication Administration, dated [DATE], showed the following: -Administer medications to residents in a safe and timely fashion; -Observe for drug reactions; -Chart on medication record dose, time given, and any pertinent observations. Review of the facility's policy titled Medication Monitoring Medication Errors and Drug Reactions, dated [DATE], showed the following: -Medication errors and drug reactions must be reported to the physician immediately; -A Medication Error Report must be completed by the person discovering the error; -An Incident Report must be completed and a 72-hour observation initiated; -Follow physicians order to monitor resident and report any significant abnormalities or adverse reactions to the physician. Review of the Food and Drug Administration's (FDA) Medication Guide for Norco (hydrocodone-APAP), dated 2019, showed the following: -Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids; -While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of Norco, the risk is greatest during the initiation of therapy or following a dosage increase. Monitor patients closely for respiratory depression, especially within the first 24 to 72 hours of initiating therapy with and following dosage (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	increases of Norco; -Life-threatening respiratory depression is more likely to occur in elderly patients because they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients; -Elderly patients may have increased sensitivity to Norco. Use caution when selecting a dosage for an elderly patient, usually starting at the low end of the dosing range; -Respiratory depression is the chief risk for elderly patients treated with opioids, and has occurred after large initial doses were administered to patients who were not opioid-tolerant or when opioids were co-administered with other agents that depress respiration; -Acute overdosage with Norco can be manifested by respiratory depression, somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, constricted pupils, and hypoxia (low blood oxygen levels). Review of the FDA's Medication Guide for Fentanyl patch, dated ,d+[DATE], showed the following: -Indicated for the management of pain in opioid-tolerant patients; -Is not indicated as an as-needed analgesic; -Use the lowest effective dosage for the shortest duration consistent with individual patient treatment goals; -Accidental exposure to even one dose can result in a fatal overdose of fentanyl; -Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids; -Life-threatening respiratory depression is more likely to occur in elderly patients because they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients; -Adverse reactions have been identified to include convulsions, depressed level of consciousness, loss of consciousness, respiratory distress, high blood pressure. 1. Review of the Resident #162's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included mini stroke, unspecified dementia, and high blood pressure. Review of the resident's hospital to facility discharge information dated [DATE], at 7:13 A.M., showed the following: -An order for olanzapine (an antipsychotic medication used to treat mental disorders and agitation) 10 milligrams (mg), take one tablet twice daily. The next dose due on [DATE] at 9:00 P.M. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(The resident did not have orders for medications for pain.) Review of a physician progress note, dated [DATE], showed the following: -The note had the name of three residents listed on it including orders for each residents; -Resident #162's name was at the top of the list. Under his/her name, the physician wrote orders for buspirone HCL (an anti-anxiety medication) and Xanax (medication used to treat anxiety disorders). The physician did not write orders for pain medication for Resident #162; -Under the orders for Resident #162, a different resident's name was listed with orders that included a fentanyl 50 microgram (mcgs) patch; -A third's resident's name was listed with several orders listed under his/her name. Review of the resident's Physician Order Sheet (POS), dated [DATE], showed the following: -An order, dated [DATE], for buspirone HCL oral tablet 10 mg, give one tablet twice a day for anxiety; -An order, dated [DATE] for olanzapine 10 mg, give one tablet twice a day for unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; -An order, dated [DATE], for Xanax 0.5 mg tablet, give one tablet every four hours for anxiety for 14 days. (The physician did not order for medications for pain.) Review of the facility's Emergency Medication Kit (E-kit - medication the facility keeps on hand to use in emergency or while waiting on pharmacy delivery) Administration Record, dated [DATE], showed the following: -On [DATE], at 10:29 A.M., RN X signed out one patch of fentanyl 50 mcg/hour (hr) for the resident; -On [DATE], at 10:33 A.M., RN X signed out one tablet for hydrocodone-APAP ,d+[DATE] mg tablet for the resident. Review of the resident's [DATE] Medication Administration Record (MAR) showed RN X did not document administration of fentanyl or hydrocodone-APAP to the resident in the resident's medical record. Review of the resident's progress note, dated [DATE],showed RN X documented the following: -At 6:40 P.M., a certified nurse aide (CNA) reported the resident having a possible seizure; -Three RNs ran back to the area and found the resident actively having a seizure; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident's blood pressure measured ,d+[DATE] millimeters of mercury (mmHG) (a reading greater than , d+[DATE] mmHg is considered high); -A nurse called 911 for transport; -The resident continued to have seizures; -Resident's pupils at 2 and non reactive (an indication of possible trauma or neurological issues);. -At 6:45 P.M., staff administered two mg lorazepam (a narcotic sedative) intramuscularly (into the muscle) in the right thigh; -At 7:08 P.M., staff rechecked the resident's blood pressure and noted it at ,d+[DATE] mmHG. Staff noted resident sweating; -At 7:20 P.M., staff measured resident's blood pressure at ,d+[DATE] mmHG with blood oxygen level (SPO2) of 74% (normal is greater than 90%); -Staff moved the resident to the floor and gave oxygen flow of 15 liters, SP02 increased to 90%; -Resident mumbled throughout most of this time, but unable to understand. Review of the resident's medication error note dated [DATE], at 10:36 A.M., showed the following: -The former Director of Nursing (DON) documented on [DATE] Norco (hydrocodone-APAP) ,d+[DATE] and fentanyl 50 mcg patch were administered to the resident; -The physician in the facility wrote new orders for the resident. Orders for multiple residents were written on the same paper with Resident #162's name at the top of the page; -A new nurse saw the physician orders for the first time. The nurse and former Administrator misread the orders for the resident, as it was thought to be the orders on the page were only for Resident #162; -Staff sent the resident to the hospital. -The physician orders were placed in the correct charts for the residents. Review of RN X's written statement, dated [DATE], showed the following: -The resident was new admit at 9:05 A.M. ([DATE]) and the physician was present in the facility to complete the initial assessment and medication orders for the resident. The physician hand wrote medication orders under the resident's name. The physician wrote orders for multiple residents on the same page; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The RN did not see where the resident's orders ended and a different resident's orders began. The RN read the order for 50 mcg fentanyl patch and Norco as being for Resident #162. Around 10:00 A.M., the RN administered the patch and the Norco with the resident's other medications due to the resident fighting staff, tried to escape the unit, and was one-on-one status; -At 6:40 P.M., a CNA came out of the resident's room and said he/she thought the resident was having a seizure. The nurse assessed the resident and measured the resident's blood pressure as ,d+[DATE]ish mmHg; -The RN administered Ativan 2 mg IM and sent the resident to the hospital; -The resident's oxygen level decreased to 76%. Staff placed the resident on the floor in case further intervention was needed. Oxygen at 15 liters given and SPO2 was at 90% plus before EMS transport. The resident mumbled and said his/her spouse's name. Review of the former Administrator's statement, dated [DATE], showed on [DATE] she personally looked at the paper that the physician had written for new orders. She did not notice the fentanyl order was listed for another resident when the RN was going to pull medications for Resident #162. During an interview on [DATE], at 12:31 P.M., the former Administrator said the following: -She was at the nurses' station and an aide sat with the resident; -The physician had just left the facility; -The physician wrote his/her orders on a piece of paper; -RN X said he/she needed to get the resident some medications; -RN X grabbed the sheet with all the orders; -She remembered seeing the resident's name and a fentanyl order; -On [DATE], she met with RN X and the former DON. The Administrator told the DON the resident had an order for a fentanyl patch and the DON said that was not the resident's order; -They looked at the paper in the shred box and the order was not for Resident #162; -The physician listed all the residents on one page and there was no line drawn on the paper between the residents; -The former Administrator said the physician writes on a piece of copy paper with names on the left and physician orders on the right, and not divided out; -If staff did not see the resident name on the left, staff could miss the order for who the order was for. It was an opportunity for a medication error; -RN X said he/she picked up the paper of the physician and gave the resident some medications; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Nursing Center	1700 South Hudson Avenue Aurora, MO 65605

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-RN X did not look at the MAR and/or POS for the resident's orders; -RN X just looked at the paper on the desk; -RN X should have entered the orders. Review of recent physician's orders, dated [DATE], [DATE], [DATE], and [DATE], showed the physician continued to write multiple residents' orders on the same piece of paper. During an interview on [DATE], at 2:53 P.M., LPN EE said the following: -On [DATE], he/she sat at the nurses' station receiving end of shift report from one of the day shift nurses, when a CNA came out of the unit and said he/she thought the resident was having a seizure. He/she, RN FF, and another night shift nurse went to the unit to assess the resident's condition. RN X, the unit's day shift nurse, had stepped away, but he/she returned shortly. The resident's color was normal, but he/she was diaphoretic (sweating profusely) and had tremors like a seizure. His/her blood pressure was very high. The nurses worried the resident would have a stroke with his/her blood pressure so high. The nurses transferred the resident to the floor in case he/she needed cardiopulmonary resuscitation (CPR - an emergency procedure that is performed when a person's heartbeat or breathing has stopped). The other night shift nurse called EMS and the nurses continued to monitor the resident's condition. -RN X left the unit and returned with lorazepam. RN X said since the resident's blood pressure was so high that maybe something to sedate him/her would help; -LPN EE did not think the resident had a seizure, but did not know exactly what was going on with the resident; -The resident calmed after RN X administered the lorazepam. EMS arrived and transported the resident to the hospital; -Sometime after midnight, the other night shift nurse received a call from the hospital. The hospital nurse said they found a fentanyl patch on the resident, but they did not find an order for it; -The next day ([DATE]), LPN EE told RN FF the hospital called and said they found a fentanyl patch on the resident. RN FF told LPN EE that RN X applied the fentanyl patch and administered a pain pill to the resident, at the same time, and did not have orders; -The physician usually wrote orders on a progress note and had a running list with different residents' names with their orders on the same page; -The nurse did not understand how the error occurred, if the nurse did not enter the order into the computer, he/she should not have administered the medication; -Usually the day shift nurse who admitted the resident entered the orders into the computer. The nurse did not know if anyone checked those orders after the admitting nurse entered them. During an interview on [DATE], 3:53 P.M., RN FF said the following: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-When a resident admitted to the facility, sometimes the MDS Coordinator entered the orders, other times the nurse who admitted the resident entered the orders; -The physician writes orders on a progress note. He/she writes several residents' orders on the same note; -The physician used to write residents' orders in each of their paper charts. When the system changed to electronic orders, he/she would electronically sign the order, but would not enter them; -On [DATE], during shift change, an aide came out to the desk (from the unit) and said it looked like the resident was having a seizure or he/she was unresponsive; -RN FF told the CNA to grab the code cart and to transfer the resident onto the floor. One of the night shift nurses called EMS; -On [DATE], during report, LPN EE said that the hospital called and told him/her that the resident received too much medication. A nurse applied a fentanyl patch on the resident. During an interview on [DATE], at 12:28 P.M., CNA Y said the following: -The resident was in a recliner in the dining room sleeping (on [DATE]); -Staff woke up the resident to do vital signs and he/she started shaking; -Nurses assessed the resident and sent him/her to the hospital; -He/she asked the resident when he/she woke up if he/she was ok and the resident said no. During an interview on [DATE], at 1:20 P.M., Certified Medication Technician (CMT) B said the following: -The resident paced back and forth and was almost manic; -Staff tried to walk the resident who appeared like he/she could not rest; -The resident appeared sleepy, but would not stay in bed. He/she mentioned to RN X that maybe the resident needed a Xanax. RN X said do not worry he/she had orders for a fentanyl patch for the resident. During an interview on [DATE], at 10:11 A.M., RN E said the following: -The resident did not have orders for a fentanyl patch or Norco; -Staff should not have administered a fentanyl patch or Norco to the resident due to the resident did not have orders for these medications; -The hospital sends orders with new admissions. Nurses review the physician orders and enter them in the computer and notify the physician with a new admission; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Medical Director/physician writes down the resident's name and order on a sheet of paper; -The physician gives the paper to the nurse when he/she completed his/her visits; -The nurses enter the orders in the computer; -The physician writes all the orders for different residents on the same paper; -The physician writes the resident name and order underneath the name and starts new order. The physician does not write a line, just puts the resident name and orders on the same page; -The physician continued with the same process of writing different residents with different orders on the same paper; -The nurse gives the paper to medical records staff after entering the physician orders in the computer. During an interview on [DATE], at 10:38 A.M., Medical Record Staff said the following: -The nurses give him/her the papers with the physician's orders once per week; -All the residents are on the same page. During an interview on [DATE], at 10:28 A.M., the Assistant Director of Nursing (ADON) said the following: -Staff should not have administered the fentanyl patch or Norco if the resident did not have a physician order; -A fentanyl patch or Norco could cause adverse reaction such as serious allergy or death, rash, or hallucinations; -The MDS/Care Plan Coordinator gets the orders and enters them in the computer; -The SSD receives a fax from the hospital of the referral and physician orders; -The physician assesses the residents and writes the orders on a piece of paper with lines on it; -The physician writes the resident name and order on the paper and signs after each order; -All the residents are on the same paper; -He/she goes down the list and checks the orders off after he/she enters them in the computer for each resident; -He/she gives the paper to medical record staff after he/she enters the orders; -The physician continues to write the residents and orders all on the same page. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on [DATE], at 10:50 A.M., and on [DATE], at 10:33 A.M., MDS/Care Plan Coordinator said the following: -The resident did not have physician orders for a fentanyl patch or Norco on his/her POS; -Staff should not have given the resident a fentanyl patch and Norco; -Adverse reactions caused from fentanyl patch and Norco could include drowsiness and lethargic; -He/she did not see documentation on the resident's MAR of administration of the fentanyl patch and Norco or any of the orders in between the resident's name and the bottom of the page; -Nurses enter the physician orders in the computer; -He/she she enters the diagnosis codes and orders in the computer for a new admission; -He/she gives the physician orders to the nurse who sends to the to pharmacy; -The Medical Director/Physician writes every resident and their orders on a progress note; -The nurse enters the physician orders into the computer when the physician has completed his/her weekly visit; -He/she did not know of staff looking at the paper and entering an order for another resident; -Different residents on the same page with orders could be a cause for a medication error; -Adverse reactions caused from fentanyl patch and Norco could include drowsiness and lethargic. During an interview on [DATE], at 12:15 P.M., the Social Service Director (SSD) said she just got off the phone with the resident's family member who said the facility medication error is believed to have caused the resident's seizure. During interviews on [DATE], at 11:55 A.M., and on [DATE], at 2:15 P.M., the Corporate Regional Director said the following: -Nurses should have entered and documented the fentanyl patch and Norco on the MAR; -Nurses should enter the physician orders in the computer at the end of the physician visit; -The nurse saw the resident's name on the paper and did not see the other residents' name on the paper who had the fentanyl patch and Norco order; -Possible effects from the fentanyl patch and Norco is just what happened, seizures. -She expected nurses to review a resident's MAR before administration of a medication instead of off a piece of paper. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at approximately 12:20 P.M., the Administrator said the following: -Nurses should enter the physician orders in the computer before they go to the E-kit; -Staff should document on the MAR of what they took from the E-kit; -She expected education with staff and the physician for the medication error. During an interview on [DATE], at 1:19 P.M., the Medical Director said the following: -She writes orders on a sheet of paper on her rounds; -She gives the paper to the nurses who enter them into the computer; -All the residents names are on the same paper with all the physician orders on front and back for several residents; -This was a medication error. The nurse thought he/she had the right resident and he/she did not see the other residents' names listed; -She expects staff to look at the physician orders, enter the orders in the computer, and administer the medications; -She expects the nursing staff to document administration of medications; -She was notified of the staff giving the resident a fentanyl patch and Norco. NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview, and record review, completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO00231592

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form to meet residents' needs when staff failed to prepare pureed food to the proper consistency in accordance with professional standards for one resident (Resident #26) out of four residents on a pureed texture diet. The facility census was 60. Review of the facility's policy titled, Meal production - Menu, undated, showed pureed food should not be thinner than pudding or thicker than mashed potatoes. 1. Review of Resident #26's face sheet (resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included senile degeneration of the brain (older individuals who suffered from cognitive decline, particularly memory loss), anxiety, and vitamin A deficiency. Review of the resident's April 2024 Physician Order Summary report showed the following: -An order, dated 03/22/23, for regular diet, pureed texture. Do not change order per physician. Review of the resident's care plan, updated 12/29/23, showed the following: -The resident had a potential nutritional problem related to decline in cognition; -The resident was on a mechanical soft diet; -Staff should provide and serve the resident, the diet ordered by the physician. (Staff did not update the care plan for the order change on 03/22/23.) Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 01/08/24, showed the following: -The resident had severe cognitive impairment; -The resident required supervision with set up and clean up of meal; -The resident was able to complete activity; -The resident received a mechanically altered diet. During an interview on 04/09/24, at 10:32 A.M., Cook L said they have four residents who received a pureed diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/09/24, at 11:54 A.M., of Dietary Aide (DA) K showed the following: -DA K took four individual serving bowls of cherry crisp and placed them in the blender; -DA K added an unmeasured amount of apple juice to the blender and turned the blender on; -DA K poured the pureed cherry crisp into four individual serving bowls; -The bowls of cherry crisp did not have equal amounts in them; -The consistency of the pureed crisp was thin and resembled a water consistency. Review of the facility's recipe for pureed cherry crisp showed staff should add milk to cherry crisp. Observation on 04/09/24, at 12:52 P.M., during lunch, showed the following: -Certified Medication Tech (CMT) B assisted the resident with eating his/her lunch; -CMT B said the dessert (cherry crisp) was really runny and could be drank through a straw; -CMT B had difficulty keeping the dessert on the spoon for the resident; -The resident said it would be easier to drink the dessert. During an interview on 04/10/24, at 1:36 A.M., DA K said the following: -Cook helpers and DAs are responsible for pureeing desserts; -Pureed food should not be runny or drinkable; -Liquids helped make food smoother when blending; -He/she received training on pureeing food from a cook when he/she started employment; -The recipe called for the use of milk, but the Dietary Manager (DM) told him/her to use apple juice; -He/she did not follow the recipes when pureeing foods. During an interview on 04/10/24, at 2:27 P.M., the DM said the following: -The cook's helper/DA is responsible for pureeing desserts at meal time; -The DAs received training on how to puree food when hired; -If the DM was not available, the cook trained the DA on how to properly puree food items; (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DM told DA K to use apple juice instead of milk when he/she pureed the cherry crisp; -The DM said it made more sense to use apple juice with the cherry crisp as both are fruits and it would mix/taste better; -The puree consistency should not be thinner than pudding or thicker than mashed potatoes; -The DM usually checked the pureed food prior to it being served; -The DM said that staff should follow recipe when pureeing food. During an interview on 04/12/24, at 7:47 A.M., the Administrator said the following: -The cook should puree all food items; -The DM should be trained on properly pureeing food and he/she should train the staff; -Pureed consistency should not be thinner than pudding or thicker than mashed potatoes; -Staff should follow all recipes to ensure that the residents are getting all the nutrients from the meal. During an interview on 04/12/24, at 9:41 A.M., the Registered Dietician (RD) said the following: -The cook or DM manager should be pureeing all food items for the residents; -Staff should follow all recipes when pureeing food; -The DM used apple juice instead of milk with the cherry crisp because using milk would require the dessert to be refrigerated after pureed; -Pureed consistency should not be thinner than pudding or thicker than mashed potatoes.

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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. 48534 Based on observation, interview, and record review, the facility failed to store food in a manner to protect it from potential contamination when staff failed to date and label stored food in refrigerators; failed to keep non-food contact surfaces clean and free of debris; and failed to sanitize dishes in the three vat sink at the minimum manufacturer's requirements. The facility's census was 60. 1. Review of the facility's policy titled, Food Storage - Refrigeration, undated, showed all leftovers shall be labeled and dated with expiration dates. Observation on 04/07/24, at 2:42 P.M., of the reach in refrigerator showed the following: -One individual serving dish of peach pie not covered, labeled, or dated; -One cheese sandwich on a plate, covered and not dated. Observation on 04/07/24, at 2:51 P.M., of the walk-in refrigerator showed the following: -An open container on the top shelf containing four apples and three lemons that were wilted, brown, and not dated; -A serving tray on the top shelf containing 12 individual condiment containers, containing a clear liquid, not labeled; -A serving tray on the top shelf containing 21 individual condiment containers, containing a yellow substance, not labeled. Observation on 04/08/24, at 9:53 A.M., of the reach in refrigerator showed the following: -Two individual serving dishes of cottage cheese not dated. Observation on 04/08/24, at 9:59 A.M., of the walk-in refrigerator showed the following: -An open container on the top shelf containing four apples and three lemons that were wilted, brown, and not dated; -A serving tray on the top shelf containing 12 individual condiment containers, containing a clear liquid, not labeled; -A serving tray on the top shelf containing 21 individual condiment containers, containing a yellow substance, not labeled. Observation on 04/09/24, at 10:01 A.M., of the reach in refrigerator showed the following: -Three plates of lettuce salad not dated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Three plates of sandwiches not dated. Observation on 04/09/24, at 10:16 A.M., of the walk-in refrigerator showed the following: -An open container on the top shelf containing four apples and three lemons that were wilted, brown, and not dated; -A serving tray on the top shelf containing 12 individual condiment containers, containing a clear liquid, not labeled; -A serving tray on the top shelf containing 21 individual condiment containers, containing a yellow substance, not labeled. During an interview on 04/10/24, at 1:18 P.M., Dietary Aide (DA) J said kitchen staff are responsible for covering, labeling, and dating food prior to it being put in the refrigerator. During an interview on 04/10/24, at 1:36 P.M., DA K said cooks or cooks' helpers are responsible for dating and labeling food prior to being put in the refrigerator. During an interview on 04/10/24, at 2:02 P.M., Cook L said the following: -Cooks are responsible for dating and labeling leftover food prior to it being put in the refrigerator; -DAs are responsible for dating and labeling food items prepared by him/her prior to being put in the refrigerator. During an interview on 04/10/24, at 2:27 P.M., the Dietary Manager (DM) said the following: -The cooks and DAs are responsible for putting food in the refrigerator; -All food should be covered, labeled, and dated prior to being put in the refrigerator. During an interview on 04/12/24, at 7:47 A.M., the Administrator said staff should label and date food prior to it being put in the refrigerator. 2. Review showed the facility did not provide a policy regarding wall and floor maintenance. Review of the Food and Drug Administration (FDA) 2022 Food Code showed the following: -Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Observations on 04/07/24, at 3:00 P.M., on 04/08/24, at 10:05 A.M., and on 04/09/24, at 10:21 A.M., showed the following: -A four foot line of peeling paint on the ceiling above the three vat sink and a food prep table. (The peeling paint could fall and contaminate food or food contact surfaces.); (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The floor under the food preparation table to the left of the steam table had an area approximately 4 feet wide by 5 feet deep area that was a rough, porous surface that appeared to be concrete where food and dirt could become trapped. The surface was not tiled like the rest of the floor; -Seven tiles were missing in random spots throughout the kitchen where food and dirt could become trapped. During an interview on 04/10/24, at 1:18 P.M., DA J said the following: -The kitchen floor was not cleanable with a mop; -Food and debris could get in spots where tile were missing; -He/she did not think there was any peeling paint in the kitchen; -All staff were responsible for cleaning and maintaining the floor and walls in the kitchen. During an interview on 04/10/24, at 1:36 P.M., DA K said pieces of the floor could be fixed. He/she was not aware of any peeling paint in the kitchen. Maintenance staff were responsible for the upkeep of the walls and floors. During an interview on 04/10/24, at 2:02 P.M., Cook L said he/she would report any floor or peeling paint issues to the DM. During an interview on 04/10/24, at 2:27 P.M., the DM said the following: -The floor in the kitchen is not a cleanable surface; -The DM reports issues with the floor, walls, and ceiling to the maintenance supervisor. During an interview on 04/12/24, at 7:47 A.M., the Administrator said staff should report maintenance issues to the maintenance supervisor either by word of mouth or through the maintenance log kept at the nursing desk. The DM is responsible for the condition of the kitchen. 3. Review of the facility's policy titled, Sanitation - Ware washing, dated November 2007, showed the following: -Dinnerware and supplies shall be washed and sanitized according to food safety practices and regulatory guidelines; -All dinnerware, utensils, and preparation and service supplies shall be washed and sanitized in the pot sink; -The pot sink shall be a three sink unit with detergent in the first sink, clear rinse water in the second, and a sanitizer in the third and final sink. Review of the FDA 2022 Food Code showed utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/09/24, at 11:21 A.M., showed Cook L used a metal pot and two flat metal pans to prepare lunch. Cook L used the three vat sink and submerged the pot and pans in the wash sink and washed them, rinsed the pot and pans, and skipped the sanitizer sink. Cook L placed the pot and pans on a clean surface to dry. During an interview on 04/10/24, at 2:02 P.M., Cook L said the following: -The three vat sink was used to wash, rinse, and sanitize pots and pans; -Staff were not using the sanitize sink for large items because the sink does not have a plug; -A dish pan sits inside the third sink to sanitize cooking utensils; -The DM was responsible for making sure plugs are available for the sink. During an interview on 04/10/24, at 1:36 P.M., DA K said staff use the three vat sink to wash, rinse, and sanitize items used to prepare food. The DM was responsible for making sure plugs are available for the sink. During an interview on 04/10/24, at 2:27 P.M., the DM said the following: -Cooks use the three vat sink to wash, rinse, and sanitize items used during food preparation; -Cooks were expected to use all three steps when washing dishes; -All pots and pans had to be sanitized; -Staff are sanitizing all pots and pans when using the three vat sink. -The DM did not know that a plug was needed for the three vat sink. During an interview on 04/12/24, at 7:47 A.M., the Administrator said that staff should be using the three vat sink to wash, rinse, and sanitize pots and pans used to prepare food.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Nursing Center	1700 South Hudson Avenue Aurora, MO 65605

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 34871 Based on interview and record review, the facility failed to review and update the comprehensive facility assessment annually, in accordance with all applicable Federal requirements. Failure to review and update the comprehensive facility assessment annually could delay the services needed to care for the residents in day-to-day operations and in emergencies. This failure could affect all facility occupants. The facility census was 60. Review showed the facility did not provide a policy regarding the facility assessment. 1. Review of the facility's assessment, showed the following: -Staff completed the facility assessment in 2020; -Staff did not document review of the facility assessment since 2020. During an interview on 04/12/24, at 2:15 P.M., the Administrator said the following: -She began the position on 04/05/24; -She is responsible for reviewing and completing the facility assessment; -The facility staff should review the facility assessment yearly; -The facility assessment determines resident acuity needs; -The facility assessment determines staffing required for resident care; -Departments heads and the physician should be involved and discuss the facility assessment; -The facility staff should review the facility assessment annually due to changes with the population, staffing, and acuity needs; -She expected the facility assessment to have been reviewed since 2020. During an interview on 04/12/24, at 2:15 P.M., the Regional Corporate Clinical Staff said she expected the facility assessment to be reviewed yearly and since 2020.

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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** 36974 Based on observation, interview, and record review, the facility failed to maintain an effective and complete infection control program when staff failed to follow the facility's policy to monitor and prevent the development Legionella bacteria (a bacteria which causes a respiratory disease when breathing in small droplets of water in the air that contain Legionella. It can become a health concern when it grows and spreads in human-made water systems) in the facility's water system. The facility also failed to update policies, educate staff, and implement policies related to Enhanced Barrier Precautions for six residents (Resident #110, #47, #160, #20, #161, and #24) out of a sample of 26 residents. The facility census was 60. 1. Review of the Centers for Disease Control (CDC) Toolkit for Legionella bacteria (officially titled Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings) showed healthcare facilities need to actively identify and manage hazardous conditions that support growth and spread of Legionella by: -Identifying building water systems for which Legionella control measures are needed; -Assessing how much risk the hazardous conditions in those water systems pose; -Applying control measures to reduce the hazardous conditions, whenever possible, to prevent Legionella growth and spread; -Make sure the program is running as designed and is effective. Review of the facility's policy titled, Water Safety Policy and Procedure, undated, showed the following: -All water outlets that are, or may remain unused, will be on a schedule of periodic flushing; -The water management team will meet quarterly forming a quarterly assessment. This assessment will be discussed at the monthly safety team meeting; -A water flow textual explanation, or flow diagram, will be maintained, reviewed, and updated when necessary on a quarterly basis; -All corrective actions will be logged in water safety team meeting notes. Review of such corrective action will be scheduled on a timeline established when corrective action is implemented. Observations on 04/10/24, starting at 9:30 A.M., showed the following: -Numerous empty resident rooms around the facility with no residents currently assigned to the rooms; -One full hall (500 hall) did not have residents assigned to the 12 rooms. Staff used some of the rooms as storage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/10/24, at 4:45 P.M., the head of Environmental Services said the following: -Housekeeping staff weekly flush all showers in the facility; -Housekeeping staff will also try to flush toilets and sinks in empty rooms. There was no schedule for how often staff should flush anything; -There was no documentation of any flushing of the sinks, showers, or toilets; -Housekeeping does not flush or check utility rooms or places other than resident rooms, since utility rooms and others are always being used; -He/she did not know of any water diagram or other assessment for areas in the building that might be prone to water stagnation; -She was not part of a water management team that met monthly or quarterly. During an interview on 04/10/24, at 4:45 P.M., the Maintenance Director said the following: -He was not aware of any procedures or policies related to reducing Legionella growth and spread in the building; -He was not checking any part of the facility, in any manner, for risk and conditions related to Legionella prevention or growth; -He was not part of a water management team that met monthly or quarterly. During an interview on 04/10/24, at 4:45 P.M., the Administrator said she was new to the facility and was not familiar with any facility policy or practice for water management or Legionella prevention. 41787 2. Review of the facility's policy, titled Infection Prevention and Control Program, dated 2019, showed the following: -Purpose was to establish and maintain an Infection Prevention and Control Program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help the development and transmission of communicable diseases and infections; -It is the policy that the facility's IPCP be based upon information from the facility assessment and follows national standards and guidelines; -The facility's policy did not address the requirement of enhanced barrier precautions (EBP - refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targets gown and glove use during high contact resident care activities). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 07/12/22, showed the following: -EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices; -High-contact resident care activities requiring gown and glove use for EBP included providing hygiene, changing briefs or assisting with toileting, device care (central line (intravenous (IV) line that goes all the way up to a vein near the heart or just inside the heart), urinary catheter (a sterile tube inserted into the bladder to drain urine), and wound care; -PPE, including gowns and gloves, should be available immediately outside of the resident rooms. Review of the facility's policy titled Infection Control - Catheter Care, dated 10/19/18, showed the policy did not address the use of gowns when providing catheter care. Review of the facility's policy titled, Central Venous (intravenous (IV) line that goes all the way up to a vein near the heart or just inside the heart) and Midline (long, thin, flexible tube that is inserted into a large vein in the upper arm) Catheter Flushing, dated April 2016, showed the policy did not address the use of gowns when providing care of central venous and midline catheter flushing. Review of the facility's policy titled Pressure Ulcer/Pressure Injury Prevention, dated April 2018, showed the policy did not address precaution to be taken with wound care. 3. Review of facility provided list received on 04/12/24, at 12:54 P.M., showed the following: -Resident #110 had a peripherally inserted central catheter line (PICC - form of intravenous access that can be used for a prolonged period of time or for administration of substances) for antibiotics; -Resident #47 had a PICC line for antibiotics; -Resident #160 had an indwelling Foley catheter; -Resident #20 had an indwelling Foley catheter; -Resident #161 with pressure ulcers on coccyx; -Resident #25 with wounds on right arm. 4. Review of Resident #110's face sheet (admission data) showed the following: -admitted [DATE] with readmitted [DATE]; -Diagnoses included osteomyelitis (inflammation of the bone cause by an infection) and diabetes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/09/24, showed the following: -Cognitive skills intact; -Received antibiotic. Review of the resident's current care plan, undated, showed the following: -The resident had intravenous (IV - fluids and medicine in the vein) access to the right side for seven days; -Monitor, document, and report to the Medical Director as needed for signs and symptoms of infiltration (fluid leaks out into the tissues under the skin where the tube has been put into the vein) at the site; -Check dressing at site daily; -Check IV site daily for redness, swelling, or drainage and report any findings to the nurse. (Staff did not care plan regarding EBP.) Review of the resident's current POS showed an order, dated 04/07/24, for ertapenem (medication used to treat infections) sodium solution reconstituted one gram (gm) IV. Review of the resident's April 2024 Treatment Administration Record (TAR) showed an order, dated 04/07/24, for ertapenem sodium solution reconstituted one gm use one gm IV every 24 hours for infection (urinary tract infection) for seven days. Staff documented administration of the medication as ordered. Observation on 04/08/24, at 9:24 A.M., showed the resident requested assistance from CNA Q to the bathroom. The resident stood up and transferred himself/herself to his/her wheelchair. CNA Q applied gloves and did not put on a gown. CNA Q assisted the resident up out of the wheelchair to the toilet. Resident sat on the toilet in his/her bathroom. CNA Q assisted the resident out of the bathroom. CNA removed his/her gloves and washed his/her hands after the resident was out of the bathroom. The facility did not have gowns inside the resident's bathroom and room. Observation on 04/08/24, at 1:12 P.M., showed the resident sat on his/her bed in his/her room. The resident had his/her call light on and told CNA O that he/she needed to use the bathroom. CNA O applied gloves and did not put on a gown. CNA O placed a gait belt around the resident. CNA O reached around the resident to place the gait belt on. CNA O wheeled the resident to his/her bathroom and assisted the resident up and onto the toilet. The resident sat on the toilet while the CNA waited outside the bathroom door to allow privacy for the resident. The resident said he/she was done and the CNA entered the resident's bathroom and assisted the resident with continence care. CNA O then assisted the resident off of the toilet to the wheelchair and wheeled the resident out of the bathroom. The CNA washed his/her hands after removed gloves. 5. Review of Resident #160's face sheet showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-admitted [DATE]; -Diagnoses included multiple sclerosis (MS - a long-lasting (chronic) disease of the central nervous system, that impacts the brain and spinal cord, which make up the central nervous system and controls everything we do), muscle wasting and atrophy (decrease in size) right and left lower leg, neuromuscular dysfunction of the bladder (the nerves and muscles don't work together very well, the bladder may not fill or empty correctly), depression, anxiety, pain, and muscle spasm. Review of the resident's care plan, dated 03/27/24, showed the following: -The resident had multiple sclerosis; -The resident had a catheter due to neurogenic bladder; -Staff should complete catheter care every shift and as needed; -Staff should position the catheter bag and tubing below the level of the bladder and away from the entrance of the room door; -Check tubing for kinks each shift; -Monitor and document intake and output as per facility policy; -Staff should monitor, record, report to physician for signs and symptoms of urinary tract infection (UTI). (Staff did not care plan related to EBP.) Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Resident had an indwelling catheter; -Required set up or clean up assistance for eating, oral hygiene, toileting hygiene, personal hygiene, upper body dressing, lower body dressing. Review of the resident's physician's order sheet, current as of 04/12/24, showed the following: -Indwelling catheter 20 French (catheter size), 10 milliliter (ml) balloon; -Flush Foley with 60 cubic centimeters (cc) of sterile water as needed; -Change drainage bag and catheter anchor every Sunday -Indwelling catheter care. Check catheter for anchor placement every shift and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview and observation 04/07/24, at 4:50 P.M., the resident said he/she had a leg bag currently attached to the catheter tubing. He/she used the larger catheter bag at bedtime. He/she said that staff wear gloves when working with the catheter, but they did not wear a protective gown. Observation on 04/10/24, at 9:10 A.M., showed staff did not wear a gown when working with the resident's catheter. 6. Review of Resident #161's face sheet, showed the following: -admitted on [DATE]; -Diagnoses included displaced fracture of first cervical vertebra with routine healing (broken bone in the neck), cardiac arrest (sudden, unexpected loss of heart function, breathing, and consciousness), and chronic pain. Review of the resident's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Use of wheelchair for locomotion. Review of the resident's physician orders, current as of 04/12/24, showed the following: -Cleanse open areas to buttocks with wound cleanser, pat dry, apply aquacel (wound dressing with medication) dressing every 72 hours until resolved; -Follow up appointment on 05/22/24 to have peg tube (tube inserted through the wall of the abdomen directly into the stomach) removed. Review of resident's care plan, dated 04/03/24, showed the following: -Resident had potential/actual impairment to skin integrity related to redness to coccyx (tailbone), peg tube in place; -Staff will monitor pressure areas for changes, report any changes to nurse; -Administer treatments as ordered and monitor for effectiveness; -Staff should assist resident to turn/reposition every two hours and more often as needed. (Staff did not care plan related to EBP/) Observation on 04/08/24, at 10:45 A.M., showed the Assistant Director of Nursing (ADON) entered the resident's room with supplies to complete wound care on the resident's coccyx. The ADON did not put on a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. During an interview on 04/10/24, at 9:30 A.M., Certified Nurse Aide (CNA) G said he/she was notified in report if a resident had wound, catheter, or any other special needs. He/she could ask the charge nurse if he/she had questions. He/she would wear gloves and wash hands when working with residents for infection prevention. He/she had heard of EBP. Staff do use barrier creams on residents and that hand hygiene was an effective method to prevent contamination. During an interview on 04/10/24, at 9:40 A.M., Registered Nurse (RN) E said when working with residents with wounds, IVs, catheters, or any other special needs, staff ensure to change tubing as ordered and catheters were changed every 30 days or as needed. He/she had not heard about EBP. They had infection control in-services related to hand hygiene. If a resident was on isolation or contact precautions staff would wear gown, gloves, masks, as needed. During an interview on 04/10/24, at 9:45 A.M., RN F said nurses were notified during report or on resident physician order sheets if a resident had wounds, catheter, or IVs. Staff should complete hand washing and wear gloves when working with the residents. He/she had not heard of EBP. The facility had transmission barrier precaution training and in-services. Staff should use gown, mask, gloves with residents in contact or isolation precaution due to infection. During an interview on 04/12/24, at 12:00 P.M., the ADON said he/she was the current facility Infection Preventionist and that he/she had not received any training or information related to EBP. He/she said that initially he/she thought about barrier creams when heard this question. During an interview on 04/11/24, at 9:40 A.M., the MDS/Care Plan Coordinator said he/she had not heard of EBP. He/she was aware of transmission based precautions when there was PPE outside a resident room door and a sign on the door for staff or visitor to see the nurse before entry. When using PPE the staff would dispose of dirty gown, gloves, and mask in a dedicated trash can in the resident room. During an interview on 04/12/24, at 9:48 A.M., the Therapy Director said the following: -She did not have training about EBP; -Staff are suppose to have education about enhanced barrier precautions; -Staff should wear gowns and gloves when assisting residents who have catheters or wounds; -She did not have residents on caseload who have catheters or wounds at this time; -Facility staff did not instruct her to wear a gown with residents with catheters or wounds. During an interview on 04/12/24, at 1:53 P.M., with the Administrator and Corporate Nurse, the Administrator said that the ADON/Infection Preventionist should be updated in clinical meetings of new infection control information. The Administrator said the plan was to implement and train on EBP this week. EBP included wearing gown and gloves when working with residents wound, protruding peg tubes, mid lines, catheters, and ostomies (a surgical procedure that creates an opening in your abdominal wall, a new way for waste to leave the body). There would be signs and education for staff to notify the nurse. There would be PPE stocked in supply rooms. The need for EBP would also be in the resident's care plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	48534 34871

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 41787 Based on interview and record review, the facility failed to implement an effective and complete antibiotic stewardship program when staff failed to track residents on antibiotics for various infections in the facility by not completing a current and ongoing antibiotic log of residents with active infections. This failure could potentially place all residents at risk of infection. The facility census was 60. Review of the facility's policy, titled 'Infection Prevention and Control Program', dated 2019, showed the following: -The primary mission is to establish and maintain an Infection Prevention and Control Program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help the development and transmission of communicable diseases and infections; -It is the policy that this facility's IPCP is based upon information from the facility assessment and follows national standards and guidelines to prevent, recognize, and control the onset and spread of infection whenever possible; -The IPCP includes a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to regulatory requirements and following accepted national standards; -The IPCP includes an antibiotic stewardship program that includes antibiotic use protocols and system to monitor antibiotic use; -The intent of this regulation is to ensure that the facility develops and implements an ongoing IPCP to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually, based upon the facility assessment and as necessary. This would include revision of the IPCP as national standards change; -Elements of the program include the facility will designate one or more individuals as the Infection Preventionist (IP) who is responsible for the facility's IPCP; -Surveillance, including process and outcome surveillance, will include monitoring, data analysis, documentation, and communicable diseases reporting (as required by State and Federal law and regulation). Surveillance activities will be conducted to identify practice, infection trends, and early identification of new infections and potential outbreak situations; -Antibiotic stewardship and review includes reviewing data to monitor the appropriate use of antibiotics in the resident population. Review of the facility's 'Infection Prevention and Control Program - Infection Preventionist: Responsibility, Qualifications and Functions, dated 2019, showed the following: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The IP is responsible for the IPCP; -Review microbiology culture and sensitivity report on a regular basis to identify types of organisms causing infections, antibiotic-resistant organisms, and transmission of organisms between residents; -The IP will oversee the facility antibiotic stewardship program; -Review of the use of antibiotics (including comparing prescribed antibiotics with available susceptibility reports) is a vital aspect of the infection prevention and control program; -Involve the consultant pharmacist with the oversight by identifying antibiotics prescribed for resistant organisms; -Track antibiotic use monthly and complete an antibiogram yearly or as directed by the Medical Director and the quality assurance committee. Review of facility's titled, Antibiotic Stewardship Policy, dated 03/26/18, showed the following: -Aurora Nursing Center will follow a policy of antibiotic stewardship by instituting the following procedures: -The facility will provide resident, family, and community education regarding appropriate use of antibiotics by offering Center for Disease Control (CDC) information and updates by; -Insertion of CDC published information regarding antibiotic stewardship program into the admission packet; -Mailing of CDC published information regarding antibiotic stewardship to all family members; -Offered with the resident newsletter a copy of CDC published information regarding antibiotic stewardship; -Review of CDC published information regarding antibiotic stewardship in resident council annually; -The Care Plan Coordinator is the leader of the antibiotic stewardship program. The facility Care Plan Coordinator will log and monitor antibiotic usage, trends, and that all documentation procedures are compliant with this policy; -The Care Plan Coordinator will meet with the Director of Nursing (DON) on a frequent basis to share information regarding antibiotic trends and policy and procedure. Antibiotic stewardship will be reported at each monthly quality assurance meetings at least quarterly; -The DON will maintain a form for all direct care nursing to use when communicating with the Medical Director. This form will include: -Symptoms of infectious concern regarding a resident; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Recent history of infection; -Recent use of antibiotics for current, or other infection; -Other interventions to reduce infectious symptoms; -Alternative medications or remedies previously effective; -Any culture, or lab results with specific type growth. 1. Review showed the facility did not provide an antibiotic log. Review of facility provided list of residents currently on antibiotics, as of 04/07/24, showed the following: -Resident #110 on ertapenem sodium solution (brand name Ivanz - used to treat certain serious infections) intravenous (IV - administers fluids, medications and nutrients directly into a person's vein) every 24 hours for 7 days due to urinary tract infection (UTI - bladder infection); -Resident #47 on ertapenem sodium IV every 24 hours for 7 days due to UTI; -Resident #55 on sulfamethoxazole-trimethoprim (brand name Bactrim - combination of two antibiotics, used to treat a wide variety of bacterial infections) tablet 800-160 milligram (mg), 1 tablet on Tuesday, Thursday, and Saturday for 84 days, no reason provided; -Resident #54 on cefdinir 300 mg (brand name Ceftin - treats bacterial infections) every 12 hours for 5 days, due to UTI. Review of facility provided certificate titled Infection Preventionist Training Program, completed on 01/09/24, showed the Assistant Director of Nursing (ADON) completed the training. During an interview on 04/10/24, at 4:00 P.M., the ADON/IP said the following: -He/she started in the position in December 2023; -He/she completed a map of the facility with colored markings for each resident that had an infection during the month; -He/she just started writing the type of treatment provided on the map as well; -He/she was unsure what happens with the information, other than keeping in a 3-ring binder at his/her desk; -He/she thinks the previous DON was reviewing the type of infection for monitoring; -He/she said that he/she had been working the floor mostly since starting the job in December; -The previous DON and/or Administrator had been monitoring antibiotic stewardship; (continued on next page)

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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	-Once a resident is started on an antibiotic, they also are started on a probiotic (foods or supplements that contain live microorganisms intended to maintain or improve the good bacteria (normal microflora) in the body) per physician standing orders; -The nurse will place the resident on daily vital signs and daily monitoring; -The DON was the person that tracked antibiotic use; -He/she was unsure if any staff audit charts. Observation on 04/10/24, at 4:15 P.M., of the Infection Surveillance 3-ring binder showed maps colored with types of infections by room and medications resident taken for when and how long, for the months of January 2024, February 2024, and March 2024. There was not a resident specific log or an evaluation of information. During an interview on 04/12/24, at 1:53 P.M., with the Administrator and the Corporate Nurse said the IP should be updated in clinical meetings of new information. Antibiotic stewardship should be done by the IP. The IP should be keeping a log of all antibiotics prescribed to residents, so infection trends can be monitored in the facility. 34871