STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to ensure residents had the right to be as independent as possible when one resident (Resident #30), in a review of 24 sampled residents, who required a power wheelchair to be fully independent with mobility, was denied the assistance in obtaining a power wheelchair. Resident #30 was told by the administrator she forbid power chairs at the facility because they could hurt someone and that he/she would need to move to another facility if he/she wanted a power chair. The resident felt hopeless and discriminated against. Resident #11 had a power wheelchair, but said the administrator had threatened to take it away. The administrator said the resident failed his/her driver test and she was looking to take the resident's chair as she did not want any motorized chairs in the building. The resident's medical record showed no documentation the resident had failed his/her driving test. The threat of having the chair taken away made the resident feel more depressed at the thought of having his/her independence taken away, causing him/her to be more dependent on staff for things he/she could do for him/herself if he/she was allowed to keep his/her motorized chair. The facility census was 98. Review of the facility policy, Use of Assistive Devices, last revised 05/18/24, showed the following: -The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity; -Assistive devices are tools, products, types of equipment or technology that help individuals perform tasks and activities. They may help the individual move around, see, communicate, eat or get dressed. Assistive devices included mobility aids (i.e. walker, cane, wheelchair, raised toilet seat); -The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care; -The facility will provide assistive devices for residents who need them. Nursing, dietary, social services and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement; -Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices. This may include education or therapy sessions for training on the use of the device, set up assistance, supervision or physical assistance as needed; (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device; -A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed. Review of the facility policy, Resident Rights, dated 07/05/23, showed residents have the to right to accommodation of needs, residents have the right to reside and receive services with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. 1. Review of Resident #30's face sheet, showed the resident was his/her own responsible party. Review of the resident's care plan, last revised 04/17/24, showed the following: -Resident had chronic pain related to chronic physical disability which is paraplegia (paralysis of legs); -He/She used a geri chair (reclining chair on wheels; (this type of chair cannot be self propelled and requires staff to push for mobility); -Resident will remain free of complications related to immobility; -Resident was non-weight bearing; -Resident was dependent on staff for locomotion using gerichair; -No indication the resident must be reclined or could not sit upright. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/27/25, showed the following: -Cognitively intact; -Diagnosis of paraplegia (paralysis of the legs and lower body); -Impairment to functional range of motion (ROM) to both lower extremities, no documentation of impairment to upper extremities; -Dependent on staff for toileting hygiene, shower/bathing, lower body dressing, all transfers and wheelchair mobility. -No therapy services. Observation on 03/02/25 at 5:54 P.M., showed the resident in his/her room in a geri chair that was reclined. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/25 at 2:17 P.M., the resident said the following: -He/She was a paraplegic. He/She had his/her own power chair for years when he/she was at another facility; -While he/she was at the hospital, he/she decided to change facilities. The previous facility threw his/her motorized wheelchair in the dumpster; it had some issues and was old, but it worked fine; -He/She has been at this facility for 17 months and therapy was trying to get him/her a new power chair; -He/She had a physician's order and it was approved by Medicaid but the administrator stopped the order; -The Administrator said she forbid power chairs at the facility because they could hurt someone; -He/She has never hurt anyone and had driven safely for over [AGE] years; -He/She felt like he/she had lost his/her independence; -He/She felt hopeless and was at the mercy of everyone else; -He/She felt he/she was discriminated against because there was another resident that had and used a power chair in the facility; -The administrator said he/she could not have the power chair and would need to move to another facility if he/she wanted a power chair; -He/She felt he/she missed out on a lot and wanted to move to a facility that allowed him/her to have a power chair because he/she wanted to be independent; -He/She was depressed because he/she was stuck in a geri chair and could not be independent in areas that he/she could be independent in; -When he/she had a power chair he/she could go all over the facility and outside independently; now he/she was stuck in a gerichair and at the mercy of the staff. No one would like to have to be dependent for every aspect of their life if there was a way to have some freedom; -He/She felt he/she had no control of his/her life even though he/she was his/her own person. During an interview on 03/19/25 at 1:30 P.M., the Therapy Director said the following: -The resident wanted a motorized wheelchair; -They spoke with the physician and got the order to have the resident evaluated by the durable medical equipment company that specialized in wheelchairs and the resident was approved; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Administrator preferred not to have power chairs at the facility because of an incident in the past when a resident in the facility was run over by a resident using a power chair; the current residents were not involved in that incident; -Therapy staff did not know of any issues with the resident utilizing a power chair; -He offered to help the resident look at a manual tilt in space chair but the resident insisted on wanting more independence that the power chair would give him/her; -He believed the resident was being discharged tomorrow to a home that would allow him/her to have a power chair. During an interview on 03/05/25 at 8:00 P.M., the Administrator said the following: -To have a motorized chair, the residents have to be safe and pass a test; -The residents go through therapy and do a testing (cognition test and abilities) and the physicians get involved; -The resident was eligible for a new chair; the chair he/she has does not fit appropriately and the wheels have fallen apart because the resident was too large for the gerichair; -The resident wanted an electric wheelchair, but the resident cannot sit upright; -The resident will not get into a regular manual wheelchair and refused the manual wheelchair; -Therapy spoke with the resident and with the wheelchair company, and they measured to see what the resident would qualify for; -She was not sure if the resident could be reclined in a motorized chair and drive it; -She told therapy not to order the motorized wheelchair for the resident and offered for him/her to go to another home. 2. Review of Resident #11's annual MDS, dated [DATE] showed the following: -Cognitively intact; -Dependent for bed mobility, transfers, dressing and bathing; -Used a motorized chair; -Functional limitation in range of motion of bilateral upper and lower extremities; -Once seated in chair, able to wheel 50 feet (ft) with two turns with no assistance from helper; -Once seated in chair, able to wheel 150 ft in corridor or similar space with no assistance from helper; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No behaviors affecting others.; -No Occupational Therapy, Physical Therapy or Restorative Nursing minutes documented. Review of the resident's Power-Mobility Indoor Driving Assessment, dated 02/06/25 showed the following: -The assessment was completed by the physical therapy department;-The resident owned his/her motorized chair; -The chair had a horn for a safety device; -The resident was able to explain or demonstrate how each accessory was used; -The resident could turn device on and off, utilize the braking system, use the speed control switch, use special features of the device and request assistance if necessary; -The resident could not transfer him/herself on and off the device; -Handwritten comments authored by the medical director, dated 2/9/25 read: I have reviewed these notes, I agree. He/She was not safe to drive based on history of running into residents repeatedly; -Score of 79% with handwritten note: Resident would benefit from mirrors to see behind/beside him/her due to impaired cervical ROM. Resident would benefit from decreased speed; -The assessment did not indicate what was a passing or failing score; -Opinion: Able to drive with some difficulty. Review of the resident's care plan, last revised 02/13/25, showed the following: -ADL self-care performance deficit related to multiple sclerosis (MS-nerve damage disrupting communication between the brain and the body) and fatigue; -Totally dependent of one to two staff for bathing, bed mobility, dressing; -Dependent on two staff and a mechanical lift for transfers; -Encourage resident to discuss feelings about self-care deficit frequently; -Encourage resident to participate to the fullest extent possible with each interaction; -Encourage use of prescribed assistive devices (12/21/23). Review of the resident's physician order sheet (POS), dated 03/2025, showed he/she had diagnoses that included MS, depression and anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's facility electronic medical record showed no documentation the resident had run his/her motorized chair into other residents repeatedly and no documented safety concerns regarding the resident's use of his/her motorized chair. There was no documentation to show mirrors had been installed on his/her motorized wheelchair or that the speed had been decreased. During an interview on 03/02/25 at 4:52 P.M., the resident said the following: -The facility told him/her that he/she could not have his/her motorized chair and had threatened to take it away; -His/Her chair was the only way he/she had any independence and could do things for him/herself; -He/She would be mostly dependent on staff without the chair; -He/She would become more depressed without the chair; -Therapy had evaluated him/her in the chair and he/she had never hit anyone in his/her motorized chair. Observations during the survey process from 03/02/25 to 03/05/25, showed the resident up in his/her motorized chair in his/her room and in the common areas without any concerns of unsafe driving of the motorized chair or excessive speed. No mirrors were observed on the resident's motorized chair. During an interview on 03/19/25 at 1:30 P.M., the Therapy Director said the following: -The scoring of the power-mobility indoor driving assessment did not indicate a pass or fail; -The resident had not run into any residents when accompanied by therapy; -Therapy could help the resident to use the chair safely. During an interview on 03/05/25, at 8:00 P.M. and 3/19/256 at 2:19 P.M., the Administrator said the following: -Therapy evaluated the resident, and the resident failed the test; -The resident wanted to drive too fast; -The resident has not had an accident she was aware of; -She worried about the safety of others; -She knew the company which provided/attached safety devices to the motorized chairs had been in the facility a few times but they always worked on the resident's chair in his/her room; -She did not know if the company had attempted to turn the speed down or apply mirrors (per the assessment recommendations) to the resident's chair or not; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident failed his/her driver test and she was looking to take his/her chair as she did not want any motorized chairs in the building; -Therapy will evaluate to put him/her in a chair in which he/she could maintain level of function.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool required to be completed by facility staff, for four residents (Resident #18, #36, #59, and #79) in a review of 24 sampled residents. This assessment should have been completed within 14 days after the facility determined, or should have determined, there had been a significant change (a decline or improvement in two or more assessed areas of resident status) in the resident's physical or mental condition which had an impact on more that one area of the resident's health status, or was placed under hospice care, and required interdisciplinary review and/or revisions of the care plan. The facility census was 98. Review of the Centers for Medicare and Medicaid Services (CMS), Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.11, Chapter 2, revised October 2023, showed the following: -The significant change in status assessment (SCSA) is a comprehensive MDS assessment for a resident that must be completed when the Interdisciplinary team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change; -A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan; - When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met; -After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record; -An SCSA is appropriate when: 1. There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments and the resident's condition is not expected to return to baseline within two weeks; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. -The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than); -An SCSA must be performed regardless of whether an assessment was recently conducted on the resident; -This is to ensure a coordinated plan of care between the hospice and nursing home is in place. Review of the facility policy, Significant Change, revised on 11/06/23, showed the following: -The facility will identify within 14 days of a significant change in two or more areas of decline or improvement in the resident's physical or mental condition; -If the resident shows a decline or improvement in two or more areas, a significant change assessment will be completed within 14 days; -A significant change will be defined as a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. -The following are the criteria for a significant change: a. Is not self limiting; b. Impacts one or more of the resident's health status; c. Being placed on hospice or discharged off of hospice care; d. Requires an inter-disciplinary review of the care plan or MDS within 14 days of the significant change; e. A significant change assessment is indicated if decline or improvement is consistently noted in two or more areas of decline or two or more areas of improvement; -If the resident experiences a significant change in status, the next annual assessment is not due until 366 days after the significant change assessment has been completed; -The MDS/Care Plan Coordinator will complete a significant change assessment when the resident meets the criteria as defined by a significant change; -The Physician, Family Member/Legal Guardian/Responsible Party and Interdisciplinary Team will be informed of any significant changes and changes in interventions included in the plan of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 06/10/24, showed the following: -Cognitively intact; -Diagnosis of dementia, diabetes mellitus (inability to control blood sugar), bipolar (a mental health condition that causes extreme mood swings emotional highs(mania) and lows (depression)), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), extrapyramidal (describes involuntary movements that you cannot control cause by antipsychotic medications) and movement disorders; -Independent with eating, rolling left and right and propelling wheelchair 150 feet; -Set up or clean up assistance from staff for oral hygiene; -Requires supervision/touching assistance from staff members for toilet hygiene, upper body dressing, put on/take off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer and toilet transfers; -Requires partial/moderate assistance from staff for lower body dressing and tub/shower transfers; -Requires substantial/maximal assistance from staff to shower/bathe; -Scheduled pain medications, with the resident saying no pain present during assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following -Severe cognitive impairment (previous assessment cognitively intact); -New diagnosis of pneumonia, and new pressure ulcer that is Stage III (Wound with full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling); -New indwelling urinary catheter (tube inserted in bladder to drain urine); -Set up or clean up assistance from staff for eating (was independent previously); -Requires substantial/maximal assistance from staff for oral hygiene (was set up), upper body dressing (was supervision/touching), lower body dressing (was partial/moderate), personal hygiene (was supervision/touching), rolling left and right (was independent), and sit to lying (was supervision/touching); -Dependent on staff for toilet hygiene (was supervision/touching), shower/bathe (was substantial/maximal), put on/take off footwear (was supervision/touching), chair/bed-to-chair transfer (was supervision/touching), tub/shower transfer (was partial/moderate) and propelling wheelchair (was independent); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Not attempted during this assessment: lying to sitting on the side of the bed, sit to stand, and toilet transfer; -New mechanical soft diet; -New Stage III pressure ulcer present. A SCSA was not completed after the resident had a decline in cognition, new diagnosis that could change the resident's care plan, new urinary catheter, decline in several activities of daily living (ADL's), new diet and new Stage III pressure ulcer. 2. Review of Resident #36's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnosis include: dementia (15/15 on cognitive test), Parkinson's (a movement disorder of the nervous system), Traumatic brain injury (TBI-an injury to the brain caused by an external force, such as a blow, bump, jolt or penetration to the head. It can result in temporary or permanent damage to the brain, affecting cognitive, physical and emotional functions), anxiety, depression, Lewy body dementia (progressive brain disorder characterized by abnormal protein deposits called Lewy bodies in the brain); -Independent with all ADL's and walks without devices; -Occasionally incontinent of bowel and bladder; -No shortness of breath when lying flat; -Weight 181 pounds (lbs); -No falls. Review of the resident's quarterly MDS, dated [DATE], showed the following: -New delusions (a false belief or judgment about external reality, held despite incontrovertible evidence to the contrary) present; -New diagnosis of bipolar disorder; -New wheelchair use; -Independent with propelling wheelchair 50 feet and wheel wheelchair 150 feet (did not use devices on last assessment); -Requires supervision/touching assistance from staff members for eating, oral hygiene, sit to lying (was independent with these ADL's); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Requires partial/moderate assistance from staff for toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfers (was independent with these ADL's); -Requires substantial/maximal assistance from staff to shower/bathe (was independent with these ADL's); -Did not attempt walking due to medical condition (ambulated independently without devices prior assessment); -Frequently incontinent of bowel and bladder (previous assessment occasionally incontinent); -New shortness of breath when lying flat; -Two or more non injury falls, and two or more injury falls; -Weight 160 lbs.; significant weight loss (11.6 percent (%) weight loss since 07/19/24), not on a physician prescribed plan; -New intravenous (IV) access. The facility failed to complete a SCSA when the resident had many changes including new delusions, diagnosis of bipolar disorder, new wheelchair use, decline in all ADL's, increased incontinence, new shortness of breath when lying flat, four or more falls, significant weight loss and new IV access. 3. Review of Resident #59's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnosis: Diabetes mellitus (DM inability to regulate blood sugar), thyroid disorder, depression, respiratory failure, acute and chronic respiratory failure with hypoxia (lack of oxygen to the brain), fluid overload, stage 3 kidney disease, chronic obstructive pulmonary (respiratory) disease and chronic pain; -Moderate signs and symptoms of depression; -Rejection of care; -Independent with wheelchair propelling 50 feet and 150 feet; -Requires partial/moderate assistance from staff for upper body dressing, personal hygiene, rolling left and right, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer and tub/shower transfer; -Requires substantial/maximal assistance from staff for toileting hygiene, shower/bathe, lower body dressing, putting on/taking off footwear and sit to lying; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Frequently incontinent; -Scheduled pain medications; -Occasionally has pain, rates pain six on one to ten scale; -Weight 258 lbs. Review of the resident's quarterly MDS, dated [DATE], showed the following: -New diagnosis of pneumonia; -Moderate cognitive impairment (decline in cognitive abilities); -Requires substantial/maximal assistance from staff for upper body dressing, personal hygiene, rolling left and right (previous assessment required partial/moderate assistance); -Dependent on staff for toileting hygiene (previous assessment required partial/moderate assistance), shower/bathe (previous assessment required partial/moderate assistance), lower body dressing (previous assessment required partial/moderate assistance), putting on/taking off footwear (previous assessment required substantial/maximal assistance), chair/bed-to-chair transfer(previous assessment required partial/moderate assistance), tub/shower transfer (previous assessment required partial/moderate assistance), wheel 50 feet (the resident was independent on the previous assessment), wheel 150 feet (the resident was independent on the previous assessment); -Not attempted due to medical or safety concerns for sit to lying, lying to sitting on side of bed, sit to stand and toilet transfer; -Always incontinent (decline from previous assessment); -Frequent pain, occasionally effects sleep, rates a five on a one to ten scale (pain increased in frequency and now effects the resident's sleep); -New shortness of breath when laying flat; -Weigh 237 lbs, significant weight loss not on a plan; -New anticoagulant medication. A SCSA was not completed by staff when the resident had multiple changes on the 01/16/25 MDS including a new diagnosis of pneumonia, decline in cognition, decline in ADL's, increase in incontinence, increase in effects from pain, new shortness of breath, a significant weight loss and new anticoagulant medication. Review of the resident's undated census sheet showed the resident started on hospice services 01/28/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's electronic medical record showed a SCSA open with an assessment reference date (ARD) of 03/09/25, the assessment had not been started or completed within 14 days of beginning hospice services (the SCSA ARD was required to be schedule on or before 02/10/25), the assessment was approximately a month late from when hospice began. During an interview on 03/04/25 at 1:36 P.M., the resident's durable power of attorney said the resident has declined physically and medically. 4. Review of Resident #79's face sheet showed the following: -The resident had a guardian; -Diagnoses include vascular dementia (brain damage caused by multiple strokes that can cause memory loss in older adults) , anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily life) and unspecified psychosis (a term used when a person experiences symptoms of psychosis that do not meet the full criteria for a specific psychotic disorder, such as schizophrenia or schizoaffective disorder) not due to a substance or known physiological condition. Review of the resident's March 2025 Physician Order Sheet (POS) showed local hospice group to evaluate and treat with an order start date of 02/07/25. Review of the resident's undated census sheet showed hospice Medicaid as primary payer with an effective date of 02/08/25. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Hospice care. Review of the resident's care plan, revised on 03/02/25, showed the resident admitted to a local hospice group for end of life care on 02/28/25. Record review showed no SCSA MDS completed within 14 days of the resident starting hospice care on 02/08/25; the SCSA MDS should have been completed by 02/22/25. During an interview on 03/05/25 at 1:36 P.M., the MDS Coordinator said the following: -She followed the RAI manual to complete an MDS; -She has been the MDS coordinator at the facility for the last few months but had been an MDS coordinator at the facility in the past and has not attended any formal MDS/RAI training; -A SCSA should be done within two weeks of the resident's changes, decline or improvement in two or more areas, or if a resident is admitted to hospice care; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was not communicated to her when Resident #79 started hospice and she noticed the SCSA had not been opened within 14 days of the resident being placed on hospice; -Since the Director of Nursing (DON) and administrator had been working the floor as charge nurses so many shifts, the daily nursing meetings were not occurring; -Resident status changes are discussed in the daily nursing meetings, and since they were not occurring, she felt like that was why she missed the communication of resident's going on hospice care; -She currently was the MDS coordinator at this facility and a sister facility. During an interview on 03/05/25 at 8:19 P.M., the DON said the following: -The MDS Coordinator had been at the facility for a few months, and had been in that same position in the past; -The MDS Coordinator was completing the MDS information for this facility and also goes to a sister facility one day a week; -She would expect the MDS Coordinator to follow the RAI manual for MDS completions; -A SCSA needs to be completed if there is a decline or improvement in two or more areas in the MDS. During an interview on 03/05/25 at 7:51 P.M., the administrator said the following: -The MDS Coordinator completed the MDS's for this facility and one day a week at a sister facility; -She would expect the MDS Coordinator to follow the RAI manual for MDS completion. 42592

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment completed by staff, according to the Resident Assessment Instrument (RAI) manual for four sampled residents (Resident #30 #33, #36 and #71), in a review of 24 sampled residents. The facility census was 98. Review of the Resident Assessment Instrument (RAI) Manual, version 1.18.11, dated October 2023, showed the following: -Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status; -The RAI process has multiple regulatory requirements. Federal regulations require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts; -It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the Interdisciplinary Team (IDT) completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment; -Cognitive patterns: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions; -Preferences for customary and routine activities: The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences and is not meant to be all-inclusive. Review of the facility policy, MDS 3.0, Care Assessment Summary and Individualized Care Plans, revised on 11/06/23, showed the following: -The MDS 3.0 with the Care Area Assessment (CAA) summaries is a much more user-friendly assessment tool that addresses the holistic person, including functional status, quality of life and individual plan of care to address and meet the needs of the individual resident; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Section C is to be completed by Social Service Director (SSD). These involve cognition, orientation and ability to recall short and long-term situations; -Section F is to be completed by Activity Director (AD) which allows the resident to determine his or her own preferences for daily activities. Patient Health Questionnaire is used here; -MDS's must be kept current and up to date. 1. Review of Resident #30's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/03/24, showed the following: -Cognitively intact; -Diagnosis of paraplegia (paralysis of the legs and lower body); -Section F Preferences for Daily Routine, for all preference: choosing what clothing to wear, take care of personal belongings or things, choose type of bathing, snacks between meals, choose own bedtime, have family involved in discussions about your care, using the phone in private and having a place to lock your things and keep them safe; are all marked somewhat important (choices are very important, somewhat important, not important at all, important but can't do or no choice, or no response); -Section F Activity Preferences, for all activities: having things to read, listen to music you like, be around animals such as pets, keep up with the news, doing things with groups of people, doing favorite activities, going outside when the weather is good and participate in religious activities/practices; are all marked somewhat important (choices are very important, somewhat important, not important at all, important but can't do or no choice, or no response). -The resident was the primary respondent for Section F. All interviews were conducted for this MDS. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Section B staff documented the resident is understood and understands with clear speech; -Brief interview for mental status should not be conducted because the resident is rarely/never understood; -Short and long term memory is ok; -Resident knows current season, location of own room, staff names and faces and that he/she is in a nursing home; -The resident is modified independent for cognitive skills for daily decision making; -Section D mood is marked the interview should not be conducted because the resident is rarely/never understood; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Section J pain interview was conducted and the resident said he/she has pain frequently and rates the his/her pain as a four; -Interviews were not conducted for Section B and D and resident marked as able to understand and understood in Section A and J, but marked as not able to understand or understood on Section B and D. On the 11/27/24 staff marked the resident as rarely/never understood for the cognitive, and mood interviews (Section C and D) but interview was conducted for section J. During an interview on 03/05/25 at 2:17 P.M., the resident was alert and oriented and could be understood. (most recent MDS showed the resident was rarely/never understood). 2. Review of Resident #33's face sheet showed the following: -The resident had a guardian; -Diagnoses include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, delusional disorders, paranoid schizophrenia , mild neurocognitive disorder due to known physiological condition with behavior disturbance and major depressive disorder. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment (the last four assessments showed the same with the last assessment showing more than severed cognitive impairment in 2022); -Unclear speech or mumbles; -Sometimes able to make self understood; -Sometimes understands others; -Section F, each question answered as somewhat important with questions indicated as answered by the resident. During an interview on 03/02/25 at 7:59 P.M. and 03/05/25 at 11:58 A.M. the resident was unable to consistently answer any questions presented by the surveyor with a routine response of yep or ok. During an interview on 03/18/25, at 2:55 P.M., the Activity Director said the following: -Resident #33 was comfortable talking to her and will have a conversation and answer yes/no questions when presented; -For the annual activity questionnaire, Section F, of the MDS she presented each question to the resident as, Is this really important and the resident would answer yes or no; if no, she would ask the resident if the specific question was kinda important and the resident answered yes to each question resulting in the 2, or somewhat important value, for the MDS assessment. 3. Review of Resident #36's admission MDS, dated [DATE], showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Diagnosis include: dementia (15/15 on cognitive test), Parkinson's (a movement disorder of the nervous system), Traumatic brain injury (TBI-an injury to the brain caused by an external force, such as a blow, bump, jolt or penetration to the head. It can result in temporary or permanent damage to the brain, affecting cognitive, physical and emotional functions), anxiety, depression, Lewy body dementia (progressive brain disorder characterized by abnormal protein deposits called Lewy bodies in the brain); -Section F Activity Preferences, for all activities: having things to read, listen to music you like, be around animals such as pets, keep up with the news, doing things with groups of people, doing favorite activities, going outside when the weather is good and participate in religious activities/practices; are all marked somewhat important (choices are very important, somewhat important, not important at all, important but can't do or no choice, or no response); -The resident was the primary respondent. During an interview on 03/04/25 at 3:32 P.M., the resident was alert and oriented. He/She was able to express his/her needs and interests. Resident said there were some activities he/she enjoyed more than others. 4. Review of Resident #71's electronic medical record census showed the resident began hospice services on 04/30/24. Review of the resident's significant change in status MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included diabetes mellitus, stroke with hemiplegia (paralysis affecting left dominant side), Schizophrenia (mental illness), Dysphagia, traumatic brain injury, impulse disorder, extrapyramidal and movement disorder (movement disorder caused by medications); -Section F Preferences for Daily Routine, for all preferences: choosing what clothing to wear, take care of personal belongings or things, choose type of bathing, snacks between meals, choose own bedtime, have family involved in discussions about your care, using the phone in private and having a place to lock your things and keep them safe; are all marked somewhat important (choices are very important, somewhat important, not important at all, important but can't do or no choice, or no response); -Section F Activity Preferences, for all activities: having things to read, listen to music you like, be around animals such as pets, keep up with the news, doing things with groups of people, doing favorite activities, going outside when the weather is good and participate in religious activities/practices; are all marked somewhat important (choices are very important, somewhat important, not important at all, important but can't do or no choice, or no response); -Functional limitation in ROM one upper and one lower extremity; -Wheelchair use; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hospice. Review of the resident's care plan, last revised on 05/08/24, showed the resident has an Activity of daily living (ADL) self-care performance deficit related to confusion, spastic hemiplegia affecting the resident's left dominate side with limited ROM and extrapyramidal and movement disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Functional limitations in ROM in both upper and both lower extremity; -No wheelchair or mobility device (no documentation to show the resident had had a significant change and no longer needed a wheelchair or mobility device); -Hospice. Review of the resident's quarterly MDS, dated [DATE], showed the following: -No limitations in functional ROM (no documentation to show the resident had had a significant change and now had no limitations); -Wheelchair use; -Resident is not receiving hospice. Review of the resident's electronic medical record census showed the resident had not been discharged from hospice since he/she was admitted to hospice services. Review of the resident's quarterly MDS, dated [DATE], showed the following: -No limits in functional ROM (no documentation to show the resident had had a significant change and now had no limitations); -Wheelchair use; -Hospice . Observation on 03/03/25 at 12:31 P.M., showed the resident in a broda style chair (reclining chair on wheels). The resident had a mechanical lift sling under him/her, was not able to use the left side of his/her body and had visible limits to range of motion on the left side of his/her body. 5. During an interview on 03/19/25 at 8:17 A.M., the Activity Director said the following: -She has been in this position for three years; -She does resident interviews for the MDS section F for comprehensive assessments; -There have been several MDS coordinators in the last year and sometimes MDS's were opened and completed and she didn't know they were scheduled; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She was doing her interviews in her section and thought they would pull over to the MDS but then found out they were not pulling over like she thought they were; -Resident' #30 and #36 are very alert and oriented and have differing preferences on what they like to do and do not like to do, she was not sure why the section F preferences and activities were all marked somewhat important. During an interview on 03/05/25 at 1:36 P.M., the MDS/Care Plan Coordinator said the following: -She has been the MDS Coordinator since January 3, 2025; -She had noticed a lot of changes on the MDS's when reviewing past MDS's; -She said some items were not coded correctly prior to her employment; she does not have time to figure out the old MDS issues so she was focusing on completing current MDS's; -There were several MDS Coordinators in the last year and corporate helped offsite at some point; -She does MDS's for this facility four days a week and for another facility one day per week; -She follows the RAI manual the best she can; -She has not had formal MDS training; -Communications about changes with the residents has been difficult since the Director of Nursing (DON) had been working the floor frequently as a charge nurse; -She was responsible for all of the sections except sections completed by other departments; -She does the nursing sections of the MDS, each discipline does their own sections; -Residents who can communicate would not be marked as unable to understand or not understood. During an interview on 03/05/25 at 8:00 P.M., the Administrator said the following: -She expected the MDS to reflect the resident and the care they needed accurately; -Staff are expected to complete the MDS accurately according to the RAI manual; -She expected staff completing MDS interviews to leave their office and go talk to the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to update and revise problems and interventions in resident care plans to reflect current care needs for four residents (Resident #18, #25, #33 and #54) in a sample of 24 residents. The facility census was 98. Review of the facility policy Comprehensive Care Plans, last revised 10/31/24 showed the following: -The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment; -The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed; -The Individualized Care Service Plan (ICSP), (also called the bedside care plan) will be updated with pertinent information needed for nursing staff on the floor to provide the needed care for residents. The ICSP is located in Point Click Care under the Point Of Care tab. 1. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/10/24, showed the following: -Cognitively intact; -Diagnosis of dementia, diabetes mellitus (inability to control blood sugar), bipolar (a mental health condition that causes extreme mood swings emotional highs(mania) and lows (depression)), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), extrapyramidal (describes involuntary movements that you cannot control cause by antipsychotic medications) and movement disorders; -Independent with eating, rolling left and right and propelling wheelchair 150 feet; -Set up or clean up assistance from staff for oral hygiene; -Requires supervision/touching assistance from staff members for toilet hygiene, upper body dressing, put on/take off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer and toilet transfers; -Requires partial/moderate assistance from staff for lower body dressing and tub/shower transfers; -Requires substantial/maximal assistance from staff to shower/bathe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, last revised 06/17/24, showed the following: -Activities of Daily Living (ADL) deficit related to dementia, limited mobility and poor safety awareness; -Requires supervision to limited assist of one staff member to move between surfaces (transfers), to dress, personal hygiene, and toilet use; -Resident requires extensive assist of one staff member for bathing/showering; -Resident requires encouragement and/or assist of one staff member for bed mobility related to turning and repositioning every two hours. Review of the resident's quarterly MDS, dated [DATE], showed the following -Severe cognitive impairment (previous assessment cognitively intact); -New diagnosis of pneumonia and new pressure ulcer that is Stage III (Wound with full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling); -New indwelling urinary catheter (tube inserted in bladder to drain urine); -Set up or clean up assistance from staff for eating (was independent previously); -Requires substantial/maximal assistance from staff for oral hygiene (was set up), upper body dressing (was supervision/touching), lower body dressing (was partial/moderate), personal hygiene (was supervision/touching), rolling left and right (was independent), and sit to lying (was supervision/touching); -Dependent on staff for toilet hygiene (was supervision/touching), shower/bathe (was substantial/maximal), put on/take off footwear (was supervision/touching), chair/bed-to-chair transfer (was supervision/touching), tub/shower transfer (was partial/moderate) and propelling wheelchair (was independent); -Not attempted during this assessment: lying to sitting on the side of the bed, sit to stand, and toilet transfer; -New Stage III pressure ulcer present. The resident's care plan did not show revision to reflect the resident's current condition after the resident had a new urinary catheter, decline in several activities of daily living (ADL's), and a new Stage III pressure ulcer. Review of the resident's census record showed the resident discharged to the hospital 10/11/24 and readmitted to the facility on [DATE]. Review of the resident's admission MDS, dated [DATE], showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe cognitive impairment; -Usually understood, usually understands (new); -Functional limitation in range of motion in both upper and both lower extremities (new); -Requires partial/moderate assistance from staff for sit to lying; -Requires substantial/maximal assistance from staff for oral hygiene, upper body dressing, personal hygiene, rolling left and right, lying to sitting on the side of the bed, -Dependent on staff for toilet hygiene, shower/bathe, lower body dressing, put on/take off footwear, chair/bed-to-chair transfer, and to wheel wheelchair; -The resident was not able to perform sit to stand, tub/shower transfer, and toilet transfer; -Indwelling urinary catheter; -New ostomy (colostomy (a surgical procedure that creates an opening in the abdominal wall to divert feces from the colon to an external collection bag) new since hospitalization); -New surgical wound. The resident's care plan did not show revision to reflect the resident's current conditions and care requirements after the resident had a new urinary catheter, new colostomy, new limits to functional range of motion, decline in several ADL's and the pressure ulcer changed to a surgical wound. Observation on 03/02/25 at 6:35 P.M., showed the following: -The resident sat in a reclined wheelchair in his/her room; -The resident had a mechanical lift sling under him/her; -The resident did not have a catheter, but had a urinal present; -The resident had a colostomy bag; -The resident was unable to communicate verbally but could nod head up and down (yes and no) and would point at what he/she was trying to convey. During an interview on 03/04/25 at 10:54 P.M., Registered Nurse (RN) B said the following: -The resident was very sick and in the hospital for an extended time; -The resident's wound originally looked like a pressure ulcer; -While in the hospital it was found that the resident had a fistula from his/her bowel that was causing the wound and it was surgically cleaned, so now the wound was coded as surgical; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was now a mechanical lift transfer because of his/her extensive physical decline and the resident now had a colostomy; -The resident had a catheter but it was removed and the resident was able to use the urinal. Review of the resident's care plan did not include evidence the care plan was revised after the resident had a decline in several ADL's before and after a long hospitalization which now required him/her to be a mechanical transfer and dependent in several areas he/she had previously only needed supervision or limited assistance with, a urinary catheter inserted then later removed, a new colostomy, a change to his/her communication abilities and a pressure ulcer that was later discovered to be a fistula with surgical intervention. 2. Review of Resident #25's care plan, last revised 12/29/24, showed it did not address the presence, the use, or the care of a peripherally inserted central catheter (PICC) line (a form of intravenous ((IV) - in the vein) access that can be used for a prolonged period of time by the insertion of a catheter entering the body through the skin and stays in place for days, weeks or even months for administration of treatment substances). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/24/25, showed the following: -Cognitively intact; -One unstageable (known but unstageable due to coverage the wound bed by slough (necrotic/avascular tissue in the process of separating from the viable portion of the body, usually light colored, soft, moist and stringy) and or eschar (thick leathery, frequently black or brown in color, necrotic tissue). Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined) deep tissue (purple or maroon area of discolored intact skin due to damage of underlying soft tissue damage. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) -One surgical wound; -Intravenous access while a resident; -IV medications while a resident. Review of the resident's physician order sheet (POS), dated 03/2025, showed the following: -Diagnoses included unstageable pressure ulcer, sacral area (referring to the lower back region, specifically the triangular-shaped bone called the sacrum) and osteomyelitis (inflammation /infection of the bone); -Change PICC line dressing and needle hub connector (device that connects to the end of the PICC catheter) to right upper extremity (RUE) via sterile technique. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's treatment medication record (TAR), dated 3/2025 showed the following: -Change PICC line dressing and needle hub connectors to right upper extremity via sterile technique on day shift every seven days (order date of 01/31/25); -Meropenem (antibiotic) IV solution reconstituted one gram: Use one gram intravenously in the evening for surgical care of right buttock pressure ulcer times 14 days (order date of 02/28/25); -Normal saline flush intravenous solution 0.9 percent (%) use 10 milliliters (ml's) intravenously in the morning for antibiotic use for 13 days. Ten ml's per lumen (the PICC line outer tube that allows fluid and medications to be administered into the body), pre and post IV antibiotic(order date of 02/15/25). Observation of the resident, on 03/02/25 at 5:15 P.M., showed the resident in his/her bed. An occlusive (a waterproof, airtight bandage that covers and seals what is below)dressing covered a PICC line located on the resident's right upper arm. During an interview on 03/02/25 at 5:20 P.M., the resident said he/she received antibiotics for a wound through his/her PICC line. 3. Review of Resident #33's face sheet showed the following: -The resident had a guardian; -Diagnoses include unspecified dementia without behavioral disturbance (symptoms of dementia but with specific underlying cause without behaviors), psychotic disturbance (a mental health condition characterized by a loss of touch with reality), mood disturbance (a group of psychiatric conditions that can cause intense and persistent changes in mood, energy and behavior), delusional disorders (a serious mental illness that causes people to have unshakeable false beliefs for at least a month), paranoid schizophrenia (a subtype of schizophrenia characterized by persistent delusions and hallucinations, often with a paranoid theme) and major depressive disorder (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities that were once enjoyable). Review of the resident's care plan, revised on 01/12/2025, showed the following: -Documented safety concerns, encourage use of assistive devices; -The resident has an activity of daily living (ADL) self-care performance deficit related to dementia and often needs staff to cue and assist to ensure he/she is getting the assistance needed; -Bathing/showering: required limited assistance of one staff for showers twice a week and as necessary; -Allow sufficient time for dressing and undressing, assist the resident to choose simple comfortable clothing that enhances his/her ability to dress self; -Need for assistance with dressing fluctuates but often needs limited assist of one staff to dress; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Personal hygiene: requires oversight or limited assist of one staff with personal hygiene and oral care to ensure it is being done, needs assistance shaving; -The resident has impaired cognitive function/dementia or impaired thought processes related to dementia, speech is clear, hearing is adequate, has trouble at times understanding what is being said or making self understood due to cognition. He/She will answer yes or no questions and speaks softly; -Ask yes/no questions in order to determine the resident's needs. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Unclear speech or mumbles (a change from clear speech); -Sometimes able to make self understood (a change from trouble making self understood); -Usually understands others (a change from has trouble at times understanding what is being said); -Other behavior symptoms not directed toward others one to three days during observation period (new documentation of behaviors towards others); -Independently ambulatory with no range of motion limitations (ambulatory status not addressed on previous care plan); -Partial to moderate staff assistance for dressing, oral hygiene, upper and lower body dressing and putting on/taking off footwear (change limited assistance); -Substantial to maximum staff assistance for personal hygiene, toileting hygiene, and bathing (change from oversight or limited assistance). Observation on 03/02/25 at 7:59 P.M., showed the following: -The resident walked down the hall with staff; -Hair was disheveled and noted to have approximately 1/2 inches of whisker growth on face; -Sweatpants front and back and hem of shirt noted to be wet and had a moderate urine smell; -Certified Nursing Assistant (CNA) K and Nursing Assistant (NA) L led the resident to his/her room with gloved hands; -Noted to be wearing a pull up incontinence product as well as an adult brief, both noted to be saturated with urine and had a strong odor of urine when removed; -CNA K sat the resident on the toilet and removed his/her wet pants; -After the resident was toileted CNA K wiped the resident's upper thighs and groin with toilet paper and applied a new adult brief; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA K assisted the resident to bed. Observation on 03/03/25 at 11:36 A.M., showed the resident walking down the hall. The resident had an approximate 1/2 inch of whisker/beard growth on his/her face and disheveled hair. Observation on 03/04/25 at 9:56 A.M., showed the resident sat in the downtown common area and had a 1/2 inch growth of whiskers on his/her face with disheveled hair. Observation on 03/04/25 at 10:31 A.M., showed the resident with wet spots in the groin area and back of his/her pants. Observation on 03/04/25 at 11:00 A.M., showed the resident continued to have wet pants and had a slight smell of urine. Observation on 03/04/25 at 11:58 A.M., showed the following: -Dietary staff took to resident to his/her room and CNA M assisted the resident to the bathroom; -The resident had been incontinent of urine; -CNA M performed peri-care; -CNA M applied a new incontinent product and dry clothes. Review of the resident's care plan showed no evidence the plan had been updated based on the most up to date MDS assessment. 4. Review of Resident #54's face sheet showed his/her diagnoses include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure with hypoxia (a condition where the lungs struggle to deliver enough oxygen to the blood, leading to low blood oxygen levels and potentially requiring long-term oxygen therapy), major depressive disorder, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain cells to die). Review of the resident's care plan, updated 02/25/25, showed the following: -The resident was independent in ADL's; -He/She will have no decline in ADL performance through the next review; -Provide protective oversight and assist where needed; -Oxygen setting: continuous humidified oxygen via nasal cannula (prongs in the nares that deliver oxygen) at three liters; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident is on enhanced barrier precautions (EBP - infection control strategy that expands the use of personal protective equipment (PPE) during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs) in addition to universal precautions (a set of infection control measures designed to prevent the transmission of bloodborne pathogens from one person to another) related to wounds requiring dressings. Review of the resident's annual MDS, dated [DATE], showed the following: -Supervision by staff for transfers, personal and toileting hygiene and dressing (a change from the resident being independent with ADL's noted on the care plan); -Substantial to maximum assist for bathing (a change from the resident being independent with ADL's);; -No skin issues (a change from the resident having wounds). -Uses oxygen therapy. Review of the resident's March 2025 Physician Order Sheet (POS) showed the following: -Elevate head of bed due to shortness of air while lying flat; -Oxygen at two liters via nasal cannula continuously when not wearing Bilevel Positive Airway Pressure (BiPaP - a non-invasive ventilation technique that helps individuals with breathing difficulties); -No current wound dressing orders. Observation on 03/03/25 at 11:18 A.M., showed the resident sat in his/her recliner in his/her room with oxygen via nasal cannula in use. No observation or need for EBP noted. Observation on 03/04/25 at 9:44 A.M., showed the resident lay awake in his/her bed with pajamas on and head of bed elevated with oxygen via nasal cannula being used. Hair was slightly oily appearance. No observation or need for EBP noted. Observation on 03/05/25 at 10:50 A.M., showed the resident sat in his/her recliner in his/her room with oxygen via nasal cannula being used. Hair was pulled slightly oily appearance. No observation or need for EBP noted. During an interview on 03/05/25 at 10:50 A.M., the resident said since he/she had been in the hospital he/she needs more help in the shower. He/She used oxygen all of the time and carting around the oxygen tank in the holder on wheels was difficult for him/her. Review of the resident's care plan showed no evidence the plan had been updated based on the most up to date MDS assessment. The plan indicated an incorrect amount of oxygen ordered for the resident and also did not address the resident's head of the bed was to be elevated when in bed or that he/she utilized a BiPaP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 03/05/25 at 1:36 P.M., the Care Plan Coordinator said the following: -She has been the MDS Coordinator and has been responsible for updating the resident care plans since January 2025; -Department heads were also responsible for updating care plans; -She normally received information to update care plans during the daily nursing meetings, but the meetings have not been occurring regularly since the Director of Nursing (DON) had been working the floor frequently as a charge nurse. During an interview on 03/05/25 at 8:10 P.M., the DON said the following: -She had not been having the daily nursing meetings due to frequently working the floor as a charge nurse; -Not having the nursing meeting affected the communication between the departments for care plan updates; -She would expect care plans to be up-to-date to reflect the most current care necessary for the resident; -Any member of the Interdisciplinary Team (IDT) can update the care plan; -The MDS Coordinator also updates the resident care plans. During an interview on 3/5/25 at 7:51 P.M., the Administrator said the following: -She would expect care plans to be up-to-date and reflect the most current level of care for the residents; -All department heads are responsible for updating care plans; -The nursing department was responsible for updating care plans for medical issues, the activity director for activities and dietary for nutrition. 38016 42592

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to ensure facility staff provided six residents (Resident #3, #11, #30, #33, #54 and #79), of 24 sampled residents that were unable to perform their own activities of daily living (ADL), the necessary care and services to maintain good personal hygiene and prevent body odor. The facility census was 98. Review of the facility's policy for ADLs, revised on 05/18/24, showed the following: -The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. -Care and services will be provided for bathing, dressing, grooming, toileting and oral care; -A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's policy for Peri-Care, revised on 06/29/23, showed the following: -The purpose of this policy is to ensure that the resident's genital area is kept clean and proper techniques are used to prevent skin break down, infections or any other impairments that can be caused from not using proper aseptic technique; -Perineal care is usually called peri care. It means washing the genitals and anal area. Peri care can be done during a bath or as a separate procedure. Peri-care prevents skin breakdown of perineal area, itching, burning, odor and infections. Perineal care is very important in maintaining the residents' comfort. More frequent care is required for residents who are incontinent or for those who have an indwelling catheter. Make every effort to respect the modesty of residents and be gentle when cleansing this sensitive area; -Other than soap and water, different products may be used when giving peri care. A non-rinse peri-wash, a peri-wash that requires rinsing, skin-barrier creams, or pre-moistened wipes are also acceptable. Use peri-care products according to the service plan and follow the manufacturer's directions for use. Review of the facility's policy for Resident Showers, revised on 06/26/24, showed the following: -It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice; -Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety; -Partial baths may be given between regular shower schedules as per facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #3's care plan, last revised 01/26/25, showed the following: -Incontinent of bladder and bowel; -Resident will remain free from skin breakdown due to incontinence; -Clean peri-area with each incontinence episodes. Wash, rinse and dry perineum. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment, completed by facility staff, dated 02/16/25, showed the following: -No rejection of care; -Independent for transfers; -Used a wheelchair; -Frequently incontinent of bladder and bowel; -Partial to moderate assist with toileting. Observation on 03/02/25 at 6:08 P.M. showed the following: -The resident ambulated to the bathroom while pulling his/her pants and feces/urine soiled incontinent pull up down and then sat on the toilet; -Nurse Aide (NA) J donned gloves, removed the soiled pull up and placed it in the trash; -NA J cleaned the resident's rectal area and buttocks with perineal wipes; -NA J did not clean the resident's front peri-area. During an interview on 03/18/25 at 10:40 A.M. NA J said that the front perineal area, as well as the back should be cleaned when performing incontinent care on a resident. 2. Review of Resident #11's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent for transfers and bathing; -Diagnoses included multiple sclerosis (MS-nerve damage disrupting communication between the brain and the body); -No rejection of care. Review of the resident's care plan, last revised 02/13/25, showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Self-care performance deficit; -Totally dependent on one to two staff for bathing twice weekly and as needed. Review of the resident's shower/bath documentation for 02/09/25 to 03/05/25, showed the following: -Resident preferred day showers; -Showers were scheduled for Tuesdays and Thursdays; -Documentation for the week of 02/09/25 through 02/15/25 showed the resident received a shower on 02/11/25 (five days from his/her previous documented shower); -There was no documentation to show the resident had been offered or refused a second shower for this week; -Documentation for the week of 02/16/25 through 02/22/25 showed no documentation the resident had been offered or refused two showers for the week; -Documentation for the week of 02/23/25 through 03/01/25 showed Certified Nurse Aide (CNA) O and NA D documented not applicable (NA) on 02/25/25; -There was no documentation to show the resident had been offered or refused a second shower for this week; -Documentation for the week of 03/02/25 through the review period of 03/05/25 showed the resident received a shower on 03/04/25 (21 days from his/her previous documented shower); -The resident was to have received seven showers for this time period but had only received two. Review of the resident's facility census showed the resident had not had a leave of abscessed or hospital stay from 02/01/25 through 03/05/25. During an interview on 03/04/25 at 11:45 A.M. the resident said he/she did not receive showers on a regular basis and definitely not two times weekly. Residents were lucky to get one shower a week. 3. Review of Resident #30's face sheet, showed the resident was his/her own responsible party. Review of the resident's care plan, last revised 01/05/25, showed the following: -Resident has an ADL self-care performance deficit related to paraplegia (paralysis of legs); -Resident is alert and oriented; -Resident is totally dependent on one staff to shower twice weekly and as necessary; -Resident refuses showers frequently if he/she feels they are too close to smoke break. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of he resident's shower record, dated 02/02/25-03/05/25, showed the following: -The resident's shower days were to be Tuesdays and Thursdays; -Documentation for the week of 02/02/25 through 02/08/25 showed no documentation the resident was offered or refused a shower twice that week; -Documentation for the week of 02/09/25 through 02/15/25 showed staff documented giving the resident a shower on 02/13/25; -There was no documentation the resident had been offered or refused a second shower for the week; -Documentation for the week of 02/16/25 through 02/22/25 showed staff documented giving the resident a shower on 02/20/25; -There was no documentation the resident had been offered or refused a second shower for the week; -Documentation for the week of 02/23/25 through 03/01/25 showed no documentation the resident was offered or refused a shower twice that week; -Documentation for the week of 03/01/25 through the review period of 03/05/25 showed no documentation the resident was offered or refused a shower twice that week; it had been 13 days since the resident's last shower. Review of the resident's facility census showed the resident had not had a leave of absence or hospital stay from 02/05/25 through 03/05/25. Observation on 03/02/25 at 5:54 P.M., showed the resident in his/her room. The resident's hair was greasy and he/she had dry flaky skin. Observation on 03/04/25 at 11:10 A.M., showed the resident had greasy, disheveled hair and flaky skin visible on his/her arms. During an interview on 03/04/25 at 11:10 A.M., the resident said the shower aide was not always able to get to him/her. He/She gets frustrated because the shower aide has time constraints and he/she could not get a shower when he/she wanted one. At minimum, the resident would like one good shower a week (Thursdays), but really wanted two showers a week. The staff only had time to do one shower a week, so if you were busy or not feeling great that day, you were out of luck. He/She should not have to miss smoke break or an activity to take his/her shower. He/She felt like he/she had no control of his/her life sometimes even though he/she was his/her own person. 4. Review of Resident #33's face sheet showed diagnoses include unspecified dementia without behavioral disturbance (symptoms of dementia but with specific underlying cause without behaviors). Review of the resident's care plan, revised on 01/12/2025, showed the following: -The resident wandered throughout the facility; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Implement a scheduled toileting program; -The resident had an ADL self-care performance deficit related to dementia and often needs staff to cue and assist to ensure he/she is getting the assistance needed; -The resident needed to be shown where his/her bathroom was; -Required limited assistance of one staff for showers twice a week and as necessary; -Required oversight or limited assist of one staff with personal hygiene and needs assistance shaving; -Toilet use need for assistance fluctuates, he/she takes self to the bathroom at times, but needs assistance when incontinent of bowel and bladder to ensure he/she was clean and changed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No rejection of cares; -Substantial to maximum staff assistance for personal hygiene, toileting hygiene, and bathing; -Always incontinent of urine and frequently incontinent of bowel. Review of the resident's electronic health record, shower/bath documentation, for 02/05/25 to 03/05/25, showed the following: -Resident prefers day showers; -Schedule bath/shower days are Monday and Thursday; -Documentation for the week of 02/05/25 through 02/08/25 showed no documentation staff offered or the resident refused the scheduled shower for 02/06/25; -Documentation for the week of 02/16/25 through 02/22/25 showed showed no documentation the staff offered or the resident refused two showers for this week; -Documentation for the week of 02/23/25 through 03/01/25 showed showed no documentation staff offered or the resident refused two showers for this week; -Documentation for the week of 03/02/25 through end of review period 03/05/25 showed no documentation of the scheduled shower on Monday, 03/03/25; -The resident was to have eight showers for this time period but had only received two, with no documentation of refusal of showers. His/Her last shower was on 02/13/25, 20 days prior to 03/05/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's facility census showed the resident had not had a leave of absence or hospital stay from 02/05/25 through 03/05/25. Observation on 03/02/25 at 7:59 P.M., showed the following: -The resident's hair was disheveled and he/she had approximately 1/2 inch whisker growth on his/her face; -The front and back of the resident's sweat pants and hem of his/her shirt were wet and had a urine smell; -Certified Nursing Assistant (CNA) K and NA L led the resident to his/her room; -CNA K assisted the resident in pulling his/her sweat pants down, the resident wore a pull up incontinent product as well as an adult brief; both were saturated with urine and a strong urine odor was noted when removed; -CNA K sat the resident on the toilet and removed his/her wet pants; -After the resident toileted, CNA K wiped the resident's upper thighs and groin with toilet paper and applied a new adult brief; -CNA K nor NA L performed peri care with the use of soap and water, peri-wash or pre-moistened wipes per the facility policy. Observation on 03/03/25 at 11:36 A.M., showed the resident walking down the hall. The resident had approximately 1/2 inch whisker/beard growth on his/her face and disheveled hair. Observation on 03/04/25 at 9:56 A.M., showed the resident sat in the downtown common area. The resident had approximately 1/2 inch whiskers on his/her face and disheveled hair. Observation of the resident on 03/04/25 showed the following: -At 10:31 A.M., the resident had wet spots, approximately the size of a baseball, in the groin area and back of his/her pants and sat down in a chair in the downtown common area; -At 11:00 A.M., the resident continued to sit with wet pants and had a slight smell of urine; -At 11:53 A.M., dietary staff assisted the resident to a standing position and took him/her toward the dining room; -At 11:58 A.M., dietary staff took the resident to his/her room and CNA M assisted the resident to toilet; the resident's adult incontinent product was saturated with urine; -CNA M performed peri-care and the resident said ouch when CNA M cleansed his/her bilateral groin areas; -The resident's bilateral groin was slightly dark pink in color; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA M applied a new incontinent product and dry clothes. During an interview on 03/05/25 at 1:15 P.M., the resident's guardian said the following: -He/She would want the resident to be neat and clean; -He/She would want the resident to be clean shaven if that is what the resident wanted on that day; -He/She would want the resident to receive his/her showers as scheduled; -He/She would expect staff to check the resident frequently for incontinence and staff change the resident in a timely manor. The resident should not walk around in soiled clothes. During an interview on 03/04/25 at 12:05 P.M., CNA M said the following: -He/She was assigned the 400 hall residents to care for but helped on 300 hall (the hall that Resident #33 resided on) when needed; -If there was not enough staff for each hall to have a CNA, the charge nurse and department heads were to help and cover the unassigned hall; -Charge nurse and department heads were helping on the 300 hall at this time; -Residents should be checked and changed at a minimum of every two hours; -He/She tries to keep extra clothes for Resident #33 on the hall he/she was working and would sometimes just take the resident into the bathroom on his/her hall and provide incontinence care for the resident since he/she wanders up and down the halls quite a bit; -Showers are supposed to be given twice a week, but when short handed, he/she was not sure if they were being given or not. During an interview 03/12/25 at 4:05 P.M., NA L said the following: -He/She assisted CNA K in providing care for the resident on 03/02/25; -The resident was noted to be wet and had two incontinent products on and his/her pants were wet; -He/She was not scheduled to work on the resident's hall that night but was helping catch up and get resident's ready for bed; -He/She had just started his/her shift at 6:00 P.M. on 03/02/25 and had not performed a check until he/she assisted CNA K; -He/She was unsure who was responsible for the resident's care prior and was unsure when he/she had been checked last as this was the resident's first check since he/she had been on shift; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents should not be double briefed at any time and is not sure why that occurred or who did the double briefing; -Peri-care should be performed every time a resident is incontinent; -Peri-care should not be performed only using toilet paper; -Residents should be checked for incontinence at least every two hours; -He/She thinks the residents are given showers a couple of times a week and as needed, but does not work the day shift when the scheduled showers are given. During an interview on 03/12/25 at 4:20 P.M., CNA K said the following: -He/She assisted NA L in providing care for the resident on 03/02/25; -The resident was noted to be wet and had two incontinent products on and his/her pants were wet; -He/She was surprised two incontinent products were on the resident as that was not a normal practice; -He/She was unsure who put two incontinent products on the resident or why that would have occurred; -He/She had just started his/her shift at 6:00 P.M. on 03/02/25 and had not performed a check until he/she assisted NA L; -He/She was unsure who was responsible for the resident's care prior and was unsure when he/she had been checked last as this was the resident's first check since he/she had been on shift; -Peri-care should not be performed with only toilet paper, but at the moment care was provided for the resident, there were no clean wash cloths to use; (meaning none available; none on the linen cart); -He/She could have used a large towel, but was frustrated that the necessary supplies were not available to use, such as the wash cloths; -Showers should be given twice a week and as needed. 5. Review of Resident #54's face sheet showed his/her diagnoses include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure with hypoxia (a condition where the lungs struggle to deliver enough oxygen to the blood, leading to low blood oxygen levels and potentially requiring long-term oxygen therapy), major depressive disorder, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain cells to die). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's electronic health record, shower/bath documentation, for 02/23/25 to 03/05/25, showed the following: -Resident prefers day shower; -Scheduled bath/shower days were Sunday and Thursday; 2/20 -Documentation for the week of 02/23/25 through 03/01/25 showed one scheduled shower on 02/23/25 documented as not applicable with no documentation to show the resident refused the shower or was out of the building; no documentation to show a second shower was offered/refused for this week; -Documentation for the week of 03/02/25 through review period of 03/05/25 showed no documentation the resident had been offered or refused a shower; -The resident was to have received three showers in this time period and had only received one and the resident had not received a shower for 13 days. Review of the resident's care plan, updated 2/25/25, showed the following: -The resident was independent in ADL's; -He/She will have no decline in ADL performance through the next review; -Provide protective oversight and assist where needed. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Able to make needs known, makes self understood and understands others; -No behaviors or rejection of cares; -Supervision by staff for personal hygiene; -Substantial to maximum assist for bathing; -Occasionally incontinent of urine, continent of bowel; -Uses oxygen therapy. During an interview on 03/02/25, at 6:19 P.M., the resident said the following: -He/She was supposed to get a shower two times a week, on Sunday or Tuesday and Thursday; -He/She preferred at least one weekly, usually on Thursday, on day shift; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She preferred to take a shower between 10:00 A.M. and 12:00 P.M. because that was when he/she felt the best due to breathing issues; -He/She had not had a shower for ten days. Observation on 03/03/25 at 11:18 A.M., showed the resident sat in his/her recliner in his/her room. His/Her hair was pulled back and had an oily appearance. During an interview on 03/03/25 at 11:18 A.M. the resident said he/she did not get a shower on 03/02/25 and would like one. Observation on 03/04/25 at 9:44 A.M., showed the resident lay awake in his/her bed. His/Her hair was pulled back and had an oily appearance. During an interview on 03/04/25 at 9:44 A.M., the resident said he/she did not receive a shower yesterday and would like one, it had been almost two weeks since his/her last shower. Observation on 03/05/25 at 10:50 A.M., showed the resident sat in his/her recliner in his/her room. His/Her hair was pulled back and had an oily appearance. During an interview on 03/05/25 at 10:50 A.M., the resident said the following: -He/She still has not received a shower this week; -He/She did not get a shower last week and so far, none this week. 6. Review of Resident #59's care plan, dated 04/05/24, showed the following: -Resident is able feed himself/herself with set up assistance at times to cut meats and open cartons; -Resident requires extensive assist of one to two staff to move between surfaces as necessary. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Diagnoses included diabetes mellitus (DM), respiratory failure, fluid overload, chronic obstructive pulmonary (respiratory) disease COPD, and chronic pain; -Functional limits in ROM both upper and lower extremities; -Required supervision/touching assistance from staff members for eating; -Required substantial/maximal assistance from staff to roll left and right; -Dependent on staff for chair/bed-to-chair transfer; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Significant weight loss not on a plan (9.5% since 7/16/24). Observation and interview on 03/02/25 at 6:15 P.M., showed the following: -NA L brought the resident's supper tray into his/her room and sat the tray on the bedside table, approximately one foot from the resident's bed; he/she took the cover off the resident's plate and left the room; -The resident lay in bed on his/her back and the resident's head was approximately two feet from the top of the bed and his/her feet were next to the footboard; -The resident tried to adjust his/her bed with the remote, but the resident's head did not rise with the bed (because of his/her placement on the bed); -The resident said he/she could not reach his/her food; -The resident said it was hard to eat in bed, especially when he/she could not reach his/her tray; -The resident said it would be easier to eat if he/she was sitting up in a chair; -He/She had a stroke and had a hard time eating; -He/She would go to the dining room, but they said he/she was not supposed to. Observation and interview on 03/02/25 at 6:45 P.M., showed the following: -The resident remained in the same position as the 6:15 P.M. observation, and his/her bedside table with supper tray sat approximately one foot from the bed; -The resident had consumed a small amount of food located at the edge of his/her plate but less than 10 percent (%) had been consumed. Review of the resident's medical record did not show any orders the resident could not get up or go to the dining room. During an interview on 03/02/25 at 6:50 P.M., NA L said the following: -He/She has been employed by the facility for two weeks; -He/She was not sure how much assistance Resident #59 needed. During an interview on 03/05/25, at 8:05 P.M., the Director of Nursing said the following: -Staff are expected to sit a resident upright and get their tray set up where everything was easily accessible to the resident; -Staff are expected to offer to get all residents up for meals and assist them during a meal; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no order that the resident could not get up to his/her wheelchair, so it was up to the resident. Staff are expected to offer and encourage the resident to get up. 7. Review of Resident #79's face sheet showed the following: -The resident had a guardian; -Diagnoses include vascular dementia (brain damage caused by multiple strokes), anxiety disorder and unspecified psychosis not due to a substance or known physiological condition (a term used when a person experiences symptoms of psychosis that do not meet the full criteria for a specific psychotic disorder). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No behaviors or rejection of cares; -Partial to moderate staff assistance for upper and lower body dressing; -Substantial to maximum staff assistance for bathing, toileting hygiene and personal hygiene; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, revised on 03/02/25, showed the following: -Needs one assist with showers; -Please ask the resident if he/she needs to use the restroom and show the resident where the bathroom was located every two hours and as needed; -Provide protective oversight and assist where needed; -The resident has bowel and bladder incontinence at times related to confusion and dementia and required one assist at times of incontinence; -Clean peri-area with each incontinence episode; -Check every two hours and as required for incontinence, wash, rinse and dry perineum; -Change clothing as needed after incontinence episodes; -Staff to direct to the bathroom every two hours while awake, due to confusion need to show the resident where bathroom was located and assist with toileting if needed. Review of the resident's electronic health record, shower/bath documentation, for 02/05/25 to 03/05/25, showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident prefers day showers; -Schedule bath/shower days were Monday and Thursday; -Documentation for the week of 02/05/25 through 02/08/25 showed staff documented not applicable on 02/07/25 with no documentation to show the resident refused the shower or was out of the building; -Documentation for the week of 02/09/25 through 02/15/25 showed staff documented not applicable on 02/14/25 with no documentation to show the resident refused the shower or was out of the building; no documentation to show a second shower was offered/refused for this week; -Documentation for the week of 02/16/25 through 02/22/25 showed showed no documentation the resident had been offered or refused two showers for this week; -Documentation for the week of 02/23/25 through 03/01/25 showed the resident received one of his/her scheduled showers on 02/27/25 (Thursday); -Documentation for the week of 03/02/25 through end of review period 03/05/25 showed no documentation of the scheduled shower on 03/03/25; -The resident was to have nine showers for this time period but had only received one with no documentation of refusal of showers. The resident's last shower was five days prior. Observation on 03/02/25 at 8:10 P.M., showed the following: -CNA K and NA L assisted the resident to the bathroom; -The resident wore two incontinent products, one pull-up type and one brief, tab type under his/her sweat pants; -The outer incontinence product was noted to be dry; -The pull-up incontinent product was wet with a slight urine odor; -CNA K removed both incontinent products and placed a clean incontinent brief on the resident; -CNA K completed no peri-care and assisted the resident to bed. Observation on 03/04/25 at 9:00 A.M., showed the following: -The resident sat in a chair in the downtown common area; -His/Her sweat pants were wet in the front; -Multiple staff members were in an around the area with no staff assisting the resident. Observation at 03/04/25 at 9:55 A.M., showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident sat in the same location in the downtown common area; -His/Her sweat pants remained wet in the front. Observation on 03/04/25 at 10:56 A.M., showed the following: -The resident in the same location with wet pants; -Hospice staff took the resident to shower and change clothes. During an interview 03/12/25, at 4:05 P.M., NA L said the following: -He/She assisted CNA K in providing care for the resident on 03/02/25; -The resident was noted to be wet and had two incontinent products on; -He/She was not scheduled to work on the resident's hall that night but was helping catch up and get resident's ready for bed; -Resident's should not be double briefed at any time. During an interview on 03/12/25, at 4:20 P.M., CNA K said the following: -He/She assisted NA L in providing care for the resident on 03/02/25; -The resident had been incontinent of urine and had two incontinent products on with only the inner incontinent product slightly wet; -He/She was surprised that two incontinent products were on the resident as that was not a normal practice; -He/She was unsure who put two incontinent products on the resident or why that would have occurred. -He/She had not performed peri care because the resident was not incontinent. 8. During an interview on 03/03/25 at 1:29 P.M. NA D said he/she was the shower aide for 200 and 400 halls. He/She would have to do 20 showers per day for all of the residents to get two showers a week, and that doesn't happen because there was not enough time. He/She tried to make sure all the residents gets one shower a week. If a resident wants more showers, it probably would not happen unless another aide had time. During an interview on 03/18/25 at 10:51 A.M., NA J said the following: -He/She normally worked the 200 hall; -Department heads do not give showers; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She thought the resident's on 100 hall (Resident #54) did their own showers. During an interview on 03/05/25 at 8:10 P.M., the Director of Nursing (DON) said the following: -She would expect peri-care to be done with each incontinent episode using soap and water or peri-care spray, and not done only using toilet paper; -Residents should not be wearing two incontinence briefs; -Every area that was exposed to urine or feces should be completely cleaned during cares; -Residents should be checked and changed at a minimum of every two hours; -She would expect a resident to be offered a shower on scheduled shower days two times a week; -If a shower was not able to be performed on the scheduled shower day it should be offered the next day; -She would expect staff to change a resident who is soiled as soon as possible; -She thought the showers were getting completed two times a week but reviewing requested shower documentation showed this was not done. During an interview on 03/05/25 at 7:51 P.M., the Administrator said the following: -If there was no specific staff member assigned to the 300 hall, the 400 hall CNA was to help those residents along with the charge nurse and any department head that was qualified to provide care; -She expected incontinent residents to be checked and changed every two hours and as needed; -She expected showers to be given two times a week; -If a resident wanted a shower at a specific time that request should be honored; -Recently there had not been enough staff to complete all of the showers. 38016 42592

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to provide restorative nursing services to assist two residents (Resident #30 and #55), in a review of 24 sampled residents, in attaining or maintaining their highest level of functioning. The facility failed to follow their policy to develop restorative plans with the problem, needs/strengths, measurable goals with a target date, specific interventions/task to be provided, frequency and duration of interventions/task, such as number of repetitions, length of time, or direction to staff to meet resident needs. The facility census was 98. Review of the facility policy, Restorative Nursing Program (RNP), dated 04/30/24, showed the following: -It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level; -Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning; -Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols; -The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment; -Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but is not limited to: -Maintaining proper positioning and body alignment; -Assisting residents with range of motion exercises, performing passive range of motion for residents who lack active range of motion ability; -All residents will receive maintenance nursing services as described above, as needed, by certified nursing assistants; -The Restorative Nurse and restorative aides receive additional training on restorative nursing program activities upon hire and as needed; -Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services and may include passive or active range of motion; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents may receive restorative nursing services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy; -The Restorative Nurse is responsible for maintaining a current list of residents who require restorative nursing services and for ensuring that all elements of each resident's program are implemented; -A resident's Restorative Nursing plan will include: -a. The problem, need or strength the restorative tasks are to address; -b. The type of activities to be performed; -c. Frequency of activities; -d. Duration of activities; -e. Measurable goal and target date; -Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting in the Electronic Health Record; -The Restorative Nurse, or designated licensed nurse, will provide oversight of the restorative aide activities, review the documentation at least weekly and evaluate the effectiveness of the plan monthly; -The facility maintains complete, accurate and organized documentation of restorative treatments and the response to those treatments; -The need for restorative nursing services will be documented in the medical record and indicated on the resident's plan of care. Documentation shall include: -a. The problem, need or strength that is being addressed; -b. A measurable goal with target date; -c. The specific interventions/treatments to be provided; -d. The frequency and duration of interventions/treatments; -Treatment provided as part of a restorative nursing program will be documented on a daily basis by the restorative aide or other trained individual providing the treatment; -a. The treatment as described in the resident's care plan will be written on the designated restorative flowsheet; -b. The specific treatment provided will be initialed daily or as specified by the care plan; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-d. If the treatment is refused or withheld, a narrative note will be written explaining why; -A weekly progress note will be written by the restorative aide and countersigned by a licensed nurse (if allowed by state practice act). The progress note shall include, but is not limited to: -a. The treatment provided (ambulation, etc.); -b. The specific distance or repetitions; -c. The use of assistive devices; -d. The endurance and tolerance level; -e. The amount of assistance needed and why; -The Restorative Nurse will document an evaluation monthly. The evaluation will include: -a. The problem, need or strength that is being addressed; -b. The resident's progress towards goals; -c. The resident's tolerance or response to the treatments; -d. Any complications or risks associated with the restorative interventions; -e. A determination regarding the need for continued restorative services or rationale for discontinuing restorative services; -The resident's plan of care will be updated at routine intervals and as indicated. 1. Review of Resident #30's care plan, last revised 04/17/24, showed the following: -Resident has chronic pain related to chronic physical disability which is paraplegia (paralysis of legs); -He/She uses a gerichair (reclining chair on wheels) pushed/propelled by staff for mobility; -Resident will remain free of complications related to immobility, including contractures; -Observe and report decrease in functional abilities, decrease Range of Motion (ROM), and withdrawal or resistance to care; -Resident is non-weight bearing; -Resident is dependent on staff for locomotion using gerichair; -Monitor/document/report contractures forming or worsening; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide gentle range of motion as tolerated with daily care. Review of the resident's Physician's Orders Sheet (POS), dated 06/07/24 (and still active), showed the resident was to receive restorative nursing for passive PROM. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 10/03/24, showed the following: -Cognitively intact; -Diagnosis of paraplegia (paralysis of the legs and lower body); -Impairment to functional ROM to both lower extremities; -Requires partial/moderate assistance from staff for personal hygiene and upper body dressing; -Dependent on staff for toileting hygiene, shower/bathing, lower body dressing all transfers and wheelchair mobility; -No documentation of restorative nursing minutes and no therapy services. Review of the resident's quarterly MDS, dated [DATE], showed no restorative nursing minutes, and not receiving therapy services. Review of the resident's electronic medical record showed no evidence the resident's order for RN and PROM had been discontinued. Review of the resident's restorative log, for January 2025, showed staff documented completing the following: -01/02/25, 10 minutes of passive ROM; -01/08/25, 10 minutes of passive ROM; -01/09/25, 12 minutes of passive ROM; -01/17/25, 10 minutes of passive ROM; -01/21/25, 10 minutes of passive ROM; -No documentation to show the resident ever refused PROM offered; -This documentation did not include the location PROM was to be completed for, the frequency of activities, duration of activities or the measurable goal and target date. Review of the resident's restorative log, for February 2025, showed staff documented the following: -02/07/25, 10 minutes of passive ROM; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-02/17/25, 10 minutes of passive ROM; -02/18/25, 10 minutes of passive ROM; -02/21/25, 10 minutes of passive ROM; -02/25/25, 8 minutes of passive ROM; -02/27/25, 10 minutes of passive ROM; -No documentation to show the resident ever refused PROM offered; -This documentation did not include the location PROM was to be completed for, the frequency of activities, duration of activities or the measurable goal and target date. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnosis of paraplegia; -Impairment to functional ROM to both lower extremities; -Requires partial/moderate assistance from staff for personal hygiene and upper body dressing; -Dependent on staff for toileting hygiene, shower/bathing, lower body dressing, all transfers and wheelchair mobility; -No restorative nursing, and no therapy. Review of the resident's electronic medical record showed no documentation of restorative minutes on 02/27/25 or 02/28/25, including refusals of PROM by the resident. Review of the resident's facility electronic medical record showed no documentation of restorative minutes on 03/01/25 through the review period of 03/03/25, including refusals of PROM by the resident. Review of the resident's restorative log, for 03/01/25 through 03/04/25, showed the resident received 10 minutes of passive ROM on 03/04/25, the documentation did not show any refusals, the body location that PROM was to be performed on, frequency of activities, duration of activities or the measurable goal and target date. Review of the resident's facility electronic medical record showed no documentation of a restorative plan of care to include restorative plans with the problem, needs/strengths, measurable goals with a target date, specific interventions/task to be provided, frequency and duration of interventions/task, such as number of repetitions, length of time, or direction to staff to meet resident needs. The electronic medical record also showed no documentation of the Restorative Nurse, or designated licensed nurse, documenting a weekly review or evaluation of the effectiveness of the plan monthly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/02/25 at 5:54 P.M., showed the resident in his/her room in a reclining chair on wheels (gerichair); the resident's lower extremities were paralyzed and contracted. During an interview on 03/05/25 at 2:17 P.M., the resident said the following: -He/She is a paraplegic and unable to move his/her legs; -He/She has contractures and was supposed to have restorative services three times per week; -The Restorative Aide (RA) says he/she is pulled to the floor and doesn't have time to complete his/her restorative program; -He/She may have one day of restorative and then go without any restorative nursing for two to three weeks; -He/She was having more spasms in his/her legs and they hurt; -He/She felt like his/her contractures were getting worse; he/she needed to have aggressive stretching to prevent worsening of contractures and to help his/her spasms. 2. Review of Resident #55's facility document, Point of Care Restorative Tasks, showed the following: -Date initiated: 02/14/2022; -Last revision: 08/28/24; -Task: Restorative: PROM; -Description: daily; -Instruction: [NAME] resting hand splint to contracture two to four hours after completion of ROM; -Frequency: Monday, Tuesday, Wednesday, Thursday and Friday, every shift, days 6:00 A.M. to 6:00 P.M. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis: stroke, hemiplegia (paralysis of one side of the body), seizure disorder and depression; -Functional limitation in ROM both upper and lower extremities; -Wheelchair propelled by staff; -Dependent all ADL's; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation of therapy and no restorative nursing. Review of the resident's Physician's Order Sheet, dated January 2025 (and still active) showed an order for passive ROM. Review of the resident's restorative log, for January 2025, showed staff documented completing the following: -Resident is scheduled for passive ROM daily: -01/01/25, 10 minutes of passive ROM; -01/02/25, 10 minutes of passive ROM; -01/03/25, 12 minutes of passive ROM; -No documentation of restorative nursing documented 01/04/25 through 01/06/25; no documentation the resident refused; -01/07/25, 10 minutes of passive ROM; -01/08/25, 10 minutes of passive ROM; -01/09/25, eight minutes of passive ROM; -01/10/25, 12 minutes of passive ROM; -No documentation of restorative nursing documented 01/11/25 through 01/13/25; no documentation the resident refused; -01/14/25, 10 minutes of passive ROM; -01/15/25, seven minutes of passive ROM; -01/16/25, seven minutes of passive ROM; -01/17/25, 12 minutes of passive ROM; -No documentation of restorative nursing documented 01/18/25 or 01/19/25; no documentation the resident refused; -01/20/25, 10 minutes of passive ROM; -01/21/25, 10 minutes of passive ROM; -01/22/25, 10 minutes of passive ROM; -01/24/25, 10 minutes of passive ROM; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No restorative nursing minutes documented between 01/25/25 and 01/31/25; no documentation the resident refused; -This documentation did not include the location PROM was to be completed for, the frequency of activities, duration of activities or the measurable goal and target date. Review of the resident's restorative log, for February 2025, showed the following: -Passive ROM scheduled daily; -No documentation of restorative nursing documented for 02/01/25 or 02/02/25; no documentation the resident refused; -02/03/25, eight minutes of passive ROM; -No documentation of restorative nursing documented for 02/04/25 through 02/12/25; no documentation the resident refused; -02/13/25, 10 minutes of passive ROM; -No documentation of restorative nursing documented for 02/14/25 through 02/16/25; no documentation the resident refused; -02/17/25, 10 minutes of passive ROM; -No documentation of restorative nursing documented for 02/18/25 or 02/19/25; no documentation the resident refused; -02/20/25, 14 minutes of passive ROM; -02/21/25, 15 minutes of passive ROM; -No documentation of restorative nursing documented for 02/22/25 through 02/23/25; no documentation the resident refused; -02/24/25, 10 minutes of passive ROM. -02/25/25, 12 minutes of passive ROM; -02/26/25, 10 minutes of passive ROM; -02/27/25, 12 minutes of passive ROM; -02/28/25, 15 minutes of passive ROM. -This documentation did not include the location PROM was to be completed for, the frequency of activities, duration of activities or the measurable goal and target date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's facility electronic medical record showed no documentation of a restorative plan of care to include: restorative plans with the problem, needs/strengths, measurable goals with a target date, specific interventions/task to be provided, frequency and duration of interventions/task, such as number of repetitions, length of time, or direction to staff to meet resident needs. The electronic medical record also showed no documentation of the Restorative Nurse, or designated licensed nurse, documenting a weekly review or evaluation of the effectiveness of the plan monthly. 4. During an interview on 03/03/25 at 2:30 P.M., Certified Nurse Assistant (CNA) O said the following: -He/She was the restorative aide (RA); -He/She was pulled to the floor a lot and was unable to fulfill the RNP or resident PROM duties; -There had been weeks when she was not able to do restorative nursing at all because of staffing, the Director of Nursing tried not to pull her but sometimes there is no choice; -He/She does not make a weekly or monthly note, he/she follows what tasks are in the electronic medical record. During an interview on 03/05/25 at 8:05 P.M. and 03/20/25 at 12:41 P.M., the Director of Nursing said the following: -She would like to see the Restorative Program stronger, -She tries very hard not to pull the RA to the floor, but sometimes had no choice; -She would like all residents to get restorative nursing; -Therapy recommends residents for restorative nursing; -She believed therapy recommended restorative nursing for Residents #30; -She was not sure if the facility still had the written therapy recommendations for restorative therapy because once the recommendation is entered in the computer, they do not keep the paper form; -Resident #55 should have PROM for the rest of his/her life due to being bedridden. During an interview on 03/05/25 at 8:00 P.M., the Administrator said the following: -Restorative Nursing is important to maintain the resident's abilities and prevent declines in function; -The restorative aide does get pulled to work as a CNA on the floor especially with recent staffing challenges. 38016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for five residents (Resident #33, #54, #29, #11 and #30) in a review of 24 sampled residents. Staff failed to provide routine showers to ensure good personal hygiene, failed to provide restorative nursing to prevent decline in Activities of Daily Living (ADL's) and new or worsening contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). The facility census was 98. Review of the Facility Assessment, dated 08/04/24, showed the following: -Federal regulations will require that facilities must provide 3.48 hours per resident day (HPRD) of direct care with 0.55 HPRD from registered nurses (RNs) and 2.45 HPRD from nurse aides (Certified Nurse Assistants (CNAs), Nurse Aides (NAs), or medication technicians/aides); -The remaining 0.48 HPRD can be a combination of nurse staff (RNs, Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs) or nurse aides) to comply with the minimum; -Listed below are some tables the facility can utilize to help determine their staffing needs based on the Federal minimum staffing standards, however, if State regulations require a higher standard, then the higher standard should be met; -The minimum staffing standard is considered the floor of the standard. Facilities with higher resident acuities and needs may need to adjust their staffing numbers higher than the minimum standard; -This staffing plan is based on the facility assessment, along with facility-based and community-based risk assessments to inform staffing decisions to ensure that there are a sufficient number of staff to care for the residents' needs; -This document is updated and adjusted as necessary based on changes to the resident population; -Additionally, this plan includes plans to maximize recruitment and retention of direct care staff along with contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care; -This can include, but is not limited to, the availability of direct care nurse staffing or other resources needed for resident care. The facility assessment did not list number of staff by discipline/shift/day. 1. Review Resident #30's care plan, last revised 01/05/25, showed the following: -Resident has an ADL self-care performance deficit related to paraplegia (paralysis of legs); -Resident was totally dependent on one staff to shower twice weekly and as necessary. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower record, dated February 2025, showed the following: -The resident's shower days were to be Tuesdays and Thursdays; -The resident only received a shower on 02/13/25 and 02/20/25; (Review showed no documentation the resident refused a shower during February.) Review of the resident's shower record for 03/01/25 through 03/05/25 showed no documentation the resident received or refused a shower. Observation on 03/02/25 at 5:54 P.M., showed the resident in his/her room. The resident's hair was greasy and he/she had dry flaky skin. Observation on 03/04/25 at 11:10 A.M., showed the resident had greasy, disheveled hair and flaky skin visible on his/her arms. During an interview on 03/04/25 at 11:10 A.M., the resident said the shower aide was not always able to get to him/her. He/She gets frustrated because the shower aide has time constraints and he/she could not get a shower when he/she wanted one. At minimum, the resident would like one good shower a week (Thursdays), but really wanted two showers a week. The staff only had time to do one shower a week, so if you were busy or not feeling great that day, you were out of luck. He/She should not have to miss smoke break or an activity to take his/her shower. He/She felt like he/she had no control of his/her life sometimes even though he/she was his/her own person. 2. Review of Resident #33's care plan, revised on 01/12/25, showed the following: -The resident had an ADL self-care performance deficit related to dementia and often needs staff to cue and assist to ensure he/she is getting the assistance needed; -Required limited assistance of one staff for showers twice a week and as necessary; -Required oversight or limited assist of one staff with personal hygiene and needs assistance shaving. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No rejection of cares; -Substantial to maximum staff assistance for personal hygiene and bathing. Review of the resident's electronic health record, shower/bath documentation, for 02/05/25 to 03/05/25, showed the following: -Schedule bath/shower days are Monday and Thursday; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation for the week of 02/05/25 through 02/08/25 showed no documentation staff offered or the resident refused the scheduled shower for 02/06/25; -Documentation for the week of 02/16/25 through 02/22/25 showed showed no documentation the staff offered or the resident refused two showers for this week; -Documentation for the week of 02/23/25 through 03/01/25 showed showed no documentation staff offered or the resident refused two showers for this week; -Documentation for the week of 03/02/25 through end of review period 03/05/25 showed no documentation of the scheduled shower on Monday, 03/03/25; -The resident was to have eight showers for this time period but had only received two, with no documentation of refusal of showers. His/Her last shower was on 02/13/25, 20 days prior to 03/05/25. During an interview on 03/05/25 at 1:15 P.M., the resident's guardian said the following: -He/She would want the resident to be neat and clean; -He/She would want the resident to be clean shaven if that is what the resident wanted on that day; -He/She would want the resident to receive his/her showers as scheduled. During an interview on 03/04/25 at 12:05 P.M., Certified Nurse Aide (CNA) M said the following: -He/She was assigned the 400 hall residents to care for but helped on 300 hall (the hall that Resident #33 resided on) when needed; -If there was not enough staff for each hall to have a CNA, the charge nurse and department heads were to help and cover the unassigned hall; -The charge nurse and department heads were helping on the 300 hall at this time; -Showers were supposed to be given twice a week, but when short handed, he/she was not sure if they were being given or not. 3. Review of Resident #54's electronic health record, shower/bath documentation, for 02/23/25 to 03/05/25, showed the following: -Resident prefers day shower; -Scheduled bath/shower days were Sunday and Thursday; -Documentation for the week of 02/23/25 through 03/01/25 showed one scheduled shower on 02/23/25 documented as not applicable with no documentation to show the resident refused the shower or was out of the building; no documentation to show a second shower was offered/refused for this week; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation for the week of 03/02/25 through review period of 03/05/25 showed no documentation the resident had been offered or refused a shower; -The resident was to have received three showers in this time period and had only received one and the resident had not received a shower for 13 days. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -No behaviors or rejection of cares; -Substantial to maximum assist for bathing. During an interview on 03/02/25, at 6:19 P.M., the resident said the following: -He/She was supposed to get a shower two times a week, on Sunday or Tuesday and Thursday; -He/She preferred at least one weekly, usually on Thursday, on day shift; -He/She had not had a shower for ten days. Observation on 03/03/25 at 11:18 A.M., showed the resident's hair had an oily appearance. During an interview on 03/03/25 at 11:18 A.M., the resident said he/she did not get a shower on 03/02/25 and would like one. Observation on 03/04/25 at 9:44 A.M., showed the resident's hair had an oily appearance. During an interview on 03/04/25 at 9:44 A.M., the resident said he/she did not receive a shower yesterday and would like one, it had been almost two weeks since his/her last shower. Observation on 03/05/25 at 10:50 A.M., showed the resident's hair had an oily appearance. During an interview on 03/05/25 at 10:50 A.M., the resident said the following: -He/She still has not received a shower this week; -He/She did not get a shower last week and so far, none this week. 4. Review of Resident #11's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent for bathing; -No rejection of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, last revised 02/13/25, showed the following: -Self-care performance deficit; -Totally dependent on one to two staff for bathing twice weekly and as needed. Review of the resident's shower/bath documentation for 02/09/25 to 03/05/25, showed the following: -Showers were scheduled for Tuesdays and Thursdays; -Documentation for the week of 02/09/25 through 02/15/25 showed the resident received a shower on 02/11/25 (five days from his/her previous documented shower); -There was no documentation to show the resident had been offered or refused a second shower for this week; -Documentation for the week of 02/16/25 through 02/22/25 showed no documentation the resident had been offered or refused two showers for the week; -Documentation for the week of 02/23/25 through 03/01/25 showed Certified Nurse Aide (CNA) O and NA D documented not applicable (NA) on 02/25/25; -There was no documentation to show the resident had been offered or refused a second shower for this week; -Documentation for the week of 03/02/25 through the review period of 03/05/25 showed the resident received a shower on 03/04/25 (21 days from his/her previous documented shower); -The resident was to have received seven showers for this time period but had only received two. During an interview on 03/04/25 at 11:45 A.M., the resident said he/she did not receive showers on a regular basis and definitely not two times weekly. Residents were lucky to get one shower a week. During an interview on 03/03/25, at 1:29 P.M., Nurse Aide (NA) D said he/she was the shower aide for 200 and 400 hall. He/She would have to do 20 showers per day for all of the residents to get two showers a week, and that doesn't happen because there was not enough time. He/She tried to make sure all the residents get one shower a week. If a resident wants more showers, it probably would not happen. 5. Review of Resident #30's care plan, last revised 04/17/24, showed the following: -Resident has chronic pain related to chronic physical disability which is paraplegia (paralysis of legs); -Resident will remain free of complications related to immobility, including contractures; -Observe and report decrease in functional abilities, decrease Range of Motion (ROM), and withdrawal or resistance to care; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor/document/report contractures forming or worsening; -Provide gentle range of motion as tolerated with daily care. Review of the resident's Physician's Orders Sheet (POS), dated 06/07/24 (and still active), showed the resident was to receive restorative nursing for passive PROM. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 10/03/24, showed the following: -Cognitively intact; -Diagnosis of paraplegia (paralysis of the legs and lower body); -Impairment to functional ROM to both lower extremities; -No documentation of restorative nursing minutes and no therapy services. Review of the resident's quarterly MDS, dated [DATE], showed no restorative nursing minutes, and not receiving therapy services. Review of the resident's electronic medical record showed no evidence the resident's order for RN and PROM had been discontinued. Review of the resident's restorative log, for January 2025, showed staff documented completing the following: -01/02/25, 10 minutes of passive ROM; -01/08/25, 10 minutes of passive ROM; -01/09/25, 12 minutes of passive ROM; -01/17/25, 10 minutes of passive ROM; -01/21/25, 10 minutes of passive ROM; -No documentation to show the resident ever refused PROM. Review of the resident's restorative log, for February 2025, showed staff documented the following: -02/07/25, 10 minutes of passive ROM; -02/17/25, 10 minutes of passive ROM; -02/18/25, 10 minutes of passive ROM; -02/21/25, 10 minutes of passive ROM; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-02/25/25, 8 minutes of passive ROM; -02/27/25, 10 minutes of passive ROM; -No documentation to show the resident ever refused PROM. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnosis of paraplegia; -Impairment to functional ROM to both lower extremities; -No restorative nursing and no therapy. Review of the resident's electronic medical record showed no documentation of restorative minutes on 02/27/25 or 02/28/25, including refusals of PROM by the resident. Review of the resident's facility electronic medical record showed no documentation of restorative minutes on 03/01/25 through the review period of 03/03/25, including refusals of PROM by the resident. Review of the resident's restorative log, for 03/01/25 through 03/04/25, showed the resident received 10 minutes of passive ROM on 03/04/25. Observation on 03/02/25 at 5:54 P.M., showed the resident in his/her room in a reclining chair on wheels (gerichair). The resident's lower extremities were paralyzed and contracted. During an interview on 03/05/25 at 2:17 P.M., the resident said the following: -He/She was paraplegic and unable to move his/her legs; -He/She has contractures and was supposed to have restorative services three times per week; -The Restorative Aide (RA) says he/she was pulled to the floor and doesn't have time to complete his/her restorative program; -He/She may have one day of restorative and then go without any restorative nursing for two to three weeks; -He/She was having more spasms in his/her legs and they hurt; -He/She felt like his/her contractures were getting worse; he/she needed to have aggressive stretching to prevent worsening of contractures and to help his/her spasms. 6. Review of Resident #55's facility document, Point of Care Restorative Tasks, showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Date initiated: 02/14/2022; -Last revision: 08/28/24; -Task: Restorative: PROM; -Description: daily; -Instruction: [NAME] resting hand splint to contracture two to four hours after completion of ROM; -Frequency: Monday, Tuesday, Wednesday, Thursday and Friday, every shift, days 6:00 A.M. to 6:00 P.M. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis: stroke, hemiplegia (paralysis of one side of the body), seizure disorder and depression; -Functional limitation in ROM both upper and lower extremities; -Dependent all ADL's; -No documentation of therapy and no restorative nursing. Review of the resident's Physician's Order Sheet, dated January 2025 (and still active) showed an order for passive ROM. Review of the resident's restorative log, for January 2025, showed staff documented completing the following: -Resident is scheduled for passive ROM daily: -01/01/25, 10 minutes of passive ROM; -01/02/25, 10 minutes of passive ROM; -01/03/25, 12 minutes of passive ROM; -No documentation of restorative nursing documented 01/04/25 through 01/06/25; no documentation the resident refused; -01/07/25, 10 minutes of passive ROM; -01/08/25, 10 minutes of passive ROM; -01/09/25, eight minutes of passive ROM; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/10/25, 12 minutes of passive ROM; -No documentation of restorative nursing documented 01/11/25 through 01/13/25; no documentation the resident refused; -01/14/25, 10 minutes of passive ROM; -01/15/25, seven minutes of passive ROM; -01/16/25, seven minutes of passive ROM; -01/17/25, 12 minutes of passive ROM; -No documentation of restorative nursing documented 01/18/25 or 01/19/25; no documentation the resident refused; -01/20/25, 10 minutes of passive ROM; -01/21/25, 10 minutes of passive ROM; -01/22/25, 10 minutes of passive ROM; -01/24/25, 10 minutes of passive ROM; -No restorative nursing minutes documented between 01/25/25 and 01/31/25; no documentation the resident refused. Review of the resident's restorative log, for February 2025, showed the following: -Passive ROM scheduled daily; -No documentation of restorative nursing documented for 02/01/25 or 02/02/25; no documentation the resident refused; -02/03/25, eight minutes of passive ROM; -No documentation of restorative nursing documented for 02/04/25 through 02/12/25; no documentation the resident refused; -02/13/25, 10 minutes of passive ROM; -No documentation of restorative nursing documented for 02/14/25 through 02/16/25; no documentation the resident refused; -02/17/25, 10 minutes of passive ROM; -No documentation of restorative nursing documented for 02/18/25 or 02/19/25; no documentation the resident refused; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-02/20/25, 14 minutes of passive ROM; -02/21/25, 15 minutes of passive ROM; -No documentation of restorative nursing documented for 02/22/25 through 02/23/25; no documentation the resident refused; -02/24/25, 10 minutes of passive ROM. -02/25/25, 12 minutes of passive ROM; -02/26/25, 10 minutes of passive ROM; -02/27/25, 12 minutes of passive ROM; -02/28/25, 15 minutes of passive ROM. Review of the resident's facility electronic medical record showed no documentation of a restorative plan of care to include: restorative plans with the problem, needs/strengths, measurable goals with a target date, specific interventions/task to be provided, frequency and duration of interventions/task, such as number of repetitions, length of time, or direction to staff to meet resident needs. The electronic medical record also showed no documentation of the Restorative Nurse, or designated licensed nurse, documenting a weekly review or evaluation of the effectiveness of the plan monthly. During an interview on 03/03/25 at 2:30 P.M., CNA O said the following: -He/She was the restorative aide (RA); -He/She was pulled to the floor a lot and was unable to fulfill the RNP or resident PROM duties; -There have been weeks when she was not able to do restorative nursing at all because of staffing, the Director of Nursing tried not to pull him/her but sometimes there was no choice. 7. During an interview on 03/05/25 at 11:41 A.M. and 8:10 P.M., the DON said the following: -The facility identified the following staffing was required to meet the needs of the residents: -Day shift: Two charge nurses (12 hour shifts), two CMTs (eight hour shifts on days) and six CNAs (12 hour shifts); -Night shift: Two charge nurses (12 hour shifts), two CMTs (eight hour shifts on evenings) and four to five CNAs; -She has not been able to maintain staffing at the levels to meet all the residents' needs; -Nursing administration was covering charge nurse and floor roles daily and other department heads have had to assist; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At times, the facility has had other departments assist with nursing tasks they can do like pass ice, make beds and washing equipment, so nursing staff can focus on care; -Agency staff stopped January 1st; that decision was not made at the facility level. Review of the facility's staffing sheets, dated 02/01/25 through 02/28/25, showed the following: -02/01/25: 6:00 A.M. to 6:00 P.M., one CNA and two NAs (department heads was written in for one of the CNA spots). (Three CNAs/NAs worked instead of the six the DON said it would require to meet residents' needs.) 6:00 P.M. to 6:00 A.M., there were three CNAs. (The DON said four to five CNAs would be required to meet the residents' needs). The facility census was 93; -02/02/25: 6:00 A.M. to 6:00 P.M., one CNA and one NA (department heads was written in for one of the CNA spots) (Two CNAs/NAs worked instead of the six the DON said it would require to meet residents' needs.) 6:00 P.M. to 6:00 A.M., there were three CNAs. (The DON said four to five CNAs would be required to meet the residents' needs). The facility census was 92; -02/03/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON), three CNAs and one NA. (Four CNAs/NAs worked this shift. One of the CNAs was the restorative aide who was scheduled with a floor assignment.) 6:00 P.M. to 6:00 A.M., there were only two CNAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 92; -02/04/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON), four CNAs and one NA. (Five CNAs/NAs worked this shift. One of the CNAs was the restorative aide who was scheduled with a floor assignment.) 6:00 P.M. to 6:00 A.M., there was only one CNA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 92; -02/05/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON), three CNAs and one NA. (Four CNAs/NAs worked this shift. One of the CNAs was the restorative aide who was scheduled with a floor assignment.) The facility census was 91; -02/06/25: 6:00 A.M. to 6:00 P.M., there were three CNAs and one NA. (Four CNAs/NAs worked this shift. One of the CNAs was the restorative aide who was scheduled with a floor assignment.) 6:00 P.M. to 6:00 A.M., there were two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 91; -02/07/25: 6:00 A.M. to 6:00 P.M., the DON as the only charge nurse. 6:00 P.M. to 6:00 A.M., there was one CNA and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 91; -02/08/25: 6:00 A.M. to 6:00 P.M., there were five CNAs (no RA or shower aide was scheduled). 6:00 P.M. to 6:00 A.M., there was one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 91; -02/09/25: 6:00 A.M. to 6:00 P.M., there were four CNAs (four out of six needed CNAs, and no RA or shower aide was scheduled); 6:00 A.M.-2:00 P.M., there was one CMT (one CMT out of two needed CMT's), 2:00 P.M.-10:00 P.M., one CMT (one CMT out of two needed CMT's); The facility census was 91; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-02/10/25: 6:00 A.M. to 6:00 P.M., the DON and the administrative were the charge nurses, three CNAs and two NAs (five out of six needed CNAs; one of the CNAs was the restorative aide who was scheduled with a floor assignment); 6:00 P.M. to 6:00 A.M., two CNAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 91; -02/11/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON), four CNAs and one NA (five out of six needed CNAs, and no RA was scheduled); 6:00 P.M. to 6:00 A.M., there were two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 92; -02/12/25: 6:00 A.M. to 6:00 P.M., there were two charge nurses (one was the DON) and three CNAs (department heads was written in with no specific assignments or job titles) (three out of six needed CNAs, and no RA or shower aide was scheduled); 6:00 P.M. to 6:00 A.M., there was one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 92; -02/13/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the administrator), four CNAs and one NA (five out of six needed CNAs, and no RA was scheduled); 6:00 P.M. to 6:00 A.M., one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 93; -02/14/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON); 6:00 P.M. to 6:00 A.M., one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 93; -02/15/25: 6:00 A.M. to 6:00 P.M., the DON and the administrator were the charge nurses, two CNAs and two NAs (four out of six needed CNAs, and no RA or shower aide was scheduled). The facility census was 92; -02/16/25: 6:00 A.M. to 6:00 P.M., two CNAs and two NAs (four out of six needed CNAs, and no RA or shower aide was scheduled). The facility census was 93; -02/17/25: 6:00 A.M. to 6:00 P.M., the DON and the administrator were the charge nurses, three CNAs and one NA (four out of six needed CNAs, and no RA was scheduled). 6:00 A. M-2:00 P.M., there was one CMT (one of two needed CMT's). 6:00 P.M. to 6:00 A.M., two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 94; -02/18/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON). 6:00 P.M. to 6:00 A.M., one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 94; -02/19/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the administrator), two CNAs and two NAs (four out of six needed CNAs. One of the CNAs was the restorative aide who was scheduled with a floor assignment.) 2:00 P.M.-10:00 P.M., there was one CMT (out of two needed CMT's). 6:00 P.M. to 6:00 A.M., two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 94; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-02/20/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON). 6:00 A.M.-2:00 P.M., one CMT (out of two needed CMT's). The facility census was 94; -02/21/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON), one CNA and three NAs (four out of six needed CNAs, with the RA being one of the CNAs on the floor assignment). 2:00 P.M.-10:00 P.M., one CMT (out of two needed CMTs). The facility census was 96; -02/22/25: 6:00 P.M. to 6:00 A.M., two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 96; -02/23/25: 6:00 A.M. to 6:00 P.M., four CNAs and one NA (five out of six needed CNAs, and no RA or shower aide was scheduled). 6:00 P.M. to 6:00 A.M., one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 95; -02/24/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON). 2:00 P.M.-10:00 P.M., one CMT (one of two needed CMTs). The facility census was 95; -02/25/25: 6:00 P.M. to 6:00 A.M., two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 96; -02/26/25: 6:00 A.M. to 6:00 P.M., the DON and the administrator were the charge nurses. 6:00 A.M.-2:00 P.M., one CMT (one out of two needed). 6:00 P.M. to 6:00 A.M., two CNAs and one NA (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 96; -02/27/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the administrator). 6:00 P.M. to 6:00 A.M., the DON was the only charge nurse (out of two charge nurses needed), one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 98; -02/28/25: 6:00 A.M. to 6:00 P.M., two charge nurses (one was the DON). 6:00 P.M. to 6:00 A.M., one CNA and two NAs (instead of four to five CNAs the DON said was needed to meet the residents' needs). The facility census was 98. During an interview on 03/02/25 at 4:21 P.M., the administrator said the facility did not have enough licensed nursing staff, have had vacancies, and have several NAs (uncertified aides); -Agency staff were utilized prior to 01/01/25 but the facility was not allowed to use agency staffing at this time. During an interview on 03/03/25 at 1:18 P.M., the Regional Director of Operations said the facility has had staffing challenges. The company may have to bring agency staffing back in the building. The agency contract ended on 01/01/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 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. 38016 Based on observation, interview and record review, the facility failed to provide a full time Director of Nursing (DON), who did not serve as a charge nurse, when the facility had a census over 60. Further review showed the facility did not have eight consecutive hours of Registered Nurse staffing daily for two days. The facility census was 98. Review of the facility Registered Nurse (RN) Policy, revised 04/30/24, showed the following: -It is the intent of the facility to comply with Registered Nurse staffing requirements; -Full-time is defined as working 40 or more hours a week; -Charge Nurse is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care; -The facility will utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week; -The facility will designate a Registered Nurse to serve as the Director of Nursing on a full time basis; -The Director of Nursing may serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents. 1. Review of the Facility Assessment, dated 08/04/24, showed the following: -Federal regulations will require that facilities must provide 3.48 hours per resident day (HPRD) of direct care with 0.55 HPRD from registered nurses (RNs); -The remaining 0.48 HPRD can be a combination of nurse staff, including RNs. The facility assessment did not list number of staff by discipline/shift/day. 2. Review of the facility's staffing sheets, dated 01/01/25 through 01/31/25, showed the following: -01/01/25 charge nurse for the 300/400 hall was the DON from 6:00 A.M. to 12:00 noon, facility census 90; -01/05/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 91; -01/10/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 91; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-01/11/25 one charge nurse (LPN) listed for day shift, and no RN listed on the staffing sheet, facility census 91 (there was not eight consecutive hours of RN coverage); -01/12/25 no RN listed on the staffing sheet, facility census 90 (there was not eight consecutive hours of RN coverage); -01/17/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92; -01/22/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 90; -01/25/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 90; -01/27/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 94; -01/28/25 charge nurse for the 300/400 hall was the DON (half the shift) 12:00 Noon to 6:00 P.M., facility census 93; -01/30/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92. Review of the facility's staffing sheets, dated 02/01/25 through 02/28/25, showed the following: -02/01/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 93; -02/02/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92; -02/04/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92; -02/05/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 91; -02/07/25 one charge nurse, the DON, listed for day shift 6:00 A.M. to 6:00 P.M., facility census 91; -02/08/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 91; -02/10/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 91; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-02/11/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92; -02/12/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92; -02/14/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 93; -02/15/25 charge nurse for the 300/400 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 92; -02/16/25 charge nurse for the 300/400 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 93; -02/17/25 charge nurse for the 300/400 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 94; -02/18/25 charge nurse for the 300/400 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 94; -02/20/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 94; -02/21/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 96; -02/22/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 96; -02/24/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 95; -02/26/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., the DON was also listed for the Certified Medication Technician (CMT) role passing medications on the 300/400 hall for 6:00 A. M. to 6:00 P.M., facility census 96; -02/28/25 charge nurse for the 100/200 hall was the DON from 6:00 A.M. to 6:00 P.M., facility census 98. Review of the facility's staffing sheets, dated 03/01/25, showed one charge nurse, the DON, listed from 6:00 A.M. to 6:00 P.M.; the facility census was 98. 3. Review of the staffing sheets, dated 03/04/25, showed the charge nurse for the 100/200 hall was the DON from 6:00 P.M. to 6:00 A.M.; the facility census was 98. Observation on 03/04/25 at 6:00 P.M., during the survey process, showed the DON worked as the charge nurse for the 100/200 hall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of the staffing sheets, dated 03/05/25, showed the charge nurse for the 100/200 hall was the DON from 6:00 P.M. to 6:00 A.M.; the facility census was 98. Observation on 03/05/25 at 6:00 P.M., during the survey process, showed the DON worked as the charge nurse for the 100/200 hall. During an interview on 03/05/25 at 11:41 A.M., the DON said the following: -Nursing administration covered charge nurse and floor roles daily and other department heads have had to assist; -The facility had used agency staff to fill charge nurse roles prior to January 1st 2025; -The facility had relied on agency staffing for licensed staffing, but that had stopped January 1st (2025); -She had worked almost every day as a charge nurse; she had been working an eight to thirteen day stretch with one day off the month of February; -The month of March, she was scheduled to be on nights full time; -In February, she only worked as the DON for eight hours; -She had not been able to keep up with education or other tasks that needed to be done; -When she was the charge nurse on the floor, she could not get interviews and new hire paper work completed; -If the facility did not have enough nurses, she had been on the floor working or helping. During an interview on 03/02/25 at 4:21 P.M., the administrator said the following: -The DON had worked the floor most of the month of February as a charge nurse; -The DON was only able to work in the DON role two days in February; -The facility did not have enough licensed nursing staff; -Agency staff had been utilized prior to 01/01/25 but the facility was not allowed to use agency staffing at this time. During an interview on 03/03/25 at 1:18 P.M., the Regional Director of Operations said the DON has been working the floor a lot. The company may have to bring agency staffing back in the building. The agency contract ended on 01/01/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38016 Based on observation, interview, and record review, the facility failed to follow policy to check temperatures during the meal service and failed to serve food items in a manner to ensure the food was at a safe and appetizing temperature. The facility census was 98. Review of the facility's policy, Receiving and Storing Food and Supplies, last revised 6/30/23, showed the following: -Record reading on Food Temperature Chart form at beginning of tray line and during the tray line. If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperature. Take the temperature of each pan of product before serving; -Acceptable serving temperatures are: casseroles (greater than 135 degrees Fahrenheit); hot pureed food (greater than 135 degrees Fahrenheit); hazardous salads and desserts (less than 41 degrees Fahrenheit). 1. During an interview on 03/02/25 at 6:05 P.M., Resident #43 said he/she sometimes ate in the dining room and sometimes ate in his/her room. The food was not very warm when served. During an interview on 03/02/25 at 6:25 P.M., Resident #44 said he/she normally ate in his/her room. The food was not always warm when served. During an interview on 03/02/25 at 6:33 P.M., Resident # 19 said he/she ate in his/her room most of the time, and his/her food was always cold. Even when he/she ate in the dining room, the food was cold. During an interview on 03/03/25 at 1:41 P.M., Resident #59 said his/her food was barely warm, it was not served hot. The food would taste better if it was hot. During an interview on 03/03/25 at 1:45 P.M., Resident # 70 said the food was warm, not hot. The food was never hot. During an interview on 03/03/25 at 2:01 P.M., Resident #30 said the food was never hot. Today's food was barely warm and that was the usual. 2. Review of the Resident Diet Type Report dated 3/2/25, showed 62 residents were on a regular diet. Review of the Diet Spreadsheet Menu for the dinner meal on 03/02/25 showed residents on a regular diet were to receive tuna noodle casserole and tossed salad/dressing. Review of the recipe for the regular tuna noodle casserole showed to maintain at 135 degrees Fahrenheit or above. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the recipe for the tossed salad/dressing showed to maintain at 41 degrees Fahrenheit or below. Observation on 3/2/25 at 4:45 P.M., showed staff took the final cooking temperatures of the food items (all were within acceptable parameters for temperature prior to meal service) and placed the food items on the steam table for the supper meal. Observation on 03/02/25 at 5:05 P.M., showed staff began the dinner meal service. Staff served plates from the steam table in the kitchen to residents in the main dining room. Observation on 03/02/25 at 5:43 P.M., showed staff served the last tray to residents in the dining room. Observation on 03/02/25 at 5:45 P.M., showed the following: -Staff began preparing hall trays from the steam table in the kitchen; -Staff placed the food items, including the tuna noodle casserole and the tossed salad on hot/warm plates on insulated bases, covered the plates with insulated tops, and placed them in a covered food transport rack. Observation on 3/2/25 at 6:02 P.M., showed staff prepared the last hall tray from the steam table. (Staff did not take the temperature of the food items during the meal service (per policy) to ensure the food was an appropriate temperature.) Observation on 3/2/25 at 6:32 P.M., showed staff served the last tray from the hall cart. Observation of the food temperatures for the test tray (received after the last tray was served from the hall tray cart) on 3/2/25 at 6:34 P.M., taken with a digital metal stem type thermometer, showed the following: -Tuna noodle casserole was 118.2 degrees Fahrenheit; -Tossed salad/dressing was 77.0 degrees Fahrenheit. During an interview on 3/3/25 at 10:30 A.M., the Dietary Manager said the following: -The cook did not always check the temperature of the food midway through meal service; -She expected meals to be served at safe and appetizing temperatures (hot foods hot and cold foods cold). During an interview on 3/5/25 at 11:30 A.M., the Administrator said she expected hot foods to be served hot and cold foods to be served cold. 44610

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44610 Based on observation, interview, and record review, the facility failed to ensure ceilings in the dishwasher room, dry food storage room, and above food preparation and serving areas were clean and maintained in good condition to ensure food items were not subject to potential contamination. The facility failed to maintain a drain air gap between the ice machine and the floor drain. The facility census was 98. Review of the facility's policy, Dietary Equipment Operations, Infection Control, and Sanitation, last revised 02/02/24, showed the following: -Ceilings must be free of chipped and/or peeling paint; -Ceilings must be washed thoroughly at least twice a year. Heavily soiled surfaces must be cleaned more frequently and as required. It is important to repair peeling paint areas as soon as they appear. 1. Observation on 3/2/25 between 2:50 P.M. and 9:00 P.M., showed the following: -A ceiling area approximately 2 feet wide by 8 feet long above the door inside the dry food storage room had moisture damage and dark stains; -The ceiling in the dishwasher room had cracked, chipped, and flaking paint above the dirty and clean ends of the dishwashing area and above the clean item racks; -Above the steam table, two ceiling vents and the areas on the ceilings around each vent had a buildup of dust and debris. During an interview on 3/3/25 at 10:30 A.M., the Dietary Manager said the following: -She had not really noticed the identified areas on the ceilings. The maintenance department would be responsible for making ceiling repairs and cleaning the ceiling vents; -The maintenance department usually checked and cleaned vents monthly. During an interview on 3/5/25 at 8:40 A.M., the Maintenance Director said the following: -He was aware of the identified ceiling areas; -The maintenance department was responsible for repairing/maintaining the ceilings in the kitchen, and cleaned the ceiling vents quarterly and as needed; -He expected the identified areas on the ceilings in the kitchen to be clean and maintained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 3/3/25 at 12:59 P.M., of the ice machine, located in the dining room, showed two 1-inch drain pipes exited the ice machine into a 3-inch flanged drain pipe at the floor. The two 1-inch drain pipes extended approximately 0.5-inches below the flood rim level of the 3-inch flanged drain pipe and did not contain an air gap. During an interview on 3/3/25 at 1:00 P.M., the Maintenance Supervisor said he was unaware the ice machine drain did not contain a sufficient air gap. During an interview on 3/5/25 at 9:00 A.M., the Administrator said she expected the ice machine drain to have an air gap, and expected the ceilings in the kitchen to be free of dust and debris and maintained in good repair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to ensure nursing staff washed their hands after each direct resident contact and between glove changes, for three residents (Resident #3, #33, #79) of 24 sampled residents, failed to ensure soiled surfaces were sanitized appropriately, failed to ensure proper infection control was utilized for respiratory care supplies for one resident, (Resident #7), and failed to wear gloves when administering eye drops for one resident (Resident #25). The facility census was 98. Review of the facility policy, Hand Hygiene, revised on 06/26/24, showed the following: -Purpose: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility; -Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR); - Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; -Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating and after using the restroom; - The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Review of the facility policy, Glove Utilization, revised on 05/18/25, showed the following: -Purpose: The purpose of this procedure is to provide guidelines for the use of gloves. To prevent the spread of infection and disease to residents and employees; to protect wounds from contamination; to protect hands from potentially infectious material; and to prevent exposure to the HIV (AIDS) and Hepatitis B (HBV) viruses from blood or body fluids; - When gloves are indicated, disposable single-use gloves should be worn; - Non-sterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces; -Wash hands after removing gloves. (Note: gloves do not replace hand washing); - When changing dressings, after the dirty dressing is removed, gloves should be removed, hands washed and clean gloves donned before applying the clean dressing; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Gloves should be removed before removing the mask and gown and should be discarded into the designated waste receptacle inside the room; - When to use gloves: When touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin. Gloves need to be used during removal of wound dressings. Gloves are to be changed and hands are washed, new gloves donned before a clean dressing is applied. When the employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis, etc. When cleaning up spills or splashes of blood or body fluids. When cleaning potentially contaminated items; -Wash hands after glove removal. 1 Review of the Resident #3's care plan, last revised 01/26/25, showed the resident was incontinent of bladder and bowel. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 02/16/25, showed the following: -Frequently incontinent of bladder and bowel; -Partial to moderate assist with toileting; -Supervision to touch assist with dressing. Observation on 03/02/25 at 6:08 P.M. showed the following: -Nurse Assistant (NA) J followed the resident to his/her room; -The resident ambulated to the bathroom in his/her room while pulling his/her pants and incontinence brief down. The brief was soiled with feces and urine. The resident sat on the toilet; -Without washing hands, NA J donned gloves, removed the soiled brief and placed it in the trash; -NA J retrieved a clean brief, without changing gloves or washing hands, and applied it over the resident's feet up to mid calf; -The resident stood and NA J cleansed the resident's buttocks and rectal area using approximately ten perineal wipes. NA J pulled the clean incontinent brief up with his/her soiled gloves; -The resident attempted to sit back on the toilet with feces noted on the toilet seat. NA J touched the resident's right arm with his/her soiled gloves and instructed the resident to not sit; -NA J wiped the feces from the seat with perineal wipes; -The resident sat back on the seat; The resident had feces on his/her socks and feces were noted on the floor; -NA J removed the resident's socks and wiped the feces from the floor with another wipe; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Without changing gloves and performing hand hygiene, NA J applied the resident's pants; -The resident stood and NA J pulled the resident's pants up; -The resident ambulated into his/her room, obtained clean socks and returned to sit on the toilet seat; -Wearing the same soiled gloves, NA J applied the clean socks; -The resident stood and ambulated back to his/her chair; -NA J picked up the bagged, soiled clothing, opened the door with his/her soiled, gloved hand, removed the soiled gloves and exited the room without washing his/her hands. During an interview on 3/18/24 at 10:40 A.M., NA J said the following: -Hands should be washed before cares, with glove changes, when they become soiled and after cares; -Clean items/areas should not be touched by soiled hands/gloves; -Gloves should be changed after becoming soiled; -He/She had only known to clean feces from surfaces with the white cloths they used for perineal care, perineal wipes or a washcloth with soap; -He/She had not been instructed or shown to use a disinfectant when cleaning feces from surfaces. 2. Review of Resident #33's care plan, revised on 01/12/25, showed the following: -The resident had an activity of daily living (ADL) self-care performance deficit related to dementia and often needed staff to cue and proved needed assistance; -Toilet use need for assistance fluctuated; the resident takes self to the bathroom at times, but needs assistance when incontinent of bowel and bladder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Substantial to maximum staff assistance for personal hygiene, toileting hygiene, and bathing; -Always incontinent of urine and frequently incontinent of bowel. Observation on 03/02/25 at 7:59 P.M., showed the following: -The resident walked down the hall with staff going to his/her room; -The front and back of the resident's sweat pants and hem of his/her shirt were wet and had a moderate urine smell; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Certified Nursing Assistant (CNA) K and NA L led the resident to his/her room with gloved hands; -CNA K assisted the resident to pull his/her sweat pants down, the resident wore a pull up incontinent product as well as an adult brief; both were saturated with urine and had a strong urine odor; -CNA K sat the resident on the toilet and removed the resident's wet pants; -After the resident used the toilet, CNA K wiped the resident's upper thighs and groin with toilet paper and applied a new adult brief. CNA K removed his/her gloves and applied a clean pair of gloves without hand hygiene prior; -NA L assisted in dressing the resident, took the trash to the soiled utility room, and removed gloves; -NA L reapplied gloves without hand hygiene between glove changes and made the resident's bed; -CNA K assisted the resident to bed, removed his/her gloves and without washing his/her hands, left the room to get a pillow for the resident. 3. Review of Resident #79's care plan, revised on 03/02/25, showed the following: -The resident has bowel and bladder incontinence related to confusion and required one assist when incontinent; -Clean peri-area with each incontinence episode; -Check every two hours and as required for incontinence, wash, rinse and dry perineum. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Partial to moderate staff assistance for upper and lower body dressing; -Substantial to maximum staff assistance for bathing, toileting hygiene and personal hygiene. Observation on 03/02/25 at 8:10 P.M., showed the following: -CNA K and NA L assisted the resident to the bathroom; -CNA K and NA L entered the resident's room with gloves on that were applied in the hallway prior to assisting the resident; -The resident's pull-up was noted to be slightly wet with a slight urine smell; -CNA K removed the incontinence product and with the same soiled gloves, he/she applied a clean brief on the resident; -CNA K noticed what appeared to be dried feces on the resident's bed sheet, removed the sheet and placed it in a bag to take to the laundry; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA K removed his/her gloves and without completing any hand hygiene left the room. During an interview on 03/12/25 at 4:05 P.M., NA L said the following: -Hands should be washed all of the time when providing for the residents in any way; -Hands should be washed before applying gloves, when changing gloves and after gloves are removed; -He/She did not wash his/her hands when providing care for Resident #33 or Resident #79 on 03/02/25; -He/She should have washed his/her hands between glove changes and when he/she removed gloves after providing resident cares. During an interview on 03/12/25 at 4:20 P.M., CNA K said the following: -He/She assisted NA L in providing care for the resident on 03/02/25; -The resident was incontinent of urine, had two incontinent products on, and his/her pants were wet; -Hands should be washed every step of resident care, before providing care, when soiled and when gloves are changed; -He/She did not wash his/her hands between glove changes when providing care for Resident #33 and Resident #79; -He/She should have washed his/her hands each time gloves were changed and between residents and did not. 4. Review of Resident #45's care plan, dated 5/24/23 showed the following: -Diabetes Mellitus (high blood glucose); -Diabetes medication as ordered by physician; -Resident approved to have accuchecks and insulin administered in the dining room. Review of the resident's POS, dated 3/2025 showed the following: -Humalog injection solution 100 unit/ml (Insulin Lispro-fast acting insulin used to treat diabetes) inject as per sliding scale: For blood glucose of: 0-149=0 units, 150-199=5 units , 200-250=10 units, 251-300=15 units, 301-350=20 units, 351-400=25 units, 401-500=30 units and call primary care physician if over 500 and give full dose subcutaneously three times daily for Type II diabetes. Observation on 3/4/25 showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:32 A.M. Registered Nurse (RN) B performed an accucheck on the resident in the resident's room, removed gloves and without washing/sanitizing his/her hands, regloved and wrapped the glucometer in a disinfectant wipe; -At 12:35 P.M. RN B prepared to administer the resident's insulin. The resident sat in his/her wheelchair in the dining room. Without washing/sanitizing hands, he/she removed the insulin from the cart, cleaned the top of the vial with alcohol, withdrew 15 units of Lispro insulin and administered it into the resident's abdomen. He/She removed his/her gloves and did not perform hand hygiene, placed the insulin vial in the cart, documented the administration in the electronic health record, locked the medication cart and pushed the cart out of the dining room. During an interview on 3/14/25 at 3:45 P.M. RN B said the following: -Hands should be washed when physically soiled and between residents; -Staff should deglove and wash/sanitize hands after administering insulin and before touching clean surfaces; -Hands should be washed/sanitized after removing gloves. 5. Review of Resident #7's care plan, last revised 1/31/25 showed the following: -Diagnoses included obstructive sleep apnea (sleep disorder in which breathing repeatedly stops and starts) and emphysema (difficulty breathing); -BiPAP (bilevel positive airway pressure-a non-invasive ventilation therapy) with distilled, humidified water at 16/8 with two liters oxygen (O2) bleed in during hours of sleep; -Total dependence of staff for transfers, hygiene and -The care plan did not address the use of a nebulizer for inhalation therapy or how to store respiratory equipment when not in use. Review of the resident's POS, dated 3/2025, showed the following; -BiPaP with distilled, humidified water at 16/8 with two liters O2 bleed in during hours of sleep (2/1/25); -Albuterol Sulfate (bronchodilator-relaxes airway muscles) inhalation nebulization solution (2.5 milligrams (mg)/three milliliters (ml)-inhale one vial via nebulizer two times daily (2/1/25); -Review of the resident's Medication Administration Record (MAR), dated 3/2025 showed the following -Albuterol Sulfate inhalation nebulization solution (2.5 mg's/three ml's)-inhale one vial via nebulizer two times daily at 6:00 A.M. and 7:00 P.M. (2/1/25). Treatment documented as administered two times daily from 3/1/25 to 3/5/25. Review of the resident's TAR dated 3/2025 showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-BiPaP with distilled, humidified water at 16/8 with two liters oxygen bleed in during hours of sleep every night shift related to obstructive sleep apnea (2/1/25). Observation showed the following: -On 3/3/25 at 11:15 A.M. the resident was up in his/her chair in his/her room. The BiPaP equipment lay unbagged, on the bedside table next to the resident's bed; -On 3/4/24 at 11:47 A.M. the resident's nebulizer equipment lay unbagged, on the bedside table. The BiPaP tubing hung from the table and the mask lay on the floor between the bed and the outside wall. During an interview on 3/4/2025 the resident said he/she had been using his/her BiPaP lately as he/she has had a cold and used the nebulizer for treatments two times daily. During an interview on 3/18/25 at 8:07 P.M. Licensed Practical Nurse P said the following: -A BiPaP/ Continuous Positive Air Pressure (CPAP) mask should not touch the floor and should be stored in a plastic bag when not in use; -If a BiPaP mask was on the floor, it should be replaced or disinfected. 6. Review of Resident #25's face sheet showed his/her diagnoses include bilateral ocular hypertension (a condition where the pressure inside both eyes is elevated above normal levels) and dry eye syndrome. Review of the resident's March 2025 Physician Order Sheet (POS) showed the following: -Artificial tears ophthalmic solution (an eye drop used to treat dry eyes), instill one drop into both eyes daily; -Timolol maleate ophthalmic solution 0.5 percent (%) (an eye drop used to treat high pressure inside the eye) instill one drop into both eyes daily. Observation on 03/04/25 at 10:28 A.M., showed the following: -Certified Medication Technician (CMT) N administered artificial tears for Resident #25 without using gloves; -CMT N used an alcohol based hand rub after exiting the resident's room. During an interview on 03/04/25 at 11:00 A.M., CMT N said he/she did not use gloves when administering eye drops to the resident and he/she should have. During an interview on 03/05/25 at 8:10 P.M., the Director of Nursing said the following: -Hands should be washed before applying gloves, when removing gloves and in between glove changes; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gloves should be worn when providing resident care; -Gloves should be worn when instilling eye drops or with wound care; -Gloves should be changed when soiled; -Hands should be washed after performing an accucheck and upon exiting a resident's room. During an interview on 03/05/25 at 7:51 P.M., the Administrator said the following: -Hands should be washed before all cares, when hands are soiled and before and after using gloves; -Gloves should be worn when providing resident care, and should be changed when soiled; -Respiratory equipment should not touch the floor and should be stored in a plastic bag when not in use. 38016 42592