

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Colonial Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 750 West Cooper Buffalo, MO 65622	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464</p> <p>Based on record review and interview, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN - form CMS-10055) or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits for one resident (Resident #49) of three sampled residents who remained in the facility upon discharge from Medicare Part A services. The facility census was 109.</p> <p>Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C -09-20), dated 01/09/09, showed the following:</p> <ul style="list-style-type: none"> -The Notice of Medicare Provider Non-Coverage (NOMNC - form CMS-10123) is issued when all covered Medicare services end for coverage reasons; -If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by use of either the SNFABN (form CMS-10055) or one of the five uniform denial letters; -The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them his/herself or through other insurance they may have; -If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. <p>Review shoed the facility did not provide a policy pertaining to the issuance of Advance Beneficiary Notices.</p> <p>1. Review of Resident #49's electronic medical record (EMR) summary page showed admitted [DATE].</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the resident's Skilled Nursing Facility Beneficiary Notification Review, completed by facility staff on 12/05/24, showed the following:</p> <ul style="list-style-type: none"> -Medicare Part A skilled services episode start date 10/14/24; -Last covered day of Medicare Part A service as 12/06/24. -The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. <p>(Facility staff did not provide the resident or his/her legal representative the required SNFABN form CMS-10055 or alternative denial letter.)</p> <p>During an interview on 12/06/24, at 10:55 A.M., the resident said he/she signed the Notice of Medicare Non-Coverage (CMS-10123-NOMNC), but the facility did not provide anything showing an estimated cost of services that would not be covered after that day. The resident said he/she did his/her own research to find out the daily cost of room/board and therapy. He/she would need to stay in the facility until he/she was able to bear weight on his/her affected leg and transfer independently.</p> <p>During an interview on 12/06/24, at 1:30 P.M., the Social Services Director (SSD) said he/she was responsible for issuing the resident or their responsible party the Medicare Part A discharge forms. He/she was told during his/her training to only issue the SNFABN for CMS-10055 if a resident was going to stay in the facility for long-term care. The SSD did not issue the form to the resident prior to the last covered day of Medicare Part A skilled services.</p> <p>During an interview on 12/06/24, at 1:05 P.M., the Administrator said if a resident might potentially stay in the facility past their last covered date of Medicare Part A services, the facility should issue a CMS-10055 to show the potential cost of services not covered.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interview and record review, the facility failed to give ensure all residents received bed hold information upon transfer when staff failed to provide the facility's bed hold policy to the resident and/or resident's representative for five residents (Residents #32, #35, #261, #31, and #68) who were transferred out to the hospital. The facility census was 109.</p> <p>Review of the facility's policy entitled Bed Hold and Re-Admission, dated 2024, showed the following information:</p> <ul style="list-style-type: none"> -Residents and their family members or legal representatives will be informed of the bed hold policy in writing upon admission as part of the admission contract; -In the case of an emergency, a written notification will be made within 24 hours of the transfer. <p>Review of the facility's bed hold policy card showed the following:</p> <ul style="list-style-type: none"> -The facility is required by Centers for Medicare and Medicaid Services (CMS) to notify residents of the bed hold policy upon any transfer or discharge from the facility. <p>1. Review of Resident #32's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included vitamin D deficiency, renal failure (when the kidneys are no longer able to filter waste and toxins from the blood), diabetes (the body doesn't produce enough insulin or use the insulin properly), and dementia (decline in thinking, memory and reasoning skills). <p>Review of the resident's nurses' notes, dated 11/21/24, showed the following:</p> <ul style="list-style-type: none"> -Resident found on floor next to bed in resident's room; -Resident sent to the emergency room (ER) for multiple head lacerations. <p>Review of the resident's medical record showed the facility did not have a copy of the bed hold policy sent, or document sending a bed hold policy, with the resident or to the resident's representative.</p> <p>31464</p> <p>2. Review of Resident #35's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses included sepsis (infection in the bloodstream), deficiency of vitamins B12 and D, low thyroid function, obesity, high cholesterol, low magnesium level, dementia, major depressive disorder, anxiety disorder, restless legs syndrome, degenerative disease of the nervous system, insomnia, chronic pain, metabolic encephalopathy (brain dysfunction due to a chemical imbalance elsewhere in the body), chronic kidney disease, atrial fibrillation (irregular heart function), history of mini-stroke, low blood pressure, and osteoarthritis.</p> <p>Review of the resident's nurse's notes, dated 08/14/24, at 1:11 P.M., showed the resident's roommate used his/her call light. On entry to the room, staff found the resident on the floor next to his/her bed. The resident said his/her head hurt and a laceration was noted to the side of his/her head.</p> <p>Review of the Emergency Medical Service (EMS) Transfer Report, dated 08/14/24, showed the following information:</p> <p>-Reason for ER visit: recent fall, decreasing blood pressure, episode of bleeding with three golf ball sized blood clots;</p> <p>-Facility checklist indicated: med list printed, face sheet printed, resident elected a status of Do Not Resuscitate (DNR), Staff did not indicate bed hold Information provided.</p> <p>Review of a transfer letter, dated 08/14/24, showed staff did not document information regarding a bed hold policy given to the resident or mailed to his/her responsible party.</p> <p>3. Review of Resident #261's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included prostate cancer, iron deficiency, deficiency of vitamins B group and D, high cholesterol, high potassium, major depressive disorder, anxiety disorder, insomnia, chronic pain, metabolic encephalopathy, high blood pressure, heart disease, history of stroke, circulatory disease, and gastro-esophageal reflux disease (GERD - stomach acid backs up into the chest and throat).</p> <p>Review of nurses' notes, dated 10/30/24, showed the resident left the facility via emergency medical services (EMS).</p> <p>Review of the EMS Transfer Report, dated 10/30/24, showed the following information:</p> <p>-Reason for ER visit: low blood pressure, high pulse, low oxygen saturation level, positive for COVID-19, and lethargy;</p> <p>-Facility checklist did not show indication of med list printed, face sheet printed, or bed hold Information given.</p> <p>Review of a Transfer Letter, dated 10/30/24, showed staff did not document information pertaining to a copy of the bed hold policy given or sent to the responsible party.</p> <p>41787</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #31's face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) , and chronic anxiety;</p> <p>-Resident was not self-responsible.</p> <p>Review of the resident's EMS Transfer Report, dated 11/06/24, showed the following:</p> <p>-Resident transferred to emergency room via ambulance with complaints of right wrist pain, back pain, and left side of head pain;</p> <p>-Phone message was left for family member;</p> <p>-Medication list and face sheet sent with resident;</p> <p>-Bed hold was not checked as provided.</p> <p>Review of the resident's medical record showed the facility did not send a bed hold policy with the resident, or to the resident's representative.</p> <p>5. Record review of Resident #68 face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included coronary artery disease (CAD - common heart disease in which there is narrowing or blockage of the coronary arteries), hypertension (high blood pressure), peripheral vascular disease (PVD - a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked), and Alzheimer's disease (progressive disease that destroys memory and other important mental functions);</p> <p>-Resident was not self-responsible.</p> <p>Review of the resident's nurses' notes showed staff documented the following:</p> <p>-On 11/10/24, at 1:28 P.M., staff called the nurse to the resident's room after lunch. The resident complained of pain to right chest that radiated to the back with breathing. Vital signs obtained. Contacted on-call physician and received order to send to emergency room . EMS arrived and the resident was transferred to the gurney. Family notified by phone.</p> <p>Review of the facility transfer letter showed the resident was sent to the emergency department on 11/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's medical record shows the facility did not send a bed hold policy with the resident, or to the resident's representative.</p> <p>6. During an interview on 12/05/24, at 8:22 A.M., the Business Office Manager (BOM) said the following:</p> <ul style="list-style-type: none"> -He/she sends out hospital transfer letters when a resident goes to the hospital; -He/she doesn't know anything about bed hold policies. <p>During interviews on 12/05/24, at 11:25 A.M. and 11:40 A.M., the Social Services Director (SSD) said the following:</p> <ul style="list-style-type: none"> -The nursing staff notify resident families of bed hold by phone and ask if they want to hold the bed when transferred to the hospital. There was no written notification of the bed hold policy sent to the resident or resident's representative. -He/she was responsible for completing the admissions paperwork and it included the bed hold policy; -He/she didn't have anything to do with sending out bed hold policies when a resident is sent out on therapeutic leave; -There is a section in the medical record where therapeutic leaves of absence are documented, but He/she doesn't know about a form to send with the resident or the resident's representative. <p>During an interview on 12/05/24, at 3:00 P.M., Registered Nurse (RN) A said bed holds are done up to 30 days on admission and up to 30 days after readmission. He/she doesn't do anything with bed holds or give residents a form when they go out on a hospital leave.</p> <p>During an interview on 12/05/24, at 3:12 P.M., RN C said the following:</p> <ul style="list-style-type: none"> -When a resident was transferred to the hospital, he/she sent a message to leadership and they put a bed hold in the record; -If it's in the middle of the night when a resident is sent out, he/she goes in the computer and puts in the medical record a bed hold; -He/she didn't know anything about a form that is sent out with the resident or to the resident's representative. <p>During an interview on 12/06/24, at 9:28 A.M., the Assistant Director of Nursing (ADON) said the following:</p> <ul style="list-style-type: none"> -When a resident goes out to the hospital, the bed hold is included in the other paperwork sent with the resident; -The BOM sends out a hospital transfer letter that also includes the bed hold. <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/06/24, at 11:40 A.M., the Director of Nursing (DON) said</p> <p>-Staff send a bed hold policy with the residents upon transfer to the hospital;</p> <p>-The policy is also mailed to the resident's representative, power of attorney or guardian.</p> <p>During an interview on 12/06/24, at 1:05 P.M., the Administrator said they have bed hold cards that are supposed to go out with the residents when they're transferred to the hospital. The BOM sends out the bed hold policy to the family.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>45176</p> <p>Based on record review and interview, facility staff failed to complete a quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) assessment for two residents (Residents #18 and #77) within 92 days of the prior assessment. The facility had a census of 109.</p> <p>Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 2, Assessments for the RAI, showed the following information:</p> <ul style="list-style-type: none"> -The quarterly assessment is an Omnibus Budget Reconciliation Act of 1987 (OBRA) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type; -The quarterly assessment is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored; and -The ARD must be not more than 92 days after the ARD of the most recent OBRA assessment of any type. <p>Review showed the facility did not provide a policy pertaining to the completion of MDS assessments.</p> <ol style="list-style-type: none"> 1. Review of Resident #18's MDS submitted reports showed the last MDS assessment ARD date was 07/24/24. Staff did not document an assessment completed since 07/24/24 (over 129 days prior). 2. Record review of Resident #77's MDS submitted reports showed the last MDS assessment ARD date was 07/29/24. Staff did not document an assessment completed since 07/24/24 (over 124 days prior). 3. During interviews on 12/05/24, at 1:40 P.M. and 1:55 P.M., the MDS Coordinator said the following: <ul style="list-style-type: none"> -Until recently, he/she has been the only one doing MDS assessments; -The facility had a tracking system, but there was a glitch and a couple of residents didn't have their quarterly assessments completed timely; -Resident #18 had his/her last assessment on 07/24/24; -Resident #77 had a quarterly assessment on 07/29/24; -The assessments are due every 92 days. <p>During an interview on 12/06/24, at 11:50 A.M., the Assistant MDS Coordinator said the following:</p> <p>(continued on next page)</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Quarterly assessments completed every 92 days, repeat the cycle until the fourth and that's the annual;</p> <p>-Resident #18's quarterly was due 92 days after 07/24/24. The report omitted the next one due so it wasn't done timely;</p> <p>-Resident #77's quarterly was due 92 days after 07/29/24. The report omitted this resident's next assessment time so it wasn't completed timely;</p> <p>-He/she recently began assisting with MDS assessments and helps a couple days per week.</p> <p>During an interview on 12/06/24, at 1:05 P.M., the Administrator said the following:</p> <p>-MDS assessments are done every 90 days and have a 10 day window;</p> <p>-He/she isn't aware of a system the MDS Coordinator uses to track assessments;</p> <p>-He/she isn't aware of any MDS assessments not completed timely;</p> <p>-He/she expected the assessment to be completed timely.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on observation, interview, and record review, the facility failed to ensure catheter (sterile tube inserted into the bladder to drain urine) usage and care per standards of practice when staff failed to obtain physician's orders regarding placement of a catheter and catheter care for two residents (Resident #29 and Resident #33) in a sample of size of 3. The facility census was 109.</p> <p>Review of a facility's policy entitled Urinary Catheterization, dated 2024, showed urinary catheters should be placed only under the direction of a physician's order.</p> <p>1. Review of Resident #29's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included obstructive and reflux uropathy (condition in which the flow of urine is blocked), retention of urine (condition that makes it difficult to empty the bladder, either partially or completely), and acute kidney failure (condition where the kidneys suddenly lose their ability to filter waste from the blood). <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 10/15/24, showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Resident had an indwelling catheter; -Resident dependent on staff for toileting hygiene and personal hygiene. <p>Review of the resident's care plan, last reviewed 12/02/24, showed the following:</p> <ul style="list-style-type: none"> -Due to urethral stricture (narrowing of the urethra (tube through which urine leaves the body) caused by scar tissue) the resident had a long term foley catheter (thin, flexible tube that drains urine from the bladder into a collection bag when a person is unable to urinate on their own). The catheter was to be changed by urology (medical and surgical specialty that treats conditions of the urinary tract) as it had to be surgically placed; -Staff should assess indwelling urinary catheter; -Staff should provide urinary catheter care; -No longer seeing urology, may change catheter every month. <p>Review of the physician's order sheet, dated 12/02/24, showed no orders for indwelling catheter or catheter care.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/02/24 showed the following:</p> <p>-At 10:00 A.M., the resident was seated in a wheelchair in the common area near the nursing desk with a catheter bag in a dignity bag located under his/her wheelchair;</p> <p>-At 12:00 P.M., the resident was seated in the dining room with a catheter bag located under his/her wheelchair.</p> <p>2. Review of Resident # 32's face sheet, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included renal failure (when the kidneys are no longer able to filter waste and toxins from the blood).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed staff did not indicate the resident had an indwelling catheter.</p> <p>Review of the resident's family nurse practitioners's note, dated 11/25/24, showed the following:</p> <p>-Resident was hospitalized due to a fall on 11/21/24;</p> <p>-Resident was found to have urinary retention, a foley catheter was placed and returned thick, purulent (containing puss) discharge.</p> <p>Observation on 12/02/24, at 11:44 A.M., showed the resident in the dining room eating with catheter bag attached to the bottom of his/her wheelchair.</p> <p>Review of the resident's physician orders showed staff did not document orders for a catheter placed or catheter care prior to 12/03/24.</p> <p>Review of the resident's care plan, updated of 12/03/24, showed staff to manage urinary catheter and continue foley catheter care.</p> <p>Review of the resident's December 2024 Physician Order Sheets showed the following:</p> <p>-An order, dated 12/03/24, to insert urinary catheter;</p> <p>-An order, dated 12/03/24, to continue foley catheter care.</p> <p>During an interview on 12/05/24, at 3:00 P.M., Registered Nurse (RN) A said the following:</p> <p>-The resident came back from the hospital with a catheter;</p> <p>-Orders for a catheter would come from the hospital;</p> <p>-Usually facility staff ask for a catheter to be removed after a resident is admitted from the hospital, but the resident has acute urinary retention;</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she pulled up the resident's record and it showed on his/her work list the resident has a catheter;</p> <p>-He/she looked at the resident's online medical record and saw an order for a catheter on 12/03/24.</p> <p>During an interview on 12/05/24, at 3:12 P.M., Certified Nurse Aide (CNA) B said the resident came from the hospital with a catheter.</p> <p>During an interview on 12/05/24, at 3:12 P.M., RN C said he/she looked at the resident #32's orders and he/she had an order for a catheter beginning 12/03/24.</p> <p>3. During an interview on 12/05/24, at 3:00 P.M., RN A said the following:</p> <p>-Orders are usually put in by the nurse or the doctor;</p> <p>-Aides have work lists and the catheter care comes up on the list;</p> <p>-Aides also document urine output;</p> <p>-He/she said all residents with a catheter should have an order.</p> <p>During an interview on 12/05/24, at 3:12 P.M., CNA B said the following:</p> <p>-He/she knew which residents had catheters as he/she learned about each resident;</p> <p>-He/she documents catheter cares in the medical record;</p> <p>-He/she also documents output of urine.</p> <p>During an interview on 12/05/24, at 2:45 P.M., Licensed Practical Nurse (LPN) J said the following:</p> <p>-Catheter care would show on the nursing staff work list interventions in the computer. The information would include when the catheter change was due and the pertinent size information.</p> <p>-He/she did not know what the care plan said.</p> <p>-He/she said that facility policy was to change any catheters every 30 days.</p> <p>-The information would not populate the due date, the nurses just were aware to check that 30 days had occurred.</p> <p>During an interview on 12/05/24, at 3:12 P.M., RN C said the following:</p> <p>-Staff know which residents have catheters as the work order pops up on the status board;</p> <p>-The aides have different work orders for documenting cares and urine output;</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Every resident with a catheter should have an order;</p> <p>-Nurse's are responsible for putting in the orders.</p> <p>During an interview on 12/06/24, at 9:28 A.M., the Assistant Director of Nursing (ADON) said residents with catheters should have an order to insert, insert/remove, and manage or continue. He/she wasn't sure if the orders would say all of this, but it would be on the staff's work list.</p> <p>During an interview on 12/06/24, at 11:40 A.M., the Director of Nursing (DON) said any resident with a catheter should have an order and the admitting nurse was responsible for putting in the order.</p> <p>During an interview on 12/06/24, at 1:05 P.M., the Administrator said nurses should be putting in orders for catheters, and all residents should have an order.</p> <p>41787</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787</p> <p>Based on observations, record review, and interview, the facility failed to provide enteral nutrition per standards of practice when staff failed to administer tube feeding consistently as ordered and failed to ensure the orders were clear and accurate for one resident (Resident #102), out of a sample of one resident. The facility census was 109.</p> <p>Review of the facility policy, titled Tube Feedings, dated 11/2023, showed the following:</p> <ul style="list-style-type: none"> -Tube feeding shall be administered by licensed nursing personnel upon recommendation of registered dietician and/or order by physician; -For continuous method of administration, staff should assure tubing is connected, fill the chamber one-half full and prime tubing, hang the container from the infusion pump pole, thread the tubing through the infusion pump, head of bed elevated 30 to 45 degrees at all times; -Connect the tubing to the feeding tube. Secure the connection with tape; -Set the rate as ordered and begin the infusion; -Staff should document the feeding and water flush; -Record intake and output; -Document residuals; -Document area of concern and notify physician. <p>1. Review of Resident #102's face sheet showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included nontraumatic subarachnoid hemorrhage from anterior communicating artery (a type of intracranial (inside the skull) bleeding that occurs when an aneurysm (bulge or ballooning in a blood vessel wall that's caused by a weakened area) in the anterior communicating artery (short blood vessel that connects the left and right anterior cerebral arteries in the brain) ruptures and leaks blood into the subarachnoid space (surrounds the brain)), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), personal history of aneurysm rupture, and craniotomy (surgical opening into the skull). <p>Review of the resident's care plan, last reviewed on 12/06/24, showed the following:</p> <ul style="list-style-type: none"> -As of 08/06/24, due to the resident's poor oral intake and frequent changes in condition, the resident had restarted tube feeding; <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-As of 08/06/24, the resident had a pureed diet with thickened liquids;</p> <p>-As of 08/06/24, the resident was on a regular diet with thin liquids and tube feeding supplementation if less than 50% of oral meal is consumed;</p> <p>-Staff should refer to the current order for tube feeding instructions.</p> <p>Review of the resident's physician note, dated 11/22/24, showed the following:</p> <p>-Staff sent a message to the physician stating the resident was currently getting jevity (therapeutic nutrition product that provides complete, balanced nutrition for people who are unable to get enough calories and nutrients by mouth) 1.5 calories every 8 hours, sometimes did not tolerate it well, and was having residual emesis (vomiting). Speech therapy (ST) and nurse discussed continuous feeding. Could staff receive an order for continuous feeding jevity 1.5 calorie at 30 milliliter (ml) per hour for 18 hours for mostly during the night and off for 6 hours to promote eating during the day and working with speech ST and can staff continue with the flushes every 8 hours;</p> <p>-The physician responded let's try this and continue to observe the resident for nausea and/or vomiting and make changes if necessary. The resident is an aspiration risk, so staff need to be monitoring him/her.</p> <p>Review of the physician orders. dated 12/06/24, showed the following:</p> <p>-An order, dated 11/13/24, for tube feeding flush of 250 ml water three times per day at 5:00 A.M., 1:00 P.M., and 9:00 P.M.;</p> <p>-An order, dated 11/22/24, jevity 1.5 calorie, to run at 30 ml/hr every 18 hours, for duration of 33 hours and 20 minutes, with a total volume of 1,000 ml.</p> <p>Observations showed the following:</p> <p>-On 12/02/24, at 11:00 A.M., the resident was in bed with his/her eyes closed. Tube feeding attached to infusion pump running at 30 ml/hr;</p> <p>-On 12/03/24, at 8:58 A.M., the tube feeding was not attached to the resident or the infusion pump and not turned on. The resident was in bed with his/her eyes closed;</p> <p>-On 12/03/24, at 11:15 A.M., the resident was in the dining room. His/her meal included pureed meat, spinach, and mashed potatoes. The resident only ate one bite of mashed potatoes.</p> <p>-On 12/04/24, at 2:40 P.M., the nurse checked the resident's blood pressure. The tube feeding was running at 30 ml/hr, the nurse prepared to administer medications;</p> <p>-On 12/05/24, at 12:00 P.M., the resident was in the dining room, with a pureed meal. The resident was not eating and had not taken any bites;</p> <p>-On 12/05/24, at 12:50 P.M., the resident was in bed. The head of bed was elevated, there was no tube feeding attached or running;</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 12/05/24, at 2:54 P.M., the resident was in bed with head of bed elevated and his/her eyes closed. There was no tube feeding running or attached;</p> <p>-On 12/05/24, at 9:05 P.M., the resident in bed with eyes closed, the tube feeding was attached and running at 30 ml/hr.</p> <p>During an interview on 12/04/24, at 2:50 P.M., Registered Nurse (RN) A said the resident's tube feeding was continuous. He/she said that every 18 hours the nursing staff change the tube feeding bag and add more jevity.</p> <p>During an interview on 12/05/24, at 2:45 P.M., Licensed Practical Nurse (LPN) J said the tube feeding was scheduled for every 18 hours on and 6 hours off. The order did not say 6 hours off. He/she said it was a rotating schedule and there was not a set time to put on and take off. The night shift would turn on the feeding and it was turned off at 11:35 A.M.</p> <p>During an interview on 12/05/24, at 9:10 P.M., RN K said the tube feeding order was a little confusing. It stated to be every 18 hours and off for 8 hours. He/she said the day staff turned off the feeding at about 11:00 A.M. this day and he/she connected and turned on at 9:00 P.M. this night.</p> <p>During an interview on 12/06/24, at 9:27 A.M., the Assistant Director of Nursing (ADON) said staff should follow the physician orders for tube feeding and administer every 18 hours. He/she was not familiar with the resident's orders.</p> <p>During an interview on 12/06/24, at 11:40 A.M., Director of Nursing (DON) said staff should give tube feeding according to physician orders and if the orders were unclear, staff should obtain clarification.</p> <p>During an interview on 12/06/24, at 12:11 P.M., the Pharmacist said the computer system should put in the times for staff to complete tube feeding. The physician order should be correct and it should cue up every 18 hours.</p> <p>During an interview on 12/06/24, at 1:45 P.M., Administrator said that staff should follow physician orders and if the orders were not clear the staff should get clarification. He was made aware of tube feeding orders being unclear.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51882</p> <p>Based on observation, interview, and record review, the facility failed to have pharmacy services in place to ensure a consistent counting, reconciliation, and destruction of controlled substances when staff failed to consistently document the number of medication packages and doses of controlled medications at the change of shift on the controlled substance shift change log and failed document administration on individual resident controlled drug record logs for three residents (Resident #13, #34, and #35) located in one of four medication carts in the facility. The facility census was 109.</p> <p>Review of the facility's policy titled Controlled Substances, PHA04-02, revised 09/24, showed the following:</p> <ul style="list-style-type: none"> -Pharmacy services is responsible for the proper safeguarding of controlled substances throughout all the hospital and facilities connected to the facility; -The purchase, storage, distribution and accounting of controlled medications will be done in accordance with all federal and state laws and standards of professional practice; -Nursing units are responsible for routine inventories of controlled substances kept in their automated dispensing cabinets (ADCs); -Nursing units will conduct narcotic counts at least weekly or per department guidelines; -Controlled substance discrepancies will be reported to the charge nurse immediately; -If the count is incorrect, licensed nursing personnel from the off-going shift will stay until the discrepancy has been resolved; -Resolution of the discrepancy must be documented in the ADC and witnessed by a second nurse; -Any controlled substances not stored in the ADC will be counted at the change of shift by both the licensed nurse leaving the shift and the nurse coming on duty. Both nurses must sign the narcotic inventory sheet thereby verifying that the count is correct; -Narcotic prescriptions are secured in a designated medication cart in each long term care facility; -Long term care facilities must establish a resident specific control sheet for each narcotic prescription delivered for resident use; -Directors of Nursing (DONs) are provided a daily report for all narcotics pulled from the e-kit. DONs are responsible for confirming all dispensing, administration, and waste records align; -Waste/destruction of controlled substances shall be done in the presence of two licensed individuals who are authorized to handle and control these drugs. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Review of the Control Medication Shift Count Sheet and Continuous Package Count: Cart/Cabinet log, dated 11/27/24 to 12/05/24, for the 100 hall/small unit medication cart, showed the following:</p> <ul style="list-style-type: none"> -On 11/27/24, at 10:00 P.M., one staff signed the shift count sheet; -On 11/28/24, at 6:00 A. M., one staff signed the shift count sheet; -On 11/28/24, at 2:00 P.M., one staff signed the shift count sheet; -On 11/30/24, at 2:00 P.M., one staff signed the shift count sheet; -On 11/30/24, at 10:00 P.M., one staff signed the shift count sheet; -On 12/2/24, at 10:00 P.M., one staff signed the shift count sheet; -On 12/3/24, at 2:00 P.M., one staff signed the shift count sheet when four controlled medication packages were removed/destroyed; -On 12/04/24, at 6:00 A.M., one staff signed the shift count sheet; -On 12/04/24, at 2:00 P.M., one staff signed the shift count sheet; -On 12/05/24, at 6:00 A.M., one staff signed the shift count sheet and no further counts were documented for the day; -On 12/06/24 staff did not document narcotic counts. <p>During an interview on 12/06/24, at 10:30 A.M., Registered Nurse (RN) C said the following:</p> <ul style="list-style-type: none"> -The last count documented on the List for Narcotics sheet showed 12/04/24 for the 7:00 A.M. to 3:00 P.M. shift signed by Registered Medication Technician (RMT) F. -Staff did not document a count for 12/05/2024, but RMT G should have counted and documented. -RMT F also did not count or document on the List for Narcotics sheet when he/she left the facility during his/her shift at 8:00 A.M. on 12/06/24 to attend an appointment. <p>During an interview on 12/06/24, at 11:25 A.M., RMT F said this morning Licensed Practical Nurse (LPN) I left the night shift, gave him/her the narcotic keys and left without counting. He/she has two medication carts to manage during his/her shift.</p> <p>2. Observation on 12/06/24, at 10:30 A.M., of the narcotics and the controlled drug record documents located on the 100 hall/small unit medication cart showed the following:</p> <ul style="list-style-type: none"> -Resident #13's oxycodone HCL (a controlled pain medication used to treat moderate to severe pain) 5 milligram (mg) tablet package contained 61 tablets. The controlled drug record showed 62 tablets available. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #34's tramadol HCL (a controlled pain medication used to treat moderate to severe pain and chronic pain) 50 mg tablet package contained 68 tablets. The controlled drug record showed 69 tablets available.</p> <p>-Resident #35's oxycodone IR 5 mg tablet package contained 26 doses. The controlled drug record showed 27 tablets available.</p> <p>During an interview on 12/06/24, at 12:56 A.M., RMT F said the following:</p> <p>-Resident #13's oxycodone HCL 5 mg package had 61 tablets.</p> <p>-Resident #35's oxycodone IR 5 mg package had 26 tablets.</p> <p>-Resident #34's tramadol HCL 5 mg package had 68 tablets.</p> <p>During an interview on 12/06/24, at 12:50 P.M., RN C said he/she administered tramadol to Resident #34 at 9:24 A.M. and oxycodone to Resident #35 at 9:46 A.M. He/she did not document the medication on either resident's controlled drug record at the time administered. He/she wrote the date and time administered on a sticky note.</p> <p>During an interview on 12/06/24, at 1:01 P.M., the Director of Nursing (DON) reviewed the electronic narcotic administration record at the nurses' station with RN C for Resident #13, Resident #35, and Resident #34. The DON said RMT G documented that he/she administered tramadol to Resident #34 on 12/05/24, at 6:39 P.M., but did not document the dose on Resident #34's controlled drug record. On 12/04/24, RMT G documented administering oxycodone to Resident #13 at 8:52 A.M., but he/she did not document the dose on Resident #13's controlled drug record.</p> <p>2. During an interview on 12/06/24, at 11:17 A.M., RMT H said he/she completed narcotic counts with a nurse in the morning, with another RMT when he/she leaves for the evening, and with any medication cart changes.</p> <p>During an interview on 12/06/24, at 11:19 A. M., RN A. said he/she would not accept responsibility for administering narcotics without counting with other staff first. For discrepancies, he/she checked to see if the discrepancy was something he/she did not document, then he/she checked with other staff that recently passed narcotics. With unresolved discrepancies, he/she contacted the DON.</p> <p>During an interview on 12/06/24, at 11:25 A.M., RMT F said he/she occasionally completed narcotic counts with other staff. He/she has two medication carts to manage during his/her shift. If he/she does not get to count the narcotics, he/she goes ahead and passes the narcotics, but tries to count them and sign the narcotic sheet as the medications are passed even though he/she is the only one counting and signing. With discrepancies, he/she talks with the staff that narcotic keys were obtained from or to the DON. He/she counted narcotics with a RMT or nurse when they were available. He/she documented on a shift sheet and a narcotic card count sheet.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/06/24, at 10:45 A.M., the DON said his/her expectation was for the nurses and RMTs to do narcotic counts at shift change and with every exchange of narcotic keys. If narcotics are missing or there is a discrepancy, he/she would expect staff to notify him/her and he/she would investigate it and report to the Administrator. When staff that administer narcotics leave the building even for a temporary amount of time, the expectation was for the narcotic count to be completed prior to the staff leaving. If there was a narcotic discrepancy that he/she cannot rectify, the staff would be held in the facility until the issue is resolved.</p> <p>During an interview on 12/06/24, at 10:55 A.M., the Administrator said he/she expected staff to complete narcotic counts with each shift change, any change of staff and if staff leave the facility during their shift. He/she would hold staff in the facility until discrepancies are resolved. At 1:43 P.M., the Administrator said the narcotic count should be completed every shift with two staff and every time the narcotic passing role changes hands. Discrepancies in narcotics need to be taken care of immediately.</p> <p>41787</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51882</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% when the facility staff made two errors out of 28 opportunities resulting in an error rate of 7.14% when facility staff failed to administer medication at the specified scheduled dosing time, before a meal and separate from other medications, for two residents (Resident # 98 and Resident # 101). The facility census was 109.</p> <p>Review of the facility's policy titled Medication Administration and Documentation, NUR09-09, revised 12/24, showed the following:</p> <ul style="list-style-type: none"> -Medications are administered in accordance with prescriber orders; -Standard administration times may be adjusted by pharmacy staff due to drug/food incompatibilities with the following agents: Thyroid preparations 6:00 A.M.; -Long Term Care (LTC) providers may exclude certain patients or medications from liberalized medication pass: Dietary and drug-drug interactions should be avoided where specifically noted in the electronic Medication Administration Record (eMAR); -Administration of medications outside their scheduled dosing times and windows will be tracked in routine reporting by the facility. <p>1. Review of Resident # 98's face sheet (brief resident profile sheet) showed diagnoses included Alzheimer's disease, unspecified.</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/07/24, showed the following:</p> <ul style="list-style-type: none"> -The resident entered the facility on 12/21/23; -The resident had severe cognitive impairment; -Diagnoses included thyroid disorder. <p>Review of the resident's current physician orders showed an order, dated 12/22/23, for the following:</p> <ul style="list-style-type: none"> -Administer levothyroxine (medication used for treatment of hypothyroidism (a condition in which the thyroid doesn't produce enough thyroid hormone) 75 micrograms (mcg) PO (by mouth) daily at 6:00 A.M. -Dose instructions included take on an empty stomach, 30 to 60 minutes before breakfast. -Label instructions to administer consistently in the morning on an empty stomach, at least 30 minutes before food or other medications. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/04/24, at 9:05 A.M., showed Registered Medication Technician (RMT) F prepared and administered levothyroxine 75 mcg tablet for the resident. RMT F administered other medications the same time as the levothyroxine.</p> <p>During an interview on 12/05/24, at 10:25 A.M., RMT G said breakfast is typically served between 7:00 A.M. and 8:00 A.M. and he/she normally administered the resident's thyroid medication between 8:00 A.M. to 9:00 A.M. He/she administered all of resident's medications at the same time (including levothyroxine). RMT G was aware that he/she was administering the levothyroxine to the resident at the wrong time, after breakfast, and with additional medications. He/she should have administered the medication at 6:00 A.M., before breakfast, and separate from other medications.</p> <p>During an interview on 12/05/24, at 1:33 P.M., Registered Nurse (RN) C said the resident's thyroid medication should be administered as ordered at 6:00 A.M., before the breakfast meal on an empty stomach and separate from other medications.</p> <p>2. Review of Resident # 101's face sheet showed diagnoses included of right femur (thigh bone) fracture.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The resident entered the facility on 6/20/24; -Moderate cognitive impairment; -Diagnosis of hypothyroidism. <p>Review of the resident's current physician orders showed the following:</p> <ul style="list-style-type: none"> -Order, dated 05/03/24, for levothyroxine 88 mcg daily by mouth scheduled at 6:00 A.M. -Dose instructions included take on an empty stomach, 30 to 60 minutes before breakfast. -Label instructions to administer consistently in the morning on an empty stomach, at least 30 minutes before food or other medications. <p>Observation on 12/05/24, at 8:57 A.M., showed RMT G prepared and administered levothyroxine 88 mcg one tablet to the resident. RMT G administered other medications at the same time.</p> <p>During an interview on 12/05/24, at 10:25 A.M., RMT G said he/she administered levothyroxine to the resident on 12/05/24 after he/she ate breakfast and all other medications were administered at the same time as the levothyroxine. It was impossible to administer the 6:00 A.M. medications before meals due to the number of residents receiving medications. He/she knew that levothyroxine was supposed to be administered on an empty stomach and separate from other medications. The resident received his/her breakfast between 7:00 A.M. to 8:00 A.M. on 12/05/24 and he/she administered all the resident's morning medications (including levothyroxine) around 9:00 A.M. this morning.</p> <p>During an interview on 12/05/24, at 1:33 P.M., RN C said the resident's levothyroxine should be administered before the breakfast meal and on an empty stomach.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Colonial Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 750 West Cooper Buffalo, MO 65622	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. During an interview on 12/05/24, at 10:25 A.M., RMT G said breakfast was typically served between 7:00 A.M. and 8:00 A.M. and he/she normally administered the morning medications between 8:00 A.M. and 9:00 A.M. All the morning medications for each resident are administered at the same time (including levothyroxine) because there is not enough time to administer medications separately due to the number of residents he/she was responsible for administering medications to. RMT's start their shift at 6:00 A.M. and finish their medication pass for all residents between 10:00 A.M. to 11:00 A.M. He/she was aware that he/she was administering levothyroxine to residents at the wrong time and it should be administered at 6:00 A.M., before breakfast, and separate from other medications.</p> <p>4. During an interview on 12/05/24, at 1:33 P.M. RN C said the facility policy allowed staff a liberal three hour window to pass medications from the time they are due. He/she did not know of any specific medications per facility policy that needed to be administered at a specific time except medications ordered with a status to be given now. The levothyroxine should be given before the meal, on an empty stomach, and he/she would expect the night shift staff to administer the levothyroxine at 5:00 A.M., but that had not been happening.</p> <p>5. During an interview on 12/06/24, at 9:23 A.M. the Director of Nursing (DON) said staff have time allowances of 30 minutes to two hours to pass medications beyond the time they are due. Some medications have exact times that they should be administered. The DON said staff should not be administering a medication after breakfast that has been ordered to be administered before breakfast. Medications that are required to be administered on an empty stomach should be administered on an empty stomach. If medications are ordered to be given without other medications they should be administered separately. The facility has a liberalized three hour window of time to give medications that are ordered in the A.M. or P.M. without a specific time listed. Staff are expected to follow parameters for medications ordered with specific instructions. It was brought to his/her attention that levothyroxine was not being administered prior to breakfast per physician orders. The DON said the medication technicians are scheduled from 6:00 A.M. to 2:00 P.M. and 2:00 P.M. to 10:00 P.M. or until all evening medications are passed. The facility has 42 residents diagnosed with hypothyroidism and his/her expectation is for staff to administer thyroid medication as ordered at 6:00 A.M. per physician orders, prior to breakfast and separate from other medications.</p> <p>6. During an interview on 12/06/24, at 1:43 P.M., the Administrator said staff are expected to administer medications within the window they are ordered to be administered in. He/she is aware of the medication timing issue with the thyroid medication.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45176</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a manner that prevent possible contamination when the ice machine has a black substance on the deflector shield, a dented can was on the shelf for use, and scoops were left in the sugar and cornstarch. This has the potential to affect all residents who consumed food from the facility kitchen. The facility census was 109.</p> <p>1. Review of the 2013 Missouri Food Code showed equipment food-contact surfaces and utensils shall be clean to sight and touch.</p> <p>Review of the facility's policy Ice Machines, dated 2024, showed the following:</p> <ul style="list-style-type: none"> -Ice machine bins shall be cleaned on a quarterly schedule by departments utilizing cubers with bins; -Ice machines shall be cleaned using the wash, rinse, and sanitize process by removing all ice and water from the bin; -Using a cleaning solution or a solution with detergent and sanitizer combined wash interior of ice bin, rinse with clear water and town dry; -Inspect the ice chute for microbial growth, and clean as needed. <p>Review of the preventative maintenance work order shows the ice machine was cleaned last on 07/31/24.</p> <p>Observation on 12/02/24, beginning at 9:27 A.M., of the ice machine showed the deflector shield, located over the ice, had multiple black spots over the entire shield.</p> <p>Observation on 12/04/24, beginning at 9:37 A.M., of the ice machine showed the deflector shield, located over the ice, had multiple black spots over the entire shield.</p> <p>During an interview on 12/04/24, at 2:14 P.M., Dietary Aide (DA) D said maintenance was responsible for cleaning the inside of the ice machine. The ice machine shouldn't have a black substance in it.</p> <p>During an interview on 12/04/24, at 2:19 P.M., DA E said he/she didn't know who was responsible for cleaning the inside of the ice machine. It should not have black spots on the inside.</p> <p>During an interview on 12/04/24, at 2:23 P.M., the Assistant Dietary Manager said they have a company that takes care of the ice machine, but they don't do anything with the inside. He/she wasn't sure who cleans the inside, but it shouldn't have black spots on the inside.</p> <p>During an interview on 12/04/24, at 3:50 P.M., Maintenance Director said the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/she cleaned the inside of the ice machine;</p> <p>-He/she had a program called preventative maintenance and the program told him/her when to clean the ice machine;</p> <p>-He/she was not aware the deflector shield had black spots. There shouldn't be black spots in the ice machine.</p> <p>During an interview on 12/04/24, at 2:50 P.M., the Administrator said the following:</p> <p>-Maintenance cleans the inside of the ice machine;</p> <p>-The system generates preventative maintenance schedules and the tasks are completed as scheduled;</p> <p>-He/she was not aware there were black spots on the deflector shield.</p> <p>2. Review of the Food and Drug Administration (FDA) 2022 Food Code FDA showed the following:</p> <p>-Depending on the circumstances, rusted, and pitted or dented cans may present a serious potential hazard.</p> <p>-Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food.</p> <p>Observation on 12/02/24, beginning at 9:27 A.M., showed a 105 ounce can of pumpkin, with a large dent on the side, located by several other cans of pumpkin on the shelf.</p> <p>Observation on 12/04/24, beginning at 9:37 A.M., showed a 105 ounce can of pumpkin, with a large dent on the side, located by several other cans of pumpkin on the shelf.</p> <p>During an interview on 12/04/24, at 2:14 P.M., DA D said they do not use cans with dents on them. They put them away from the other cans.</p> <p>During an interview on 12/04/24, at 2:19 P.M., DA E said they do not use cans with dents. They put them in a bucket.</p> <p>During an interview on 12/04/24, at 2:23 P.M., Assistant Dietary Manager said the following:</p> <p>-They have two cans of pumpkins with dents;</p> <p>-If the dents are minor, or if the staff sometimes drop them and they have a dented rim they will use them;</p> <p>-If the cans come in with dents they will send them back.</p> <p>During an interview on 12/04/24, at 2:50 P.M., the Administrator said if dented cans come in from the truck dented, they should be returned. If staff cause the dent, they should be disposed of and not used.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Observation on 12/02/24, beginning at 9:27 A.M., showed the following:</p> <ul style="list-style-type: none"> -Large plastic container of sugar with a scoop halfway in the sugar; -Large plastic container of cornstarch with the scoop partially in the cornstarch. <p>(The scoop handles could come in contact with the sugar or cornstarch causing potential contamination.)</p> <p>Observation on 12/04/24, beginning at 9:37 A.M., showed the following:</p> <ul style="list-style-type: none"> -Large plastic container of sugar with a scoop halfway in the sugar; -Large plastic container of cornstarch with the scoop partially in the cornstarch. <p>During an interview on 12/04/24, at 2:14 P.M., DA D said as far as he/she knew the scoops are okay to be down inside of the containers of sugar and cornstarch.</p> <p>During an interview on 12/04/24, at 2:19 P.M., DA E said scoops should not be left in the plastic containers. They should be stored elsewhere.</p> <p>During an interview on 12/04/24, at 2:23P.M., the Assistant Dietary Manager said he/she didn't know if scoops could be left down in the containers of food.</p> <p>During an interview on 12/04/24, at 2:50 P.M., the Administrator said scoops should not be left in containers with food such as sugar and cornstarch.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45176</p> <p>Based on observation and interview, the facility failed to maintain a sanitary environment for all residents and staff when staff failed to ensure the fans located in the walk-in refrigerator and walk in freezer were kept clean. The facility census was 109.</p> <p>Review showed the facility did not provide a policy that addressed maintenance of the refrigerator or freezer fans.</p> <p>1. Review of the facility's weekly cleaning schedule showed the staff responsible for cleaning the fans in the freezer or refrigerator was not listed.</p> <p>Observation on 12/02/24, beginning at 9:27 A.M., showed the following:</p> <ul style="list-style-type: none"> -Black and brown substances on the plastic casing on the refrigerator fans; -Black and brown substance on the plastic casing covering the fans in the freezer. <p>Observation on 12/04/24, beginning at 9:37 A.M., showed the following:</p> <ul style="list-style-type: none"> -Black and brown substances on the plastic casing on the refrigerator fans; -Black and brown substance on the plastic casing covering the fans in the freezer. <p>During an interview on 12/04/24, at 2:14 P.M., Dietary Aide (DA) D said maintenance is responsible for cleaning the fans in the refrigerator and freezer. He/she hasn't noticed them being dirty or he/she would have told maintenance.</p> <p>During an interview on 12/04/24, at 2:19 P.M., DA E said he/she had not been at this facility long, but in other facilities the maintenance person has been responsible for cleaning the fans in the walk in freezer and refrigerator. He/she had not noticed them being dirty.</p> <p>During an interview on 12/04/24, at 2:23 P.M., the Assistant Dietary Manager said he/she didn't know how to turn the fans off to clean them. He/she wasn't sure if maintenance or dietary staff were supposed to be cleaning the fans. He/she had not noticed the fans being dirty.</p> <p>During an interview on 12/04/24, at 3:50 P.M., the Maintenance Director said the following:</p> <ul style="list-style-type: none"> -Normally the task of cleaning the fans inside of the freezer and refrigerator would generate on the preventative maintenance; -He/she didn't know when they were cleaned last, but he/she should be getting reminders; -The fans shouldn't have black or brown substances on them. <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/04/24, at 2:50 P.M., the Administrator said maintenance is responsible for cleaning the fans in the walk in refrigerator and freezers.</p>