STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265247	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46506 Based on interview and record review, the facility failed to treat four residents (Resident #2 #1 #12 and #18) with dignity and respect, in a review of 18 sampled residents. Staff did not speak respectfully to residents and did not promptly respond to an incontinent resident when he/she required staff assistance. The facility census was 49. Review of the facility's policy titled Dignity, dated February 2021, showed the following: -Residents are treated with dignity and respect at all times; -Staff speak respectfully to residents at all times; -Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents by promptly responding to a resident's request for toileting assistance; -Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: a. Addressing the underlying motives or root causes for behavior; b. Not challenging or contradicting the resident's beliefs or statements. 1. Review of Resident #2's annual Minimum Data Set (MDS) a federally mandated assessment instrument, dated 8/9/24, showed the following: -The resident had severe cognitive impairment; -He/She had adequate hearing; -He/She had the ability to express ideas and wants; -He/She had clear comprehension to understand others; -He/She required maximum assistance with upper and lower body dressing, bathing, and bed mobility; (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was dependent on staff for transfers, personal hygiene, toilet use, and locomotion; -He/She was always incontinence of bladder and bowel. Review of the resident's Care Plan, updated 8/10/24, showed the following: -The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations; -All staff conversed with the resident while providing care; -The resident was able to use the call light when he/she needed assistance, staff to keep call light within his/her reach at all times when he/she was in the room; -The resident was totally dependent on two staff for repositioning and turning in bed every two hours and as necessary; -The resident required total assistance by one to two staff with personal hygiene; -Encourage the resident to discuss any feelings or concerns with remining in long-term care. During an interview on 9/27/24 at 11:20 A.M., the resident said the following: -A staff member told the resident his/her taxes paid for the resident to live at the facility; -How could this be considered his/her home with the way staff treated him/her?; -The staff would come in the room, turn off the call light and never come back to provide assistance. During an interview on 9/27/24 at 11:20 A.M., Resident #1, Resident #2's roommate, said the following: -He/She was in the room in bed the day Certified Nurse Aide (CNA) E made the comment about how his/her taxes paid for their stay at the facility; -Resident #1 was upset with the comment because he/she paid income taxes too. 2. Review of Resident #1's Care Plan, updated 8/14/24, showed the following: -The staff helped make the resident's room as home like as possible; -The resident was able to use the call light when he/she needed assistance, staff kept the call light within reach at all times when the resident was in his/her room and answered the call light in a timely manner; -The resident needed assistance with two staff members and a mechanical lift for all transfers to the wheelchair and back to bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's admission MDS, updated 8/14/24, showed the following: -The resident was cognitively intact; -He/She required maximum assistance with upper body dressing, bathing, personal hygiene, and bed mobility; -He/She was dependent on staff for transfers, lower body dressing, toilet use, and locomotion; -He/She experienced frequent incontinence of bladder and bowel. During an interview on 9/27/24 at 11:20 A.M., Resident #1 said the following: -He/She was upset about how he/she was treated in the facility; -The staff came into the room and shut off his/her call light and said they would be back, but they never did come back until he/she activated the call light again; -CNA E told the resident that he/she used the call light too much; -Staff left a reusable incontinence pad behind his/her back making the chair uncomfortable and everyone else could see it which was embarrassing; -The resident asked the staff to move it and the staff said, they would fix it later when the staff had more time; -Staff walked by the room while the call light was activated but would not stop; -He/She was concerned about how Resident #2 was treated by staff when staff told Resident #2 their taxes paid for the resident's stay at the facility. Observation in the resident's room on 9/27/24 at 11:20 A.M., showed a reusable incontinence pad positioned behind the resident's back and visible from across the room. 3. Review of Resident #12's quarterly MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/She required maximal assistance for upper and lower body dressing, personal hygiene, bed mobility, and transfers; -He/She was dependent on staff for toilet use; -He/She was always incontinent of bladder and bowel. Review of the resident's care plan, updated 9/16/24, showed the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident needed assistance with one staff member and wheeled walker for all transfers, ambulating, and toileting, he/she attempted to transfer and ambulate without assist; -The resident had a potential for falls and injuries due to diagnosis of impaired cognition and making poor decisions. Observation in the hallway across from the nurses station on 10/1/24 at 9:40 A.M., showed the following: -The resident stood up from his/her wheelchair and looked down the hallway; -Certified Medication Technician (CMT) B walked into the hallway past the resident; -Resident #15 told CMT B the resident was wet and CMT B nodded in acknowledgement; -CMT B told Resident #12 to sit down and continued to walk down the hall. During an interview on 10/1/24 at 8:55 A.M., Licensed Practical Nurse (LPN) A said the following: -The resident will stand up from his/her wheelchair, so staff are supposed to try to determine if the resident's needs were met; -The resident was incontinent, so LPN A assisted the resident to provide peri care and change clothes; -LPN A said he/she did not know CMT B walked by the resident without stopping to address the resident; -LPN A said CMT B should have at least stopped and addressed the resident. 4. Review of Resident #18's Care Plan, updated 7/24/24, showed the following: -Help make the resident's room as home like as possible; -Encourage and allow the resident to make choices related to cares and schedule; -Keep the resident's call light within reach at all times when he/she was in the room and answer it in a timely manner; -Encourage the resident to verbalize feelings and give realistic feedback; -He/She had diagnoses of unspecified psychosis, depression, and anxiety which he/she took antipsychotic, antidepressant, and antianxiety medications daily; -Encourage participation in self-calming behaviors such as breathing exercises, meditation, or guided imagery. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was cognitively intact; -He/She had verbal behaviors towards others; -He/She was dependent on toilet use and locomotion; -He/She was frequently incontinent of bladder and occasionally incontinent of bowel. During an interview on 10/4/24 at 5:50 A.M., Certified Nurse Aide (CNA) J said the following: -He/She told Resident #16 not to use the call light so much; -The resident did not like being alone in his/her room, so the resident would turn on the call light, then tell staff he/she did not need anything, but as soon as staff left the room, the resident activated the call light again; -The resident did this several times a shift, every shift. During an interview on 10/10/24 at 10:18 P.M., the resident's family member said a staff member told the resident that he/she was using the call light too much. This upset the resident. 5. During an interview on 10/2/24 at 6:20 P.M., Staff O said the following: -CNA E was rude to the residents; -CNA E told residents to stop using their call light so much, they should quit being lazy and do things themselves; -He/She notified administration and the corporate office, but nothing was done about it. During an interview on 10/1/24 at 12:45 P.M., the Director of Nursing (DON) said the following: -The expectation was staff treated the residents with dignity and respect; -She was unaware of staff telling residents they used their call lights too much and the residents felt they were not being treated with dignity and respect. During an interview on 9/27/24 at 1:45 P.M., the Administrator said the following: -No one reported a staff member told a resident they used the call light too much, said their tax dollars paid for the resident's stay, or did not treat any resident without dignity and respect; -His expectation was staff report to the charge nurse or administration when a resident was not treated with dignity and respect so the issue could be addressed immediately; -Communication between staff members was an issue the facility was trying to improve. MO242619

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(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** 46506 Based on observation, interview, and record review, the facility failed to provide four residents (Resident #2, #3, #16, and #8), of 18 sampled residents, with assistance with activities of daily living (ADL). Staff did not ensure Resident #2 had glasses to see when eating, left his/her hair wet after bathing, and did reposition or check for incontinence. Staff failed to check Residents #3, #16, and #8 for incontinence and reposition the residents timely. The facility census was 49. Review of the facility's Activities of Daily Living (ADL), Supporting policy, dated March 2018, showed the following: -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: -a. Hygiene (oral care); -b. Mobility (transfer); - c. Elimination (toileting). 1. Review of Resident #2's annual MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/She required maximum assistance with upper and lower body dressing, bathing, and bed mobility; -He/She was dependent on transfers, personal hygiene, toilet use, and locomotion; -He/She was always incontinence of bladder and bowel. Review of the resident's Care Plan, updated 8/10/24, showed the following: -The resident had an ADL self-care performance deficit related to left hemiplegia (paralysis on one side of the body); -He/She was totally dependent on one staff to provide shower; -He/She was totally dependent on two staff for repositioning and turning in bed every two hours and as necessary; -He/She required assistance of one staff to eat. Observation on 9/27/24 at 10:02 A.M., showed the resident sat in a Geri chair in front of a television in his/her room with eyes closed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/27/24 at 11:06 A.M., the resident said the following: -The staff did not ensure he/she had his/her glasses on when he/she ate breakfast so the resident could see what he/she was eating; -The staff left his/her hair wet after a bath so he/she was cold and did not have a blanket; -The resident had to yell at staff to get him/her a blanket because the call light was not in reach; -The staff left the resident to sit in his/her Geri chair all day, which happened frequently. Observation on 9/27/24 at 11:06 A.M., showed the following: -The resident was not wearing glasses; -His/her hair was still wet; -The call light was in a chair behind the resident and out of reach. Observation in the dining room on 9/27/24 at 12:20 P.M., showed staff brought the resident to the dining room table in the Geri chair. During an interview on 9/27/24 at 12:20 P.M., the resident said staff did not check him/her for incontinence or reposition him/her before staff brought him/her to the dining room that day. Observation in the dining room on 10/1/24 at 9:10 A.M., showed the resident sat in a Geri chair at the dining room table, feeding himself/herself breakfast. The resident was not wearing glasses. The resident had difficulty getting the food onto his/her silverware. Food fell on the table and his/her clothing protector. During an interview on 10/1/24 at 9:20 A.M. and 10:20 A.M., Licensed Practical Nurse (LPN) C said the resident was supposed to have glasses on for meals. 2. Review of Resident #3's quarterly MDS, dated [DATE], showed the following: -The resident had severely impaired cognitive skills for daily decision making; -He/She was dependent on staff for toileting hygiene and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 8/13/24, showed the following: -The staff checked the resident for incontinence during routine rounds and as needed; -The resident was incontinent of bowel and bladder, he/she was unable to let staff know, the staff anticipated the resident's needs during routine rounds, as needed and per family request; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She needed two staff assistance and Hoyer lift for all transfers and toileting; -The staff performed the resident's perineal care as needed, made sure the resident was clean, dry and odor free; -He/She had a potential for decrease in cognition due to diagnoses of dementia and Alzheimer's disease (brain disorder that causes a gradual decline in memory, thinking, and other cognitive abilities that eventually interferes with daily life). Observation in the common area on 9/27/24 at 9:15 A.M., showed the resident sat in a wheelchair in common area in front of the television, leaned down, and placed his/her head on his/her knees. Observation in the common area on 9/27/24 at 10:05 A.M., showed the resident continued to sit in a wheelchair in front of the television, leaned down with his/her head on his/her knees in the same spot as 9:15 A.M. Observation in the common area on 9/27/24 at 11:03 A.M., showed the resident continued to sit in a wheelchair in front of the television, leaned down with his/her head on his/her knees in the same spot as 9:15 A.M. Observation in the dining room on 9/27/24 at 12:40 P.M., showed staff brought the resident from the common area over to the dining room table in his/her wheelchair. Staff did not reposition the resident or check him/her for incontinence. The resident's hair was disheveled. Observation in the dining room on 10/4/24 at 7:10 A.M., showed staff brought the resident in a wheelchair to the dining room table. Observation in the dining room on 10/4/24 at 9:10 A.M., showed staff took the resident in the wheelchair from the dining room table to the common area and sat the resident in front of the television. Staff did not reposition the resident or check him/her for incontinence. During an interview on 10/4/24 at 12:40 P.M., CNA L said staff did not check the resident for incontinence prior to going to the dining room table. 3. Review of Resident #16's quarterly MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/She was dependent on staff for toileting hygiene and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 9/5/24, showed the following: -The resident ate all meals in the dining room, he/she needed to sit up for one hour after all meals before laying down; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was always incontinent of bladder and bowel due to history of cerebrovascular accident (CVA, stroke) and not always knowing when he/she needed to use the toilet; -The staff assisted the resident with perineal cleansing as needed and checked with routine rounds; -The resident required two staff assist with Hoyer lift for all transfers; -He/She was at risk for skin breakdown due to diagnoses of dementia and bowel and bladder incontinence; -The staff assisted the resident with position changes, he/she needed assistance with two staff for repositioning when he/she was in the wheelchair; -The staff kept the resident's skin clean and dry, performed perineal care after each incontinence episode. Observation in the dining room on 10/4/24 at 7:29 A.M., showed the staff brought the resident to the dining room in his/her wheelchair. Observation on 10/4/24 at 9:20 A.M., showed the resident sat in the wheelchair in his/her room, next to the bed. The resident's eyes were closed. Observation on 10/4/24 at 10:35 A.M., showed the resident sat in the wheelchair in his/her room, next to the bed with his/her eyes closed. During an interview on 10/4/24 at 12:20 P.M., CNA M said he/she did not check the resident for incontinence or reposition the resident between breakfast and lunch because CNA M was busy with another resident causing CNA M to be behind on getting everyone checked for incontinence and getting them up for lunch. This happened at least twice a week. 4. Review of Resident #8's Admission MDS, dated [DATE], showed the following: -The resident had severely impaired cognitive skills for daily decision making; -He/She was dependent on staff for toileting hygiene and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's Care Plan, dated 7/10/24, showed the following: -The resident had an ADL self-care performance deficit; -The staff were to anticipate the residents needs during routine rounds and as needed. Observation on 10/4/24 at 7:15 A.M., showed staff brought the resident to the dining room table in a Geri chair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/4/24 at 9:10 A.M., showed staff took the resident back to his/her room and left the resident sitting in the Geri chair without repositioning the resident or checking him/her for incontinence. During an interview on 10/4/24 at 12:40 P.M., CNA L said staff did not transfer the resident to bed or check the resident for incontinence after breakfast. 5. During an interview on 10/4/24 at 12:20 P.M., CNA M said the residents who were incontinent, needed assistance with toileting, or had dementia were supposed to be checked for incontinence and turned before meals but some days it did not get done until after lunch because he/she was busy caring for other residents. During an interview on 10/4/24 at 12:30 P.M., CNA K said, the staff were supposed to provide incontinence care before meals but some days the staff were too busy, so it was done after lunch. During an interview on 10/4/24 at 12:40 P.M., CNA L said ideally, the residents should be checked every two hours but that day there was not enough time to get everyone cared for before lunch. During an interview on 10/4/24 at 2:02 P.M., the Director of Nursing said the following: -The expectation was staff checked residents for incontinence and repositioned them during routine rounds and more often when needed; -The routine rounds did not have a specific time frame, but it would be at least before meals and at bedtime; -She felt like there was enough staff to care for the residents. MO241170 MO243016

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 36185 Based on interview and record review, the facility failed to provide care and treatment following a fall with injury for one resident (Resident #9) with a personal history of a stroke and who was on Xarelto (anticoagulant or blood thinning medication) of nine sampled residents. The resident complained of right sided rib pain at the time of the fall and continued to complain of pain 9 out of 10 (on a scale from 0 to 10 with ten being the worst pain) to the right side. Approximately 2-1/2 hours after the resident was found, the resident's family member arrived at the facility to check on the resident and requested the resident be re-evaluated by staff due to the resident's severe pain, along with shortness of breath. Approximately 10-3/4 hours after the resident was found, the resident continued to complain of pain of 7 out of 10. Staff described the resident as very tearful and in a lot of pain when repositioned, and the physician was not notified. On 10/22/24, the resident's physician gave orders to send the resident to the emergency room (ER) for evaluation, nonemergent, due to a high blood potassium level. In the emergency department the resident was found to have a large right sided hemothorax (when a collection of blood accumulates in the chest cavity, often caused by trauma or injury, symptoms can include difficulty breathing and pain) with multiple displaced rib fractures and a right scapular fracture (a rare injury that occurs when the shoulder blade is directly or indirectly impacted by a significant amount of force such as a fall or blow to the shoulder). At the time of the fall, the on-call physician, who was not the resident's primary care physician, was notified that the resident had slipped from the wheelchair and there was no injury and the notification was facility procedure. The physician was not notified the resident was in pain after the fall and continued to have pain throughout the night, the use of an anticoagulant medication, the resident's shortness of breath or that the fall was unwitnessed. The facility census was 51. The administrator was notified on 11/21/24 at 12:30 P.M of the Immediate Jeopardy (IJ) which began on 10/21/24. The IJ was removed on 11/21/24, per onsite verification. Review of the facility's policy, Acute Condition Changes, dated March 2018, showed the following: -The physician will help identify individuals with a significant risk for having acute changes of condition during their stay; -The nurse shall assess and document/report baseline information to include current level of pain and recent changes in pain level, onset, duration and the severity, all active diagnoses, and current medications; -Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the nurse; -Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness. Phone calls should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident's current symptoms and status. Review of the facility's policy, Pain Assessment and Management, dated March 2022, showed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The purpose of this procedure is to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain; -The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choice related to pain management; -Pain management is a multidisciplinary care process that includes assessing the potential for pain, recognizing the presence of pain, addressing the underlying causes of the pain; -Report to the physician significant changes in the resident's level of pain. 1. Review of Resident #9's care plan dated 10/17/24 showed the following: -The resident required assistance of two staff for bed mobility, for pulling up in bed, repositioning in bed, dressing, toileting, and transfers (Date initiated, 10/17/24); -The resident will attempt to do things without assistance, staff to anticipate needs during routine rounds, as needed and per request (Date initiated, 10/17/24); -The resident was up in the wheelchair, leaned forward, and fell to the floor. Experienced right rib pain. Interventions for staff to continue to educate about not leaning forward in wheelchair, keep call light within reach at all times. (Date initiated, 10/21/24 and revised on 11/6/24). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/21/24, showed the following: -Moderate cognitive impairment; -The resident had pain occasionally and received as needed (PRN) pain medications; -Pain rarely affected sleep; -Pain occasionally affected day to day activities; -No range of motion impairment to upper extremities; -Range of motion impairment in both lower extremities; -Wheelchair used for mobility; -Substantial to maximum assistance required from a staff member to move from sitting to lying position, and for chair/bed to chair transfer; -The resident had one fall since admission with no evidence of injury. Review of the resident's physician order sheet (POS) dated October 2024 showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included acquired absence of left leg above knee, acquired absence of right leg above the knee, malignant neoplasm of the frontal lobe (a cancerous tumor in the frontal lobe of the brain), muscle wasting and atrophy (decrease in muscle mass and strength) and diabetes; -An order for Xarelto 20 milligram (mg) daily. Review of the resident's Nursing Note dated 10/21/24 at 5:25 P.M. showed the following: -Registered Nurse (RN) A was called to the resident's room by Certified Nurse Assistant (CNA) E. The resident was found lying on the floor on his/her back in front of his/her wheelchair. The resident said he/she was up in his/her wheelchair, leaned forward and fell out of the wheelchair. This fall was not witnessed; -The resident complained of right-side rib pain, but no apparent injury was noted. Staff transferred the resident from the floor to the wheelchair with the assist of two staff members and a mechanical lift. Staff assisted the resident to the dining room. Neurology checks (quick assessment that evaluates the health of someone's nervous system through a series of tests) started, and vital signs (measurements of the body's basic function including temperature, pulse rate, respiration rate and blood pressure) obtained; -On call physician notified of the fall at 5:40 P.M. and no new orders received. Family notified of the fall. Review of the resident's Medication Administration Record (MAR), dated 10/21/24 at 8:30 P.M.,. showed the resident complained of pain in his/her right rib area and rated it a 9 on a scale from 0 to 10 with ten being the worst pain. Staff administered Tramadol (medication used to treat moderate to severe pain) 50 mg and the medication was noted as effective. Review of the resident's Nursing Note, dated 10/21/24 at 9:17 P.M., showed the resident was tearful and said he/she wanted to go home at times. The resident complained of right sided rib pain. Upon palpation resident was tender to touch on the right side and 3 to 4 inches below the axilla (armpit). There was no documentation of the physician being notified. Review of the resident's Nursing Note, dated 10/22/24 at 4:12 A.M., showed the resident complained of pain in his/her right side and rated it a 7 on a 0 to 10 scale with ten being the worst. Staff administered two Tylenol Extra Strength 500 mg tablets (analgesic used to treat mild to moderate pain) and it was noted to be effective. Review of the resident's MAR, dated 10/22/24 at 7:12 A.M., showed the resident complained of right-side rib pain and rated it a 6 on a scale from 0 to 10. Staff administered Tramadol 50 mg one tablet for right sided rib pain, and it was ineffective. No further treatment for pain was initiated when the Tramadol did not effectively relieve the pain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's Nursing Note, dated 10/22/24 at 8:21 A.M., completed by Licensed Practical Nurse (LPN) C, showed the on-call physician's office called and gave an order to send the resident to the emergency department for evaluation due to a critical potassium level and to send the resident nonemergent. Notified the resident's family member of the order. At that time the family member voiced concerns about the fall from the night before and said the resident was still in a lot of pain. LPN C was unaware of the fall. The family member reported the resident was complaining of arm, shoulder, side, and back pain. The resident rated his/her pain a 10. Message sent to the physician to see if he/she wanted any x-rays while at the hospital. After receiving an order from the physician on 10/22/24 at 8:21 A.M. to send the resident to the hospital, Emergency Medical Services (EMS) was contacted to transport the resident. Review of the resident's Nursing Note dated 10/22/24 at 9:15 A.M., showed staff spoke with the ER nurse regarding the fall and complaint of pain, along with high potassium level. The ER nurse said they were in the process of doing x-rays for the resident. Review of the resident's Hospital Discharge Summary, dated 10/25/24 at 1:30 P.M., showed the following: -The resident presented through the emergency room department with complaints related to a fall out of his/her wheelchair. The resident was found to have a large right sided traumatic hemothorax with multiple displaced rib fractures and a right scapula fracture. Evacuation hemothorax was achieved through tube thoracotomy (a surgical procedure that involves making an incision in the chest wall and inserting a tube to drain fluid or air from the pleural space); -It was easy to identify that this injury pattern would be quite disruptive to the resident's quality of life and there would be a long road to any meaningful recovery if meaningful recovery was achievable. Aggressive pain control measures were taken; -The resident will discharge back to the facility with hospice arrangements. During an interview on 11/19/24 at 3:00 P.M., Certified Nurse Assistant (CNA) E said the following: -He/She found the resident on the floor on his/her back. The resident had fallen out of his/her wheelchair and CNA E notified RN A. During an interview on 11/21/24 at 5:15 P.M., CNA F said the following: -On 10/21/24 he/she worked 11:00 P.M. to 7:00 A.M.; -He/She was notified of the resident having a fall in report; -At 4:00 A.M., the resident was tearful and complained of right rib pain. The resident had a lot of pain when staff turned him/her, it was not normal for the resident to have rib pain. CNA F reported that to the charge nurse. During an interview on 11/19/24 at 12:50 P.M., RN A said the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On the evening of 10/21/24, CNA E found the resident on the floor. The resident complained of right sided rib pain after the fall. He/She touched the resident's side and the resident had discomfort; -He/She notified the physician on call (not the resident's primary physician) the resident had a fall and had some rib soreness. He/She did not receive any orders. He/She did not communicate to the physician the resident was on a blood thinning medication; -The resident had increased pain at bedtime, but RN A didn't feel it required urgent care or the physician being notified. If the resident had a rib fracture nothing really could be done for it; -RN A scheduled a mobile x-ray for the following day. During an interview on 11/20/24 at 7:54 A.M., LPN C said the following: -He/She worked the 7:00 A.M. to 3:00 P.M. shift on 10/22/24; -He/She received no information during shift change report regarding the resident or a fall from the staff on the previous shift; -The resident's family member reported the morning of 10/22/24 the resident was crying out in pain and hurt all over since the fall; -The resident had been sent out for a critical potassium level. LPN C called the hospital and requested the resident have x-xays due to pain from the fall. During an interview on 11/20/24 at 5:30 P.M., the resident's family member said the following: -On the evening of 10/21/24, RN A called him/her and said the resident fell out of his/her wheelchair onto the floor. RN A said he/she had checked the resident over and didn't have any concerns; -On 10/21/24 approximately 8:00 P.M., the resident's family member arrived at the facility to check on the resident. The resident complained of right sided rib pain and had concerns his/her ribs were broken. He/She questioned RN A about the resident's increased pain. RN A said he/she would schedule a mobile x-Ray for the next day; - On 10/22/2024 when the resident's family member arrived at the facility, the resident was crying out in pain, hurting all over and having some difficulty breathing. The family member reported the pain to LPN C and LPN C was not aware the resident had fallen the evening before; -The resident was diagnosed with multiple rib fractures and a right shoulder fracture. He/she felt the resident should have been evaluated in the emergency room the night of the fall. The resident was in a lot of pain throughout the night; -Due to the extent of the injuries after the fall, the resident elected to go on hospice and return to the facility with no surgical intervention. During an interview on 11/19/24 at 2:15 P.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-She would expect any resident who sustained a fall and was on a blood thinning medication be sent out for evaluation due to a risk of bleeding; -She would expect all staff to notify the administrative staff member on call of a resident fall. RN A did not notify the administrative staff on call of the fall; -RN A did not provide the physician on call with enough information regarding the resident and the fall or make the physician aware the resident was on blood thinning medication; -The post fall assessment was not thorough and there was no evidence the night charge nurse evaluated the resident following the fall for any increased pain or change in status; -The resident had increased pain and should have been sent out for evaluation at the time of the fall. During an interview on 11/26/24 at 11:02 A.M., the Administrator said the following: -He would expect staff to follow the facility policy regarding a change in condition and pain assessment; -He would expect staff to assess a resident for pain following a fall and relay any concerns or an increase in pain to the physician. During an interview on 11/20/24 at 11:10 A.M., the Physician Q (on call physician) said the following: -He was the physician on call on 10/21/24, but had not seen or evaluated the resident in the past; -He was notified the resident slipped from the wheelchair and it was procedure to notify the physician on call, but was told no injury had occurred; -The nurse described the resident as having some tenderness, but nothing more; -He would expect staff to notify him that the fall was unwitnessed, the resident was on a blood thinning medication or any continued or an increase in pain; -Communication played a role and if he had received all the details regarding the fall and the resident's history and use of a blood thinner, he would have sent the resident out for evaluation at the time of the fall. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO244074

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36185 Based on interview and record, review the facility failed to develop a care plan with interventions to prevent falls for one resident (Resident #9) of nine sampled residents, who was at risk for falls and was admitted to the facility after having falls at home. The resident sustained a fall while at the facility on 10/21/22. Staff failed to complete a thorough post fall assessment or notify the Director of Nursing (DON), as directed by facility policy, at the time of the fall. The facility failed to communicate the resident's fall to the oncoming shift at shift change. The facility failed to communicate pertinent information regarding the fall to the on-call physician, who was not familiar with the resident which delayed evaluation and treatment. As a result of the fall, the resident sustained a large right sided hemothorax (when a collection of blood accumulates in the chest cavity, often caused by trauma or injury, symptoms can include difficulty breathing and pain) with multiple displaced rib fractures (broken ribs where the pieces of bone have moved so that a gap has formed around the fracture, complications can include punctured lungs and damage to other organs) and a right scapular fracture (a rare injury that occurs when the shoulder blade is directly or indirectly impacted by a significant amount of force such as a fall or blow to the shoulder). The facility census was 51. Review of the facility's policy titled, Care Plans-Baseline, December 2016 showed the following: -A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission; -The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan; -The interdisciplinary team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including, but limited to initial goals based on admission orders, physician orders, dietary orders, therapy services and social services. Review of the facility's policy titled, Assessing Falls and Their Causes, dated March 2018, showed the following: -The purposes of this procedure was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall; -Review the resident's care plan to assess for any special needs of the resident, identify current medications and active medical conditions; -Falls are the leading cause of morbidity and mortality among the elderly in nursing homes, falling maybe related to underlying clinical or medical conditions, overall functional decline, medication side effects or environmental risk factors; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-If a resident has just fallen, or is found in the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities; -If an assessment rules out significant injury or condition change, notify the practitioner routinely by fax, or phone the next day; -Observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall, and document findings in the medical record; -Document any observed signs or symptoms of pain, swelling, bruising or deformity, and/or decreased mobility, and any changes in level of responsiveness/consciousness or overall function. Note the presence or absence of significant findings; -After an observed or probable fall, clarify details of the fall, such as when fall occurred and what the individual was trying to do at the time if the fall; -Distinguish falls as rolling, sliding, or dropping from bed or chair to floor; -Within 24 hours of the fall, begin to try to identify the likely cause of the incident; -When a resident falls, record in the medical record the condition in which the resident was found, assessment data, including vital signs and any obvious injuries. Interventions or treatment administered, notification to the physician and family, as indicated, completion of falls risk assessment, appropriate interventions to prevent future falls; -Report to the attending physician (timing of notification may vary, depending on whether injury was involved), the DON and the nursing supervisor on duty 1. Review of Resident #9's Nursing Note, dated 10/14/24 at 9:13 P.M., showed the following: -The resident was admitted from the hospital emergency room ; -The resident transfers with assist of two staff and slides from wheelchair to bed and has bilateral amputation of lower extremities. History of falls which was the reason the resident was in the emergency room today. Review of the resident's Care Plan, dated 10/17/24, showed the following: Diagnoses included acquired absence of left leg above knee, acquired absence of right leg above the knee, malignant neoplasm of the frontal lobe (a cancerous tumor in the frontal lobe of the brain), muscle wasting and atrophy (decrease in muscle mass and strength) and diabetes; -The resident required assist of two for bed mobility, for pulling up in bed, repositioning in bed, dressing, toileting, and transfers (Date initiated, 10/17/24); -The resident will attempt to do things without assistance, staff to anticipate my needs during routine rounds, as needed and per request (Date initiated, 10/17/24) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The care plan did not address the resident's risk for falls or include interventions to prevent falls. Review of the resident's Fall Risk Evaluation, dated 10/20/24, showed the following: -Upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan; -Staff documented the resident had no falls in the past three months, was bedbound/continent, had a change of condition in the last 14 days, had a recent hospitalization , took one to two medications that increased the likelihood for falls, and had multiple predisposing diseases that increased the likelihood for falls; -The resident's score was 17 showing the resident was at high risk for falls, the section of the evaluation Risk for Falls including options for interventions, was not completed by staff. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/21/24, showed the following: -Moderate cognitive impairment; -The resident had pain occasionally and received as needed (PRN) pain medications; -Pain rarely affected sleep; -Pain occasionally affected day to day activities; -No range of motion impairment to upper extremities; -Range of motion impairment in lower extremities; -Wheelchair used for mobility; -Substantial to maximum assistance required from a staff member to move from sitting to lying position, rolling left to right, and for chair/bed to chair transfer; -The resident had one fall since admission with no evidence of injury. Review of the resident's Occupational Therapy Evaluation, dated 10/17/24, showed the following: -The resident will increase sitting balance during Activities of Living (ADL) to fair and using righting reactions 75% of the time to reduce the risk of falls, facilitate upright posture and increase participation with functional tasks; -Sitting during meals percentage baseline was less than 25% and was poor (sits unsupported with minimal assist and unable to weight shift). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Nursing Note, dated 10/21/24 at 5:25 P.M., showed the following: -Registered Nurse (RN) A was called to the resident's room by Certified Nurse Assistant (CNA) E. The resident was found on the floor on his/her back in front of his/her wheelchair. The resident said he/she was up in his/her wheelchair, leaned forward and fell out of the wheelchair; -The resident complained of right-side rib pain, but no apparent injury was noted. Staff transferred the resident from the floor to the wheelchair with the assist of two staff members and a mechanical lift. The resident was assisted to the dining room; -Staff notified the call physician at 5:40 P.M. and no new orders were received. Review of the resident's Unwitnessed Fall Report dated 10/21/24 at 6:07 P.M., showed the following: -RN A was called to the resident's room, the resident was on the floor on his/her back in front of the wheelchair. The resident said he/she leaned forward in the wheelchair and fell out; -The resident was assisted to the wheelchair by two staff members and use of a mechanical lift and brought to the dining room. No apparent injury noted. The resident complained of right-sided rib tenderness; -Level of pain was a 5 on a 0 to 10 scale with 10 being the worse; -The section for environmental factors and situational factors was not completed; -Predisposing factors: weakness/fainted and trunk control and balance issue. Review of the resident's medical record showed staff did not document on 10/21/24 (11:00 P.M. to 7:00 A.M.) that the 11-7 shift charge nurse assessed the resident post fall for any delayed complications, pain or injury. Review of the resident's hospital Discharge Summary, dated 10/25/24 at 1:30 P.M., showed the following: -The resident presented through the emergency room department with complaints related to a fall out of his/her wheelchair. The resident was found to have a large right sided traumatic hemothorax with multiple displaced rib fractures and a right scapula fracture. Evacuation hemothorax was achieved through tube thoracostomy. -It was easy to identify that this injury pattern would be quite disruptive to the resident's quality of life and there would a long road to any meaningful recovery if meaningful recovery was achievable. Aggressive pain control measures were taken. -The resident will discharge back to the facility with hospice arrangements. Review of the resident's care plan, revised 11/6/24, showed fall on 10/21/24, right rib pain. Up in wheelchair and leaned forward and fell to floor. Interventions for staff to continue to educate about not leaning forward in wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/20/24 at 5:30 P.M., the resident's family member said the following: -The resident was admitted directly to the facility from the emergency room after a fall at home. The resident had fallen multiple times at home trying to transfer; -On the evening of 10/21/24, RN A called him/her and said the resident fell out of his/her wheelchair onto the floor. RN A said he/she had checked the resident over and didn't have any concerns; -On 10/21/24 approximately 8:00 P.M. the family member arrived at the facility to check on the resident. The resident complained of right sided rib pain and had concerns his/her ribs were broken. He/She questioned RN A about the resident's increased pain. RN A said he/she would schedule a mobile x-ray for the next day; -The following day (10/22/24) when the family member arrived at the facility the resident was crying out in pain, hurting all over and having some difficulty breathing. The family member reported the pain to Licensed Practical Nurse (LPN) C and he/she was not aware the resident had fallen the evening before; -The resident ended up with multiple rib fractures and a right shoulder fracture. He/she felt the resident should have been evaluated in the emergency room the night of the fall. The resident was in a lot of pain throughout the night; -Due to the extent of the injuries after the fall, the resident elected to go on hospice and return to the facility with no surgical intervention. During an interview on 11/19/24 at 3:00 P.M., CNA E said the following: -He/She was not aware the resident had a history of falls. He/She didn't know of any fall interventions that were in place to prevent falls for the resident; -He/She found the resident on the floor on his/her back. The resident fell out of his/her wheelchair and CNA E notified RN A. During an interview on 11/20/24 at 1:36 P.M., CNA P said the following: -The resident was typically in bed, the resident was so weak he/she wasn't sure the resident could hold himself/herself up if in the wheelchair for very long. CNA P was afraid to even leave the resident in the wheelchair while he/she changed the bed linens on shower day; -CNA P made a comment to one of the charges nurse that he/she was concerned with leaving the resident in his/her wheelchair unsupervised because the resident was so weak; -CNA P wasn't sure if the resident had a history of falls. During an interview on 11/20/24 at 7:54 A.M., LPN C said the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She was not aware the resident had a fall in the past or prior to admission. He/She could not recall any fall prevention interventions that were in place for the resident prior to his/her fall on 10/21/24; -He/She worked the 7:00 A.M. to 3:00 P.M. shift on 10/22/24; -The off-going nurse provided no information at shift change to LPN C regarding the resident or a fall. If any resident had a recent fall, he/she evaluated the resident at the start of his/her shift to assure there was no post fall concerns. This was not done as LPN C was not aware of the resident's fall; -The resident's family member reported that morning the resident was crying out in pain and hurt all over since the fall; -The resident had been sent out for a critical potassium level, LPN C called the hospital and requested the resident have x-rays due to pain from the fall. During an interview on 11/20/24 at 9:00 A.M., LPN B said on 10/21/24 he/she worked the 11:00 P.M. to 7:00 A.M. shift. LPN B did not recall if the resident had a fall prior to his/her shift. He/She could not recall if the resident had any pain throughout his/her shift. During an interview on 11/20/24 at 10:00 A.M. with Physical Therapy Assistant (PTA) O said the following: -The resident was very weak and required a mechanical lift for transfers; -The resident's core strength was very poor. The resident was often slumped over in bed and required assistance to sit up in bed due to his/her weakness; -The resident was not safe to sit in his/her wheelchair unsupervised due being visibly weaker prior to the fall. PTA O thought the nursing staff were aware of this, but was not sure if it was communicated to them. During an interview on 11/19/24 at 2:15 P.M., the DON said the following: -The resident was admitted to the facility from the emergency room following a fall at home. A fall care plan and interventions should have been put in place upon admission; -She would expect the Fall Risk Evaluation be completed accurately. The fall incident report should be thorough and attempt to find the root cause of the fall; -She was not aware that therapy staff had concerns with the resident being up in the wheelchair unsupervised. That information was not relayed to her, she would expect for therapy to relay that information to the nursing staff; -The facility also had a weekly meeting with therapy to discuss the residents and any concerns or recommendations; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-She would expect staff to report any falls to the oncoming shift at change of shift and documentation of the resident's status following the fall; -She would expect all staff notify the administrative staff member on call of a resident fall. RN A didn't notify the administrative staff on call of the fall; -The post fall assessment was not thorough and there was no evidence the night charge nurse evaluated the resident following the fall for any increased pain or changes in status; -The resident had an increase of pain and should have been sent out for evaluation at the time of the fall; -She would expect for the baseline care plan be completed at admission by the admitting nurse. During an interview on 11/26/24 at 11:02 A.M. the Administrator said the following: -He would expect staff to follow the facility policy regarding falls; -He would expect staff to assess a resident for pain following a fall and relay any concerns or an increase in pain to the physician. During an interview on 11/20/24 at 11:10 A.M. the Physician Q (on call physician on) said the following: -He was the physician on call on 10/21/24, but had not seen or evaluated the resident in the past; -He was notified the resident slipped from the wheelchair and it was procedure to notify the physician on call, but was told no injury had occurred; -The nurse described the resident as having some tenderness, but nothing more. MO244074

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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** 36185 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for five sampled residents (Resident #7, #8, #2, #6, and #1). The facility failed to have adequate staffing to check and provide incontinence care to residents in a timely manner, to provide routine showers to ensure good personal hygiene, to answer call lights in a timely manner and to assist residents out of bed for meals, and ensure all residents were served meals. The facility census was 51. Review of the facility policy titled, Staffing, dated October 2017, showed the following: -Our facility provides sufficient numbers of staff with skill and competency necessary to provide care and services for all residents in accordance with the resident's care plan and the facility assessment; -Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services; -Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Review of the Facility Assessment Tool, updated on 8/1/24, showed the following: -The persons involved in completing the assessment included the Administrator, Director of Nursing (DON) and Governing Body with the corporation; -The Quality Assurance Team and Quality Assurance Performance Committee reviewed the assessment on 10/16/24; -Assistance with toileting showed 47 residents out of 50 were independent; -Assistance with transfers showed 31 residents required assist of 1-2 staff and 13 were dependent on staff; -Licensed Practical Nurses (LPN) providing direct care showed 6-10 daily; -Nurse Aides 13-20 daily. Review of the facility's list of residents who required a two person transfer or mechanical lift transfer dated, 11/19/24, showed a total of 27 residents. 1. Review of Resident #7's Care Plan, dated 8/29/24, showed the following: -Diagnoses included dementia, major depressive disorder and anxiety; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident required substantial assistance with personal hygiene, the resident wore incontinence briefs day and night; -Check the resident during each routine rounds and as needed, dependent with changing incontinence briefs and with changing clothes; -The resident needed assistance of one staff with grooming. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/14/24 showed the following: -Severe cognitive impairment; -Always incontinent of bowel and bladder; -Dependent with toilet hygiene; -The resident required substantial to maximal assistance with personal hygiene. Observation on 11/19/24 at 9:45 A.M., showed the resident sat in his/her geri chair (large padded wheelchair that usually reclines) in his/her room. There was a strong, foul odor of urine in the resident's room. Observation on 11/19/24 at 10:45 A.M., showed the following: -Certified Nurse Aide (CNA) N and CNA H transferred the resident to bed; -A strong odor of urine permeated the room; -CNA N and CNA H removed the resident's incontinence brief. The resident's brief was saturated with urine and the resident's skin was red where the brief was located with imprints of the brief in the resident's skin. During an interview on 11/19/24 at 10:55 A.M., CNA H said the following: -Staff assisted the resident out of bed at approximately 7:45 A.M. that morning; -Staff tried to check and change residents that were incontinent every two hours, but it was usually three hours or more before staff changed many of the incontinent residents; -The facility was short staffed and there was so many mechanical lifts it was hard to get it all done in a timely manner. 2. Review of Resident #8's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Dependent on staff for toilet hygiene; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 9/5/24, showed the following: -Always incontinent of bladder and bowel due to history of stroke; -Assist with perineal cleansing as needed, check on routine rounds and as needed (PRN): -Keep skin clean and dry, perform peri care after each incontinence episode. Observation on 11/19/24 at 8:15 A.M., showed the resident sat in a geri chair in the dining room eating breakfast. Observation on 11/19/24 at 9:15 A.M., showed the resident in his/her room, sitting in a geri chair. During an interview on 11/19/24 at 9:15 A.M., the resident said he/she was wet with urine and needed to be changed. There was a strong odor of urine and feces noted in the resident's room. Observation on 11/19/24 at 10:00 A.M., showed the resident remained in his/her room in a geri chair. An odor of urine and feces persisted in the room. Observation on 11/19/24 at 10:30 A.M., showed the following: -CNA J and CNA K entered the resident's room and transferred the resident to bed with a mechanical lift; -CNA J and CNA K removed the resident's incontinence brief. The incontinence brief was saturated with urine and soiled with feces. The resident's skin was red where it touched the brief with imprints from the incontinence brief on the resident's skin. During an interview on 11/19/24 at 10:40 A.M., CNA J and CNA K said the following: -Staff assisted the resident out of bed at 7:30 A.M. that morning; -Staff had not checked he resident for incontinence or changed the resident since 7:30 A.M. -The resident was always wet with urine and soiled with feces by the time staff were able to change him/her; -It was difficult to get residents changed in a timely manner because of the high level of care needed for each resident, multiple mechanical lift transfers, and not enough staff to provide care. 3. Review of Resident #2's Care Plan, revised 4/17/24, showed the following: -The resident was dependent on staff to help with his/her activities of daily living (ADL) tasks related to decreased mobility and tremors. Staff to anticipate needs; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assist the resident with using the bed pan during routine rounds, as needed (PRN) and per the resident's request. -Check during routine rounds for episodes of incontinence of bowel and bladder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Diagnoses included aphasia (a disorder that affects communication), seizure disorder and and depression. -Cognitively intact; -Always incontinent of bowel and bladder; -Dependent on staff for toilet hygiene and with showering. Review of the facility's shower schedule showed the resident was to receive a shower on Monday and Thursday of each week. Review of the facility shower sheets showed staff did not provide the resident a shower on 11/18/24. Observation on 11/19/24 at 11:00 A.M., showed the following: -The resident lay in bed, his/her hair was oily and appeared dirty. CNA J and CNA K entered the resident's room and said they were going to check to see if the resident was dry and get the resident up for the day; -CNA J and CNA K removed the resident's incontinence brief. The brief was saturated with urine and the resident's skin was red where it was in contact with the brief. There were imprints from the incontinence brief in the resident's skin. During an interview on 11/19/24 11:10 A.M., CNA J and CNA K said they checked the resident around 6:45 A.M. for incontinence and the resident was dry at that time. Staff had not checked the resident for incontinence from 6:45 A.M. until 11:00 A.M The facility was short staffed and they could not get all care provided to residents in a timely manner. During an interview on 11/19/24 at 1:30 P.M., the resident's family member said the following: -The resident didn't always receive routine showers; -The resident's hair was oily and dirty because the resident didn't receive his/her scheduled shower on 11/18/24; -The facility was short staffed at and resident care got missed. 4. Review of Resident #6's admission Baseline Care Plan, dated 10/30/24, showed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included displaced intertrochanteric fracture of the left femur (a break in the thigh bone which is displaced), history of falling, muscle weakness, need for assistance with personal care, muscle weakness, pain, diabetes and unsteadiness on feet; -Independent with eating once the meal was placed in front of the resident; -Partial to moderate assistance needed with toileting, bathing, to roll from left to right, lying to sitting on the side of the bed; -Substantial to moderate assistance with dressing lower body, putting on and taking off footwear and personal hygiene. Review of the resident's comprehensive admission Care Plan, dated 11/1/24, showed the following: -The resident was a fall risk, evaluate fall risk at admission. -The Care Plan did not address staff assistance required for ADLs or any other care areas. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Understood and understands others; -Limited range of motion impairment to the lower extremity on one side; -Used a walker and wheelchair for mobility; -Independent with eating once setup help provided; -Independent with toilet hygiene; -Required substantial to maximum assistance from staff with toilet transfers and walking 10 feet; -Occasionally incontinent of bowel and bladder. During an interview on 11/19/24 at 1:00 P.M., the resident said the following: -The resident had only been at the facility for a few weeks; -There was not enough staff to care for him/her or the other residents; -He/She often waited two hours for his/her call light to be answered, as a result he/she was incontinent of urine waiting for someone to assist him/her, this upset the resident; -He/she had missed being served a meal four or five times; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She asked staff to walk him/her over three hours ago and staff said they didn't have time, not enough staff; -He/She was going back home tomorrow because he/she was not receiving care like he/she should at facility because of the lack of staff. 5. Review of Resident #1's Care Plan, revised 9/4/24, showed the following: -Coping was impaired, provide assistance with activities of daily living (ADLs) as needed, include resident in determining next steps in care; -Required assistance of two staff with all transfers and use of mechanical lift. Review of the resident quarterly MDS, dated [DATE], showed the following: -Diagnoses included multiple sclerosis, anxiety, and depression; -Cognitively intact; -The resident had the ability to express ideas and wants; -The resident was understood and had clear comprehension to understand others; -The resident required supervision or touching assistance with personal hygiene; -Dependent with toileting; -Dependent with chair/bed to chair transfer; -Frequently incontinent of bowel and bladder. During an interview on 11/19/24, Resident #1 said the following: -At times there was not enough staff to get him/her out of bed. He/She had to remain in bed all day; -Sometimes he/she had to wait long periods for a bedpan and would become incontinent waiting for staff at assist and this upset him/her. During an interview on 11/19/24 at 10:40 A.M., CNA J said it was difficult for staff to get residents changed in a timely manner because of the high level of care needed for each resident, multiple residents required mechanical lifts for transfers which required two staff members and there was not enough staff to provide the care residents required. During an interview on 11/19/24 at 10:55 A.M., CNA H said the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff tried to check and change residents that were incontinent every two hours, but it usually was three hours or more before staff could check and change many of the incontinent residents due to not having enough staff; -The facility was short staffed and there were so many residents who required the mechanical lift for transfers it was very hard to get it all done in a timely manner. During an interview on 11/19/24 at 3:00 P.M., CNA E said the following: -Several residents didn't get up for supper because there was not enough staff to get them out of bed. The facility had almost 30 residents who required a mechanical lift for transfers, there wasn't enough staff available to get all of the residents up for meals and back to bed in a timely manner; -Staff did not get incontinent residents didn't get changed in a timely manner and many resident showers weren't completed because of being short staffed. During an interview on 11/20/24 at 12:00 P.M., CNA G said the following: -Residents who were incontinent went long periods without being checked or changed because of being short staffed; -The residents refused to get out of bed sometimes because they didn't want to stay up for a long period because there was not enough staff available to get them back to bed; -Staff did not provide residents with oral care, or wash residents' faces and hands routinely and did not get room trays passed timely because of being short staffed; -Staff had gone to the Administrator and Director of Nursing (DON) multiple times about not having enough staff to meet the needs of the residents, but nothing changed. During an interview on 11/26/24 at 1:15 P.M., CNA I said the following: -The facility was short staffed and residents were not getting the care they needed; -Staff were unable to get residents checked and changed every two hours, the residents also went long periods without being repositioned because of being short staffed; -Staff were unable to pass ice water to residents, complete oral care or wash the residents' hands and faces in the morning because of being short staffed; -Staff also missed completing resident showers and residents had to wait long periods for assistance because of being short staffed. During an interview on 11/19/24 at 12:45 P.M. Licensed Practical Nurse (LPN) M said the following: -The facility didn't have enough staff to meet the needs of the residents; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility had almost 30 residents who were a mechanical lift transfer, this required two staff members for each transfer and was very time consuming; -Residents weren't repositioned, checked for incontinence and changed in a timely manner, showers were missed, water and snacks didn't get passed as a result of being short staffed. During an interview on 11/20/24 at 7:54 A.M., LPN C showed the following: -The facility was short staffed and as a result room trays were missed getting passed; some residents remained in bed for meals because staff didn't have time to get them up; -Some residents chose not to get up for meals because they would have to sit up for a long period, waiting for assistance back to bed; -Staff couldn't care for the residents properly with the number of staff they have, only the basics are done; -Residents don't receive oral care, hair doesn't get brushed, and showers are often missed During an interview on 11/19/24 at 2:35 P.M., Certified Medication Technician (CMT) L said the following: -The facility had almost 30 residents who required the mechanical lift for transfers, this required two staff members, because of this many other things didn't get done because there was not enough staff available; -The residents complained about waiting long periods for staff to assist with getting out of bed and back to bed in a timely manner because of being short staffed. Staff could not complete showers like they were supposed to because of being short staffed. During an interview on 11/20/24 at 12:30 P.M., the Administrator said the following: -He was new as an administrator, and this was the first time he had completed the facility assessment; -He was not familiar with the form/process; -He completed the assessment with assistance from the Corporate Administrator. He did not know the assessment required involvement by the Quality Assurance Team or other disciplines; -For Assistance with Activities of Daily Living (ADL), he documented there were 47 residents independent with toileting. That was completed incorrectly; -The facility currently had 27 residents who required transfer with mechanical lifts, who would be dependent with transfers. He did not feel the number he documented was correct, he documented 13 and thought it should be much higher. During interviews on 11/20/24 at 12:15 P.M. and 11/26/24 at 2:15 P.M., the DON said following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility had enough staff to meet the needs of each resident; -Nursing staff didn't work efficiently and manage their time well; -She did not feel the facility was short staffed; -The facility had enough staff to transfer 27 residents who were a mechanical lift; Staff needed to be prepared and have all the supplies needed prior to the transfer and work efficiently, but she felt it could be done; -The facility did not have 47 residents who were independent with toileting and there were more residents dependent with transfers then what the facility assessment indicated; -She thought the issue with residents not being served a meal tray was an issue with meal cards, she thought this had been addressed with the new dietary manager. During interviews on 11/20/24 at 12:15 P.M. and 11/26/24 at 11:02 A.M., the Administrator said the following: -He did not feel the facility was short staffed, the issue was nursing staff not working efficiently; -The facility had enough staff to transfer 27 residents who were a mechanical lift; -The facility had plenty of staff to meet the needs of the resident. MO244120, MO745734

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 36185 Based on interview and record review, the facility failed to review and update the facility wide assessment to determine what resources were necessary to care for residents competently during their day to day operations and emergencies as required. The facility census was 51. Review of the facility policy titled, Facility Assessment, dated October 2018, showed the following: -A facility assessment is conducted annually to determine and update capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment; -The team responsible for conducting and reviewing and updating the facility-wide assessment includes the administrator, a representative of the governing body, the medical director, the director of nursing (DON), the infection preventionist and also the director from environmental services, physical operations, dietary services physical operations, dietary services, social services, activity services and rehabilitative services; -The facility assessment includes a detailed review of the resident population, which includes need for assistance with activities of daily living (ADL); -The facility assessment is reviewed and updated annually and as needed. 1. Review of the Facility Assessment Tool, updated on 8/1/24, showed the following: -The persons involved in completing the assessment included the Administrator, Director of Nursing (DON) and Governing Body with the corporation; -The Quality Assurance Team and Quality Assurance Performance Committee reviewed the assessment on 10/16/24; -Assistance with toileting showed 47 residents out of 50 were independent; -Assistance with transfers showed 31 residents required assist of 1-2 staff and 13 were dependent. During an interview on 11/20/24 at 12:15 P.M., the DON said she did not have any involvement with completing the facility assessment. The facility did not have 47 residents who were independent with toileting and more residents were dependent with transfers then what the facility assessment indicated. During an interview on 11/20/24 at 12:30 P.M., the Administrator said the following: -He was new as an administrator, and this was the first time he had completed the facility assessment; (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He was not familiar with the form/process; -He completed the assessment with assistance from the Corporate Administrator. He did not know the assessment required involvement by the Quality Assurance Team or other disciplines; -For Assistance with Activities of Daily Living (ADL), he documented there were 47 residents independent with toileting. That was completed incorrectly; -The facility currently had 27 residents who required transfer with mechanical lifts, who would be dependent with transfers. He did not feel the number he documented was correct, he documented 13 and thought it should be much higher.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265247	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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. 36185 Based on observation and interview, the facility failed to ensure proper signage on the entrance of the building, notifying visitors of Coronavirus Disease 2019 (COVID-19) outbreak in the building and failed to post transmission based precaution signage outside of one COVID-19 positive room for (Resident #5) in nine sampled residents. The facility census was 51. Review of the facility policy titled, COVID-19 Prevention, Response and Reporting, dated 5/29/24, showed the following: -It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections; -The Infection Preventionist will assess facility risk associated with COVID-19 through surveillance activities of COVID-19 infection in the community and illness present in the facility; -Threat detected-the facility will respond promptly and implement emergency and/or outbreak procedures; -The facility will establish a process to identify and manage individuals with suspected or confirmed -SARS-CoV-2 infection ensuring everyone is aware of the recommended infection prevention and control (IPC) practices in the facility by posting visual alerts (signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations. Review of the Centers for Disease Control and Prevention's Infection Control Guidance for SARS-CoV-2 (Severe Acute Respiratory Syndrome, virus that causes COVID-19)/COVID-19 infections revised 6/24/24 showed the following: -This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency; -Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection; -Ensure everyone is aware of recommended IPC practices in the facility. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. -Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: -A positive viral test for SARS-CoV-2; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP). 1. Observation on 11/26/24 at 7:45 A.M., showed there was no signage on the front entrance of the building stating there was a COVID-19 positive resident in the building. Review of Resident #5's Facesheet, undated showed the following: -Admission: 11/20/24; -Diagnoses included fracture (break) of the right femur (thigh bone). Review of the resident's nursing note dated 11/24/24 at 8:12 A.M., showed Rapid COVID test positive for COVID. Review of the resident's nursing note dated 11/24/24 at 8:15 A.M., showed the resident was placed in isolation for COVID precautions. Observation on 11/26/24 at 8:00 A.M., showed the following: -There was a three-drawer cart sitting outside of the resident's room with gloves, gowns, N95 masks, surgical masks, and shoe covers; -There was no signage posted on the resident's door or wall by his/her door stating what precautions to take before entering his/her room; -There was no sign posted to alert staff or visitors to check with the nurse before entering the room. During an interview on 11/26/24 at 8:45 A.M., Licensed Practical Nurse (LPN) C said the following: -He/She found out yesterday the resident tested positive for COVID-19 on 11/24/24; -The resident had wheezes (high pitched, musical sound that occurs when air passes through narrowed or blocked airways in the lungs) in his/her lungs and a cough. During an interview on 11/26/24 at 8:55 A.M., the Infection Control Nurse said the following: -He/She received information through a text that the resident tested positive for COVID-19 over the weekend (11//23/24 or 11/24/24), he/she thought the resident was symptomatic, but wasn't sure; -He/She had been working the floor and didn't get signage posted at the entrance alerting visitors that there was COVID in the building or signage on the resident's door alerting visitors to check with the nurses before entering the room. During an interview on 11/26/24 at 2:15 P.M., the Director of Nursing said the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She worked on 11/24/24, the resident showed symptoms of COVID-19 and had a cough. She completed a rapid response COVID-19 test on the resident and it indicated the resident was positive; -She would expect the facility to post signage alerting staff and visitors of a COVID-19 outbreak in the facility at the entrance of the facility; -She did alert all staff working that the resident tested positive; -She would expect the facility to post signage notifying staff and visitors of precautions required upon entering a COVID-19 positive room. During an interview on 11/26/24 at 1:00 P.M., the Administrator said he would expect the facility to follow their policy regarding COVID-19.