

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Bellevue Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Bellevue, MO 63623	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48532 Based on observation and interview, the facility failed to protect residents' right to privacy by not ensuring other residents did not enter the shower room during showers. This affected three residents (Residents #57, #64, and #51) out of 20 sampled residents and five additional residents (Residents #8, #21, #29, #79, and #85). The facility census was 96. The facility did not provide a policy regarding protection of privacy during bathing. Observation on 04/09/24 at 11:00 A.M., of the women's shower room showed: - The toilet located in the front of the room and to the left of the door with a curtain; - The shower in the back of the room to the right and facing the door with a curtain. Observation on 04/15/24 at 2:09 P.M., showed: - Resident #85 entered the shower room a few minutes prior; - The running water from the shower could be heard outside the door; - Without knocking, Resident #21 entered the shower room; - A Certified Nurse Assistant (CNA) cracked open the shower room door and said Resident #85 was showering and Resident #21 was using the toilet. During an interview on 04/09/24 at 9:31 A.M., Resident #8 said his/her only concern was the lack of privacy during a shower. Other residents just walked right in and used the toilet while he/she was in the shower. During an interview on 04/09/24 at 8:49 A.M., Resident #29 said he/she did not think it was right that other people came in the bathroom and used the toilet while he/she was in the shower. During an interview on 04/09/24 at 9:35 A.M., Resident #79 said he/she really didn't like people coming in when he/she was in the shower. They didn't knock, came in, and used the toilet. (continued on next page)		

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/11/24 at 4:32 P.M., Resident #64 said he/she required assistance with showers. Every time he/she took a shower, another resident always walked in and usually used the toilet. That bothered him/her. He/She preferred people not walk in during his/her shower. The shower rooms were not private like they should be. During an interview on 04/11/24 at 4:39 P.M., Resident #51 said he/she showered independently. The resident said every time the resident showered, another resident always walked in, without knocking. Then that resident usually used the toilet. During an interview on 04/15/24 at 12:50 P.M., Resident #57 said he/she showered without assistance. He/She said someone always walked in while he/she was in the shower without knocking. There were curtains around the shower and the toilet. Other residents always opened the curtain during his/her shower. During an interview on 04/15/24 at 1:15 P.M., CNA B said he/she had been in the shower room a few times assisting residents with a shower and another resident just walked in. He/She called out that someone was in there, but the other residents just walked on in, most of the time to use the toilet. The residents had shared restrooms, but some just wanted to use the toilet in the shower room. During an interview on 04/15/24 at 1:22 P.M., CNA C said some residents knocked and some just walked on in. He/She tried to stop them, but most of the time they just came in and used the toilet. During an interview on 04/11/24 at 2:58 P.M., the Assistant Director of Nursing (ADON) said he/she was unaware of any concerns with privacy during showering. It hadn't been mentioned. During an interview on 04/11/24 at 2:59 P.M., the Administrator said she had not heard of concerns regarding residents walking in on each other in the shower room. They would have to come up with a plan to fix it.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview and record review, the facility failed to evaluate and provide an assistive device to adequately meet the needs of one resident (Resident #13) out of three sampled residents. The facility census was 96. The facility failed to provide a policy regarding assistive devices. 1. Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility staff, dated 01/20/24, showed: - An admitted [DATE]; - Diagnoses of a stroke affecting the left non-dominant side and hemiplegia (paralysis on one side of the body); - Impairment to one side in the upper and lower extremities; - Substantial to maximal assistance for all additional activities of daily living; - Used a wheelchair. Observations showed: - On 04/09/24 at 11:59 A.M. and 04/10/24 at 12:07 P.M., the resident sat in a large 20 inch (in.) wheelchair with a thick concave pad on top of the left wheelchair armrest in the dining room. The resident's left arm sat on the concave pad which raised his/her left shoulder to the bottom of his/her left ear lobe; - On 04/11/24 at 3:05 P.M., the resident sat in a 18 in. wheelchair with a thick concave pad on top of the left wheelchair armrest outside in the smoking area. The resident's left arm sat on the concave pad which raised his/her left shoulder to the bottom of his/her left ear lobe; - On 04/12/24 at 9:32 A.M. and 04/15/24 at 1:15 P.M., the resident sat in an 18 in. wheelchair with a thick concave pad on top of the left wheelchair armrest in the hallway. The resident's left arm sat on the concave pad which raised his/her left shoulder to the bottom of his/her left ear lobe. During an interview on 04/12/24 at 9:32 A.M., Resident #13 said keeping his/her arm in that position was uncomfortable and hurt. During an interview on 4/11/24 at 4:12 P.M., the Assistant Director of Nursing (ADON) said hospice was switching out the resident's wheelchair for a different one. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/24 at 1:27 P.M., Restorative Aide (RA) I said the wheelchair was provided by hospice, so the facility staff was not able to work on it at all. RNA I was unsure if the facility would provide a different one if hospice was unable to get one that worked. He/She said the pad on the armrest raised the resident's left arm too high. The resident used to have one where the left arm sat lower, but it broke and hospice got the one the resident had now. During an interview on 04/15/24 at 1:55 P.M., the Administrator said hospice was coming again today to evaluate the resident for a wheelchair. If they were unable to provide one that fit the resident, it was ultimately the facility's responsibility to provide one. During an interview on 04/16/24 at 2:59 P.M., the Medical Director said he/she would expect the resident to have a chair that suited and protected the resident as well as it could.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on interview and record review, the facility failed to consistently document a code status for two residents (Residents #37 and #89) out of 20 sampled residents. The facility census was 96. The facility did not provide a policy regarding a resident's code status. 1. Review of Resident #37's medical record showed: - An admitted [DATE]; - A Nurse's Note, dated [DATE], showed the resident admitted to hospice on [DATE]; - The facesheet, dated [DATE], showed a full code (if a person's heart stopped beating and/or they stopped breathing, cardiopulmonary resuscitation (CPR) procedures would be provided) status; - The Physician's Order Sheet (POS), dated [DATE], showed a full code status; - A Do Not Resuscitate (DNR - does not want CPR) form signed by the resident and responsible party on [DATE], and signed by the physician on [DATE]. 2. Review of Resident 89's medical record showed: - An admitted [DATE]; - The revised care plan, dated [DATE], showed a DNR status; - The POS, dated [DATE], showed a full code status. During an interview on [DATE] at 1:00 P.M., Resident #89 said he/she wanted to be a full code and the paperwork was signed for a full code. A green tag to indicate he/she was a full code, was placed on his/her door about a month ago. He/She originally requested a DNR status. During an interview on [DATE] at 1:47 P.M., the Assistant Director of Nursing (ADON) said the resident's room number and name sign had a colored dot that indicated the code status. A green dot meant a full code and a red dot meant a DNR. A resident's code status should be documented consistently throughout the medical record and the indicator dot should match what is in the chart. It was the Director of Nursing's (DON) responsibility to ensure all code status information matched, but the facility didn't have a DON right now. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:40 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said he/she would expect a resident's code status to be documented consistently throughout the resident's medical record. Resident #37 had just recently been admitted to hospice and that was the cause of his/her information not matching. It was the MDS Coordinator's responsibility to ensure the care plan was consistent with the code status and was missed. During an interview on [DATE] at 4:45 P.M., the Administrator said she would expect a resident's code status be documented consistently throughout the resident's medical record and the indicator dot should match what is in the chart. 46521		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46521 Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and failed to have the resident's Notice of Medicare Non-Coverage (NOMNC) signed by the resident representative for one resident (Resident #33) out of three sampled residents who remained in the facility when benefits were not exhausted. The facility's census was 96. The facility did not provide a SNF ABN and NOMNC policy. 1. Review of Resident #33's NOMNC showed: - The resident discharged from skilled services on 02/08/24, with skilled Medicare days remaining; - The resident remained in the facility; - The resident's representative provided verbal consent on 02/28/24, and the representative did not sign the NOMNC; - The facility failed to provide a SNF ABN to the resident and/or the resident representative. During an interview on 04/16/24 at 1:17 P.M., the Social Services Designee (SSD) said the SNF ABN and NOMNC forms should have been completed timely and signed appropriately. Being new to the SSD role had created a challenge and some forms were not completed. During an interview on 04/16/24 at 1:20 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said the SNF ABN and NOMNC forms should have been completed timely and signed appropriately. There have been staff changes that led to confusion with the forms and they did not get completed. During an interview on 04/16/24 at 1:59 P.M., the Administrator said she would expect the SNF ABN and NOMNC forms to be completed timely and signed appropriately. A change in personnel and management led to the forms not getting done. There was no SSD at the time the forms should have been given.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46521 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment. The facility census was 96. The facility did not provide a maintenance policy. Review of the facility's Maintenance Request Log, dated [DATE], showed: -No request made or completed after [DATE]; -No maintenance request made regarding a musty odor. 1. Observations on [DATE] at 9:30 A.M. and 1:43 P.M., [DATE] at 11:10 A.M., and [DATE] at 12:10 P.M., showed A and B Halls with a strong, unidentifiable musty odor. 2. Observations on [DATE] at 9:30 A.M., 9:43 A.M. and 9:55 A.M., showed: - Room A11 with grime and debris beneath four resident beds, a fan with excessive dust buildup, missing light fixture cover, and the door with a damaged surface near the door handle area; - Room A13 with missing drawer front on the wooden clothing cabinet; - Room A14 with grime and debris beneath two resident beds; - Room A17 with a missing drawer front on two wooden clothing cabinets; - [NAME] A Hall men's shower room with a hole in the wall about 1 foot (ft) by 1ft and the shower stall floor with a damaged coated surface; - East A Hall men's shower room stall floor with separated caulking bead in the corner where the wall and floor meet. During an interview on [DATE] at 9:30 A.M., the resident in room A11 said he/she had not seen staff clean his/her room. Cleaning was mainly done in the halls. During an interview on [DATE] at 9:40 A.M., the resident in room A14 said he/she cleaned under his/her own bed, but staff came in and tidied up the room sometimes. During an interview on [DATE] at 9:43 A.M., the resident in room A17 said there was a missing drawer face on his/her cabinet, and it needed to be fixed. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:32 A.M., Certified Nurse Aide (CNA) L said he/she cleaned the male resident rooms every two hours while on shift but did not clean under the beds. The housekeepers should do that. 3. Observation on [DATE] at 12:26 P.M., of the A and B Hall dining room showed a missing wooden cabinet door and drawer front behind the steam table. 4. Observation on [DATE] at 12:14 P.M., of the A Hall nurses' office showed a four ft piece of missing vinyl baseboard with a black substance below the window. During an interview on [DATE] at 11:10 A.M., the Housekeeping Supervisor said housekeepers were expected to report damage and work order forms were kept up in the front office. There were problems with mice and roaches in the facility. They were worse if the areas were not kept clean. Residents were known to put food in the drawers also, so rooms were expected to be checked daily as well as the halls. There was an odor in the halls due to the residents throwing their dirty clothes and briefs in the closets sometimes. During an interview on [DATE] at 11:15 A.M., Housekeeper J said maintenance should be notified if there were problems in the resident rooms or other parts of the facility. He/she told maintenance directly or filled out paperwork when damage was noticed in resident rooms. During an interview on [DATE] at 4:30 P.M., the Interim Maintenance Director said there was a process in place for staff to turn in maintenance requests. They were placed in the maintenance door and turned into the office up front. There was no logbook available because the past Maintenance Director took care of that. Maintenance should repair walls because they should be free of damage. Doors and furniture should be in good repair. During an interview on [DATE] at 11:51 A.M., Licensed Practical Nurse (LPN) A said damage was usually reported to maintenance verbally. There were also work order forms to fill out and issues were addressed. The facility should not smell bad and be kept in good repair. During an interview on [DATE] at 1:59 P.M., the Administrator said problems were to be reported by staff using maintenance request forms. The Interim Maintenance Director would address and fix the problems. Corporate also had a maintenance log kept in a file folder. There should not be a body odor or other smells throughout the halls of the facility. Better cleaning methods could be put in place. The building and furniture should be kept in good repair.		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility staff failed to ensure residents were free from abuse when the maintenance supervisor (MS) grabbed the arm and wrist of one resident (Resident #91) out of 20 sampled residents. The resident had a history of mental health support needs, including behavioral problems. During a behavioral episode, the MS grabbed the resident's arms/wrists and struggled to physically restrain the resident which resulted in bruising to the resident's right upper arm. The facility failed to take appropriate steps to protect the resident from additional abuse and allowed the MS to continue to work around the residents. The facility census was 96. The administrator was notified on 04/09/24 at 9:50 A.M., of an Immediate Jeopardy (IJ) which began on 04/03/24. The IJ was removed on 04/10/24, as confirmed by surveyor onsite verification. Review of the facility's policy titled, Abuse, undated, showed: - Ensure that each resident is free from abuse; - Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish; - Staff members will observe for possible indicators of abuse; - Every staff member must immediately report any observed or suspected abuse of a resident; - The Director of Nursing (DON) will ensure all alleged violations are reported immediately, but not later than two hours after the allegation if the events alleged involve abuse or result in serious bodily injury; - The facility will ensure that all alleged violations are thoroughly investigated; - To protect the residents during the abuse investigation, the DON and/or Administrator will reassign or suspend the involved employee at their discretion. Review of Resident #91's medical record showed: - admitted on [DATE]; - Diagnoses of post traumatic stress disorder ((PTSD - a mental health condition triggered by a terrifying event), autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships), oppositional defiant disorder (a disorder marked by defiant and disobedient behavior to authority figures), disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, and attention deficit hyperactive disorder (ADHD - a chronic condition including attention difficulty, hyperactivity and impulsiveness). (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's care plan, updated 03/22/24, showed: - Behavioral problems (history of manipulation, aggression, aggressive toward others); - Intervene as necessary to protect the rights and safety of others; - Approach/speak in a calm manner and divert attention; - Potential to be physically aggressive; - When resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation; - If response is aggressive, staff is to walk calmly away and approach later. Review of the resident's progress notes showed: - Nurse's note, created on 04/04/24 at 10:09 P.M., showed on 04/03/24 at 7:20 A.M., this nurse was at the B hall nurse's station when he/she heard yelling near the dining area. As he/she walked toward the dining area, the resident was blocking the path of the medication cart and yelling at Certified Medication Technician (CMT) E; - No additional documentation related to the resident/staff incident on 04/03/24; - On 04/10/24 at 2:26 P.M., documentation showed a skin evaluation was completed with bruising to the back of the right arm, yellow to green in color, three centimeter (cm) x four cm. Review of the Administrative Investigation Form, completed on 04/04/24 at 10:30 A.M., showed: - Resident #91 as the involved resident in an allegation of abuse; - The Assistant Director of Nursing (ADON) notified the Administrator that a resident said a staff member grabbed him/her by the arm. The Administrator instructed the ADON to watch the camera system, gather statements and have a full body assessment done on the resident; - The ADON reported he/she watched the camera and there was no indication staff grabbed the resident. Nurse's notes stated no skin issues and did not note bruising; - The form indicated the State Agency was not contacted; - The form had no signature of who completed the investigation; - The Administrator signed the form on 04/09/24. Review of the Administrative Investigation Form, completed on 04/09/24, showed: - Follow up from the event 04/04/24, involving Resident #91 and Staff MS; (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 7:23:52 A.M., Resident #91 shoved the MS away from the medication cart and the MS stumbled. The MS immediately turned toward Resident #91 and grabbed his/her right upper arm then right wrist. The MS continued to hold onto the resident's wrist until 7:24:06 A.M.; - At 7:24:19 A.M., the MS walked away. During an interview on 04/09/24 at 9:50 A.M., the resident said: - Last week, the resident was very upset and stood in the way of CMT E moving the medication cart; - The MS grabbed the resident by the arms and left a bruise; - He/she reported the incident to LPN F on the morning of 04/04/24; - On the morning of 04/04/24, the day after the incident, LPN F took a picture of the bruise; - No other staff had interviewed the resident other than LPN F on 04/04/24; - He/she didn't know if LPN F forgot to report it as he/she had not heard anything. Observation on 04/09/24 at 9:50 A.M., showed a large bruise on the back of Resident #91's upper right arm. During an interview on 04/10/24 at 3:59 P.M., CMT E said on 04/03/24, the resident was having behaviors and blocking the medication cart. The MS stepped in to assist in letting him/her move the cart. The resident then shoved the MS, and the MS turned and grabbed the resident's wrist. During an interview on 04/09/24 at 11:02 A.M., the MS said, I help with behaviors. I'm pretty good at de-escalating the situation. I can usually calm them down. The MS said on 04/03/24 at 7:20 A.M., the resident got loud and blocked CMT E from moving the medication cart. While assisting, the resident shoved the MS and the MS got a hold of the resident's wrists. The MS said he/she had never done anything like that before. During an interview on 04/09/24 at 11:30 A.M., Certified Nursing Assistant (CNA) G said on 04/03/24 at 7:20 A.M., he/she was bringing breakfast trays back to the kitchen and the resident was blocking CMT E from moving the medication cart and yelling. The MS was trying to block the resident and the resident shoved the MS. The MS turned and grabbed the resident's wrists. A kitchen worker was yelling at the MS to stop. During an interview on 04/09/24 at 11:39 A.M., the Assistant Dietary Manager (ADM) said on 04/03/24 at 7:20 A.M., the resident was blocking the CMT from moving the medication cart and staff tried to divert him/her. The MS stepped between the resident and the medication cart. The resident shoved the MS, and the MS turned and grabbed the resident's wrist. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/09/24 at 11:10 A.M., LPN H said on 04/03/24 at 7:20 A.M., he/she was at the nurse's station and heard yelling by the dining room. The resident blocked CMT E from moving the medication cart. There were a lot of people jumbled all around and someone yelled out to let him/her go. LPN H said there were too many people around to see anything. The ADON was not there, and they didn't have a DON. A staff member called and reported it to the ADON the next morning. If staff saw something that was out of line or questionable, they should intervene and notify the ADON or DON immediately. During an interview on 04/09/24 at 1:20 P.M., the ADON said the incident was reported to him/her on 04/04/24 at 10:29 A.M., via a text by LPN F. The ADON reported the incident to the Administrator. The ADON completed his/her part of the investigation by getting statements and viewing the video. He/She saw nothing on the video to make him/her feel like it was abuse or a reportable incident. He/She did not interview the resident or staff and did not assess the resident. During an interview on 04/09/24 at 2:32 P.M., the Administrator said her part of the investigation was the follow-up. The ADON had reviewed the video and informed the Administrator it did not show the MS put his/her hands on the resident. It was decided it was not a reportable incident. The Administrator said she honestly believed it did not occur. During an interview on 04/09/24 at 2:57 P.M., the ADON said he/she was the only person that reviewed the video and missed the part where the resident was grabbed by his/her upper arm. The ADON said the text from LPN F did contain a picture of the bruise on the resident's arm. The ADON did not document anything about it in the medical record and did not make an observation. During an interview on 04/16/24 at 02:59 P.M., the Medical Director (MD) said he had not been notified of the altercation, and was not aware an abusive situation had occurred between the resident and staff. The MD said he/she did not think the facility could adequately care for some of the resident's behaviors. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO235359		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility failed to notify the state survey agency regarding an allegation of staff to resident abuse when a staff member grabbed one resident (Resident #91) out of 20 sampled residents by the arm and wrist resulting in a bruise to the arm. The facility census was 96. Review of the facility policy titled, Abuse, undated, showed: - The facility will ensure each resident is free from abuse; - Every staff member must immediately report any observed abuse of a resident by another staff member, resident, family member, or visitor; - The Director of Nursing (DON) will ensure all alleged violations are reported immediately, but not later than 2 hours after the allegation is made if the events that caused the allegation involve abuse; - Report to the administrator of the facility and to other officials (including State Survey Agency and Adult Protective Services) not later than 24 hours if the event that causes the allegation did not involve abuse. 1. Review of Resident #91's medical record showed: - admitted on [DATE]; - Diagnoses of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships), oppositional defiant disorder (a disorder marked by defiant and disobedient behavior to authority figures), disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, and attention deficit hyperactive disorder (ADHD - a chronic condition including attention difficulty, hyperactivity and impulsiveness); - A nurses note created on 04/04/24 at 10:09 P.M., (regarding the 04/03/24 incident), showed this nurse was at the B Hall nurse's station when he/she heard yelling near the dining area. As he/she walked toward the dining area, the resident was observed blocking the path of the medication cart and yelling at Certified Medication Technician (CMT) E; - No additional documentation related to the incident on 04/03/24; - Skin evaluation completed on 04/10/24 at 2:26 P.M., showed bruising noted to the back of the right arm, yellow to green in color, three centimeter (cm) x four cm. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Administrative Investigation Form, completed on 04/04/24 at 10:30 A.M., showed: - On 04/04/24, the Assistant Director of Nursing (ADON) notified the Administrator she had been notified by Licensed Practical Nurse (LPN) F that Resident #91 had made an allegation the Maintenance Supervisor (MS) had grabbed him/her by the arm, on 04/03/24 around 07:30 A.M.; - The ADON was instructed to watch the camera system, gather statements and have a full body assessment of the resident completed; - The ADON reported to the Administrator that she watched the camera and there was no indication the MS grabbed the resident; - No report made to the state agency. During an interview on 04/09/24 at 9:50 A.M., the resident said: - Last week, the resident was very upset and stood in the way of CMT E moving the medication cart; - The MS grabbed the resident by the arms and left a bruise; - He/she reported the incident to LPN F the next morning; - LPN F took a picture of the bruise on 04/04/24, the day after the incident occurred on 04/03/24; - He/she didn't know if LPN F forgot to report it as he/she had not heard anything. Observation on 04/09/24 at 9:50 A.M., showed a large bruise on the back of the resident's right upper arm. During an interview on 04/09/24 at 1:20 P.M., the ADON said the incident was reported to her on 04/04/24 at 10:29 A.M., by text from LPN F. The ADON then reported it to the Administrator. The ADON said she completed the investigation, got staff statements, viewed the video, and nothing was seen to make her feel like it was abuse or a reportable incident. The ADON said she did not interview the staff or resident, or complete a skin assessment. The ADON did not report it to the state agency. During an interview on 04/09/24 at 2:57 P.M., the ADON said she did receive a text containing a picture of a bruise from LPN F when the incident was reported on 04/04/24. During an interview on 04/09/24 at 2:32 P.M., the Administrator said the ADON reported the incident to her on 04/04/24 at 10:30 A.M., by text. She he would expect an investigation to begin immediately, be followed with a determination if the incident was abuse, and her part would be the follow-up. She did not view the video, the ADON reported to her that it did not show the MS put his/her hands on the resident but staff interviews showed the MS grabbed the resident by the wrists after being pushed. She honestly believed it didn't happen and it was decided it was not a reportable incident. She said the incident should have been reported to the state agency.		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to thoroughly investigate an allegation of staff to resident abuse and failed to implement interventions to prevent further abuse from occurring for one resident (Resident #91) out of 20 sampled residents after the Maintenance Supervisor (MS) grabbed the resident's arm and wrist in a restraining manner that resulted in a physical struggle and bruising to the resident's right upper arm. The facility also failed to follow their policy, resulting in the MS continuing to work around the resident. The facility census was 96. The administrator was notified on 04/09/24 at 9:50 A.M. of an Immediate Jeopardy (IJ) which began on 04/03/24. The IJ was removed on 04/10/24, as confirmed by surveyor onsite verification. Review of the facility's abuse policy, undated, showed: - Ensure that each resident is free from abuse; - Abuse- the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish; - Staff members will observe for possible indicators of abuse; - Every staff member must immediately report any observed or suspected abuse of a resident; - The Director of Nursing (DON) will ensure all alleged violations are reported immediately, but not later than two hours after the allegation if the events alleged involve abuse or result in serious bodily injury; - The facility will ensure that all alleged violations are thoroughly investigated; - To protect the residents during the abuse investigation, the DON and/or Administrator will reassign or suspend the involved employee at their discretion. Review of Resident #91's medical record showed: - admitted on [DATE]; - Diagnoses of Post-Traumatic Stress Disorder ((PTSD) a mental health condition triggered by a terrifying event), autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships), oppositional defiant disorder (a disorder marked by defiant and disobedient behavior to authority figures), disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, attention deficit hyperactive disorder (a chronic condition including attention difficulty, hyperactivity and impulsiveness). Review of the resident's care plan, updated 03/22/24, showed: (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #91 has behavioral problems (history of manipulation, aggression, aggressive toward others); - Intervene as necessary to protect the rights and safety of others; - Approach/speak in a calm manner; divert attention; - Resident #91 has potential to be physically aggressive; - When resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation; - If response is aggressive, staff is to walk calmly away and approach later. Review of the resident's progress notes showed: - Weekly skin assessment completed on 04/03/24 at 2:51 P.M., showed no skin issues; - Nurse's note created on 04/04/24 at 10:09 P.M., (regarding incident on 04/03/24), showed this nurse was at the B hall nurse's station when he/she heard yelling near the dining area. As he/she walked toward the dining area, the resident was blocking the path of the medication cart and yelling at Certified Medication Technician (CMT) E; - Skin evaluation completed on 04/10/24 at 2:26 P.M., with bruising noted to back of right arm, yellow to green in color, three centimeter (cm) x four cm. Review of the Administrative Investigation Form, completed on 04/04/24 at 10:30 A.M., showed: - Resident #91 as the involved resident in an allegation of abuse; - The Assistant Director of Nurses (ADON) notified Administrator that a resident stated a staff member grabbed him/her by the arm. Administrator instructed ADON to watch the camera system, gather statements and have a full body assessment done on the resident; - The ADON reported that he/she watched the camera and that there was no indication staff grabbed the resident. Nurse's notes stated no skin issues, did not note bruising; - The form indicated the State Agency was not contacted; - The form had no signature of who completed the investigation; - The Administrator signed the form on 04/09/24. Review of the Administrative Investigation Form, completed on 04/09/24, showed: - Follow up from event 04/04/24 involving Resident #91 and staff MS; (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The Administrator watched the camera system footage and noted MS did grab Resident #91's arms. MS suspended pending investigation; - The MS's employment was terminated effective immediately; - The Administrator signed the form on 04/10/24. Review of the facility payroll detail for the period of 04/01/24-04/30/24 showed the MS worked the following dates: - 04/03/24; - 04/04/24; - 04/05/24; - 04/08/24; - 04/09/24. Observation on 04/09/24 at 1:00 P.M., of the facility security camera footage, dated 04/03/24, showed: - At 7:22 A.M., CMT E and Resident #91 walked out of the dining room. CMT E pushed the medication cart down the hall as Resident #91 walked alongside the cart; - At 7:23:04 A.M., Resident #91 hurriedly walked in front of the medication cart and blocked movement of the cart. CMT E attempted to move the cart a couple of times then pushed the cart against the wall. CMT E stood next to Resident #91 talking; - At 7:23:13 A.M., LPN H approached CMT E and Resident #1 and walked away at 7:23:40; - At 7:23:30 A.M., MS approached and stood to the right of Resident #91; - At 7:23:45 A.M., MS walked to the left side of Resident #91 as other staff approached. CMT E moved the medication cart away from the wall, and as he/she turned the cart the MS stepped in between the medication cart and Resident #91; - At 7:23:52 A.M., Resident #91 shoved the MS away from the medication cart and MS stumbled. The MS immediately turned toward Resident #91 and grabbed his/her right upper arm then right wrist. MS continued to hold onto the resident's wrist until 7:24:06 A.M.; - At 7:24:19 A.M., MS walked away. During an interview on 04/09/24 at 9:50 A.M., the resident said: - Last week, the resident was very upset and stood in the way of the CMT E moving the medication cart; (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- MS grabbed the resident by the arms and left a bruise; - He/she said it was reported to Licensed Practical Nurse (LPN) F the next morning; - The resident stated a picture was taken of the bruise; - The resident said he/she didn't know if LPN F forgot to report it as he/she had not heard anything. Observation on 04/09/24 at 9:50 A.M., showed a large bruise on the back of Resident #91's upper right arm. During an interview on 04/09/24 at 11:02 A.M., the MS said, I help with behaviors. I'm pretty good at deescalating the situation. I can usually calm them down. The MS said on 04/03/24 around 7:20 A.M., the resident got loud and blocked CMT E from moving the medication cart. While assisting, the resident shoved the MS and the MS got a hold of the resident's wrists. The MS said he/she had never done anything like that before. During an interview on 04/10/24 at 3:59 P.M., CMT E said on 04/03/24 around 7:20 A.M., the resident was having behaviors and blocking the medication cart. The MS stepped in to assist in letting him/her move the cart. The resident then shoved the MS, and the MS turned and grabbed the resident's wrist. The MS usually has a good rapport with the residents and that is the only time he/she had witnessed him/her get a hold of a resident. CMT E told LPN H about the incident afterwards. On 04/04/24 the ADON asked CMT E to write a statement, he/she wrote the statement and sent it by text on 04/04/24 at 01:04 P.M. CMT E said he/she was not interviewed, just asked to write a statement. During an interview on 04/09/24 at 11:10 A.M., LPN H said on 04/03/24 around 7:20 A.M., he/she was at the nurse's station and heard yelling by the dining room. The resident blocked CMT E from moving the medication cart. There were a lot of people jumbled all around and someone yelled out let him/her go. LPN H said there were too many people around to see anything. The ADON was not there, and they don't have a DON. A staff member called and reported it to the ADON the next morning. If staff sees something that is out of line or questionable, they should intervene and notify the ADON or DON. LPN H did not report the incident to the ADON or Administrator or initiate an investigation. During an interview on 04/09/24 at 11:30 A.M., Certified Nursing Assistant (CNA) G, said he/she was bringing breakfast trays back to the kitchen on 04/03/24 around 7:20 A.M., and the resident was blocking CMT E from moving the medication cart and yelling. The MS was trying to block the resident and the resident shoved the MS. The MS turned and grabbed the resident's wrists. A kitchen worker was yelling at the MS to stop. CNA G didn't report the incident to anyone. During an interview on 04/09/24 at 11:39 A.M., the Assistant Dietary Manager (ADM) said on 04/03/24 around 7:20 A.M., the resident was blocking the CMT from moving the medication cart and staff was trying to divert him/her. The MS stepped between the resident and the medication cart. The resident shoved the MS, and the MS turned and grabbed the resident's wrist. The ADM didn't report anything because there were a lot of people and didn't really see anything that needed reported or investigated. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/09/24 at 1:20 P.M., the ADON said the incident was reported to him/her on 04/04/24 at 10:29 A.M., (over 24 hours after the incident occurred) via a text by LPN F. The ADON reported it to the Administrator. The ADON completed his/her part of the investigation by getting statements and viewing the video. The ADON said he/she saw nothing on the video to make him/her feel like it was abuse or a reportable incident. The ADON said he/she did not interview the resident or staff and did not assess the resident. During an interview on 04/09/24 at 2:32 P.M., the Administrator said her part of the investigation was the follow-up and she did not interview the resident. An investigation should be started immediately and followed with a determination of abuse or no abuse. The ADON had reviewed the video and informed the administrator it did not show the MS put his/her hands on the resident. It was decided it was not a reportable incident. The Administrator said she honestly believed it did not occur. However, the staff statements showed the MS grabbed the resident's wrists after he/she pushed the MS. During an interview on 04/09/24 at 2:57 P.M., the ADON said he/she was the only person that reviewed the video and missed the part where the resident was grabbed on the upper arm. The ADON said the text from LPN F did contain a picture of the bruise on the resident's arm. The ADON did not document anything about it in the medical chart and did not make an observation. During an interview on 04/16/24 at 02:59 P.M., the Medical Director (MD) said he was not aware an abusive situation had occurred between the resident and staff. The MD said he did not think the facility could adequately care for some of the resident's behaviors. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO235359		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to notify a representative of the office of the Missouri State Long-Term Care Ombudsman (an advocate for residents in a long-term care facility) and the resident and/or the resident's representative in writing of a facility-initiated transfer when three residents (Residents #78, #91 and #97) out of seven sampled residents transferred to the hospital. The facility census was 96. The facility did not provide a facility-initiated transfer policy. 1. Review of Resident #78's medical record showed: - Resident transferred to the hospital for medical evaluation on 01/13/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications to the resident and/or the resident's representative of the resident's transfer to the hospital. 2. Review of Resident #91's medical record showed: - Resident transferred to the hospital for medical evaluation on 03/01/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications to the resident and/or the resident's representative of the resident's transfer to the hospital; - No documentation of notification to the Ombudsman's Office for the transfer. 3. Review of Resident #97's medical record showed: - Resident transferred to the hospital for medical evaluation and treatment on 01/30/24, and returned to the facility on [DATE]; 02/25/24, and returned on 02/26/24; 03/01/24, and returned on 03/02/24; and on 03/07/24, and did not return; - No documentation of the written notifications to the resident and/or the resident's representative of the resident's transfers to the hospital on 01/30/24, 03/01/24, and 03/07/24; - Transfer/Discharge Physician and Guardian Notification form, dated 2/25/24, showed the contact method of the medical director not selected, the guardian was contacted by a message left, and signed by the nurse; - No documentation of the notification to the Ombudsman's Office for the transfers on 02/25/24, 03/01/24, and 03/07/24. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/24 at 4:15 P.M., the Social Service Designee (SSD), said the nurse was supposed to fill out the transfer/discharge and bed hold paper, and fax it to the guardians. He/She did not follow up on them and did not mail them. During an interview on 04/15/24 at 4:15 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said it previously had been the Director of Nursing (DON) who would follow up, but they no longer had a DON. He/She emailed the transfer/discharge and bed holds to the guardians, but if the guardian was a family member, they probably didn't have an email address and they didn't get it mailed. During an interview on 04/15/24 at 5:21 P.M., Licensed Practical Nurse (LPN) A said the nurses did the transfer/discharge and bed hold notice. After it was completed, they faxed it to the guardian. The SSD would be the one to follow up on the form since it was turned into him/her. During an interview on 04/16/24 at 11:51 A.M., LPN A said the transfer and discharge checklists were completed by the nursing staff and sent on to the DON and SSD. Notifications should be sent by the SSD for the Ombudsman, the resident, and the guardian. During an interview on 4/16/24 at 1:15 P.M., the SSD said nursing sent the checklist for bed holds and transfer/discharge notices when residents were sent out of the facility. Transfer and discharge notices should be sent when a resident transferred out to the hospital. During an interview on 04/16/24 at 2:00 P.M., the Administrator said she would expect transfer/discharge forms to be issued and signed when a resident transferred out to the hospital. 46521 47445		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47445 Based on interview and record review, the facility failed to provide written notification of their bed-hold policy to residents and/or their representatives at the time of transfer for three residents (Resident #78, #91, and #97) of seven sampled residents. The facility census was 96. 1. Review of Resident #78's medical record showed: - admitted [DATE]; - Resident transferred to the hospital on 01/13/24, and readmitted to the facility on [DATE]; - No written documentation of the notification for the bed hold policy provided to the resident and/or the resident's responsible party. 2. Review of Resident #91's medical record showed: - admitted [DATE]; - Resident transferred to the hospital on 03/01/24, and readmitted to the facility on [DATE]; - No written documentation of the notification for the bed hold policy provided to the resident and/or the resident's responsible party. 3. Review of Resident #97's medical record showed: - admitted [DATE]; - Resident transferred to the hospital on 01/30/24, and returned to the facility on [DATE]; - Resident transferred to the hospital on 03/01/24, and returned to the facility on [DATE]; - Resident transferred to the hospital on 03/07/24, and did not return to the facility; - No documentation of the notification for the bed hold policy provided to the resident and/or the resident's representative for transfers on 01/30/24, 03/01/24, and 03/07/24. During an interview on 04/15/24 at 4:15 P.M., the Social Service Designee (SSD) said the nurse was supposed to fill out the bed hold paperwork and fax it to the guardians. The SSD got the paperwork from the nurses and filed them. He/She did not follow up on the notifications and did not mail them out. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/24 at 4:15 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said it previously had been the Director of Nursing (DON) who followed up on the bed holds, but they no longer had a DON. He/She emailed the transfer/discharge and bed hold paperwork to the guardians. During an interview on 04/15/24 at 5:21 P.M., Licensed Practical Nurse (LPN) A said the nurse was responsible for the transfer/discharge and bed hold notices. During an interview on 04/16/24 at 2:00 P.M., the Administrator said she would expect the bed hold notification to be issued and signed when a resident transferred to the hospital.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview and record review, the facility failed to develop and implement an individualized comprehensive care plan with specific interventions for six residents (Residents #3, #13, #57, #59, #61, and #68) out of 20 sampled residents and one resident (Resident #20) outside of the sample. The facility's census was 96. The facility did not provide a care plan policy. Review of the facility's policy titled, Smoking, undated, showed: - The supervising staff member will notify the unit nurse when a resident's ability to smoke safely is in question; - On admission, the unit nurse will ascertain the resident's wishes about smoking and respect the resident's decision; - Assess the resident's ability to smoke safely by completing a smoking assessment that includes an evaluation of the resident's safety awareness, judgement, cognitive ability, and manual dexterity; - Instruct staff members to notify the unit nurse immediately if it is suspected the resident has violated the facility smoking policy or if the resident's clothing or skin has signs of cigarette burns; - The Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Nurse will evaluate each resident who smokes for smoking safety with every MDS assessment, and document the resident's need for supervision in the care plan, and update with any change in the resident's capabilities and needs. 1. Review of Resident #3's medical record showed: - admitted on [DATE]; - Diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone or posture) and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and other mental function). Review of the resident's significant change MDS, dated [DATE], showed: - Severe cognitive impairment; - Impairment to both sides of the upper and lower extremities; - Dependent for bed mobility; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Bed rails not used. Observations of the resident showed: - On 04/09/24 at 04:16 P.M., 04/10/24 at 9:31 A.M., and 1:12 P.M., the resident lay in a low bed with a fall mat in the floor and the upper 1/2 bed rails in the raised position on both sides of the bed; - On 04/10/24 at 2:51 P.M., 04/11/24 at 9:12 P.M., 04/12/24 at 9:42 A.M., and 04/15/24 at 1:15 P.M., the resident lay in a low bed with a fall mat in the floor and the upper right 1/2 bed rail in the raised position on the left side of the bed against the wall. Review of the resident's care plan, dated 01/03/24, showed it did not address the use of bed rails. 2. Review of Resident #13's medical record showed: - admitted on [DATE]; - Diagnoses of stroke affecting the left non-dominant side and hemiplegia (paralysis on one side of the body). Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Impairment to the left upper and both sides of lower extremities; - Dependent for putting on and removing foot wear; - Substantial to maximal (helper does more than half) assistance for all additional activities of daily living; - Bed rails not used. Observations of the resident showed: - On 04/09/24 at 4:19 P.M., and 04/10/24 at 2:57 P.M., the resident lay in a low bed with the upper 1/4 bed rails in the raised position on both sides of the bed; - On 04/10/24 at 9:27 A.M., the resident sat on the bedside, with the left upper 1/4 bed rail in the raised position to the left side of the resident and the upper 1/4 bed rail in the raised position on the right side of the bed. Review of the resident's care plan, dated 04/14/24, showed it did not address the use of bed rails. 3. Review of Resident #20's medical record showed: - admitted on [DATE]; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnosis of Huntington's Disease (a rare inherited disease causing progressive breakdown of brain nerve cells, having an impact on functional abilities, usually resulting in movement, cognitive and psychiatric disorders). Review of the resident's significant change MDS, dated [DATE], showed: - Severe cognitive impairment; - Impairment to both sides in the upper and lower extremities; - Dependent on bed mobility; - Bed rails times two used daily. Observations of the resident showed on 04/10/24 at 1:12 P.M., and 2:54 P.M., and 04/15/24 at 1:15 P.M., the resident lay in a low bed with a fall mat in the floor and the left upper 1/2 bed rail in the raised position on the wall side of the bed; Review of the resident's care plan, dated 01/15/24, showed: - The resident with a bed rail to help with positioning and safety; - Did not address additional interventions. 4. Review of Resident #57's medical record showed: - admitted [DATE]; - Diagnoses of delusional disorders (a mental health condition which a person can't tell what's reality and imagined), major depressive disorder (MDD - persistently low mood), anxiety disorder, post traumatic stress disorder (PTSD - a disorder that occurs if a traumatic event has been witnessed or experienced), bipolar disorder (mental illness that causes unusual shifts in mood), and vascular dementia (impaired thought processes caused by impaired blood flow to the brain). Review of the resident's quarterly MDS, dated [DATE], showed a diagnosis of PTSD. Review of the resident's care plan, dated 3/11/24, showed it did not address the identification of the resident's triggers and specific interventions related to the PTSD diagnosis. 5. Review of Resident #59's medical record showed: - admitted [DATE]; - Diagnoses of encephalopathy (condition that causes brain dysfunction), PTSD, autistic disorder (developmental disability that caused by differences in the brain), impulse disorder (inability to control impulses and behaviors), personality disorder (behavior that deviates from accepted behavior), muscle weakness, and difficulty walking; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No smoking assessment completed. Review of the resident's significant change MDS, dated , 10/24/23, showed the resident used tobacco. Review of the resident's quarterly MDS, dated , 2/4/24, showed: - Diagnosis of PTSD; - Cognitively impaired. Review of the resident's Progress Notes, dated 2/6/24-3/28/24, showed the resident had falls on 2/6/24, 2/16/24, 3/4/24, and 3/28/24. Review of the resident's care plan, dated 2/2/24, showed: - Did not address the identification of the resident's triggers and specific interventions related to the PTSD diagnosis; - Did not address the tobacco use or the need for any protective devices while smoking; - Did not address the resident's fall risks or interventions for falls. 6. Review of Resident #61's medical record showed: - admitted on [DATE]; - Diagnoses of diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), congestive heart failure (CHF - an inability of the heart to pump sufficient blood flow to meet the body's needs), lumbago with sciatica (low back pain that shoots down the legs, sometimes even going all the way to the toes), neuropathy (a disease of the nerves causing tingling, burning or loss of sensation), suicidal ideations, generalized osteoarthritis (a type of arthritis marked by cartilage deterioration of joints and vertebrae), psychotic disorder with hallucinations, spinal stenosis(the narrowing of one or more spaces within the spinal canal), unsteadiness on feet, and shortness of breath. Review of the resident's Smoking Safety Evaluation, dated 02/20/23, showed: - Used tobacco; - Supervision required for all residents during designated smoking times; - Balance problems while sitting or standing. Review of the resident's admission MDS, dated [DATE], showed: - Moderately cognitively impaired; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Used tobacco. Review of the resident's care plan, dated 03/19/24, showed: - Did not address the resident used tobacco; - Did not address the resident's smoking safety; - Did not address any specific smoking interventions. Observations of the resident, showed on 04/10/24 at 1:40 P.M., 04/12/24 at 8:33 A.M. and 10:30 A.M., and on 04/15/24 at 1:30 P.M. and 1:42 P.M., the resident smoking outside in smoking area, without smoking apron, staff member present. Observations of the resident showed: - On 04/10/24 at 1:40 P.M., the resident sat on a rollator walker outside smoking a cigarette, and ash from the cigarette fell on resident's right pant leg, with staff member present. - On 04/12/24 at 8:33 A.M., the resident sat outside on the seat of the rollator walker smoking, tapped 1/2-inch ash off the cigarette with his/her finger, and ash fell down the right side of resident's jacket onto the right knee of his/her pants. The resident's jacket was noted to have 6 burn holes to the bottom right area, the resident held the cigarette in his/her right hand with first two fingers. There were 3 burn holes noted on the left wrist area of the left jacket arm. There was no protective apron in place. The resident rested his/her upper arms on the handle of the rollator, with his/her hands close together; - On 04/15/24 at 1:30 P. M., the resident was outside in the smoking area sitting on the rollator, smoking a cigarette, the resident's bilateral upper extremities on the handles of the rollator. The resident flicked the cigarette and ash blew back on the resident's leg and clothing. - On 04/15/24 at 1:42 P.M., the resident smoked a cigarette down to the butt, tapped the lit end of the butt with a fingertip when finished, and continued to smoke. The resident sat on the seat of the rollator with his/her back to the smoke aide at this time. 7. Review of Resident #68's medical record showed: - admitted [DATE]; - Diagnoses of Alzheimer's disease (progressive mental deterioration), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), CHF, peripheral vascular disease (PVD - a condition that causes partial or complete obstruction of blood flow), Parkinsonism (brain conditions that cause slowed movements, stiffness and tremors), MDD, shortness of breath, hypersomnia (a condition in which you feel extreme daytime sleepiness despite getting sleep that should be adequate, or more than adequate), disorientation, other symptoms and signs involving cognitive functions and awareness, hypertension (high blood pressure), anxiety disorder, dysphagia (difficulty swallowing), straining to urinate, and history of falling. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Substantial/Maximal assistance for toileting, hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene; - Partial/moderate assistance for upper body dressing; - Supervision or touching assistance for toilet transfer and tub/shower transfer; - Always incontinent of bowel and bladder. Review of the resident's care plan, dated 02/04/24, showed: - Did not address Activities of Daily Living (ADL's); - Did not address incontinence of bowel and bladder. During an interview on 04/15/24 at 11:02 A.M., the Administrator said she would expect bed rails to be addressed on the care plans. During a phone interview on 04/25/24 at 11:41 A.M., the Administrator said a resident's need for assistance with ADL's should be addressed on their care plan. She said smoking should also be addressed on the care plan. During a phone interview on 04/25/24 at 11:50 A.M., the Assistant Director of Nursing (ADON) said ADL's, such as toileting, dressing, bathing, feeding, transfer assistance, behaviors, and sometimes input and output of bowel and bladder should be addressed on the care plan. Smoking should also be addressed on the care plan. 47445 48532		

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility failed to follow physician's orders for three residents (Residents #37, #89 and #91) out of 20 sampled residents, and three residents (Resident #40, #43, and #50) outside of the sample. The facility census was 96. The facility did not provide a policy regarding following physician orders, medication administration or transporting residents. 1. Review of Resident #37's medical record showed: - Date of Admission 04/09/15; - Diagnoses of altered mental status, Alzheimer's (progressive mental deterioration) disease, schizoaffective (a condition characterized by abnormal thought processes and deregulated emotions) disorder, bipolar (a mental disorder that causes unusual shifts in mood) disorder, and generalized anxiety disorder (GAD - persistent worry and fear about everyday situations); - April 2024 Physician Order Sheet (POS) showed an order for Invega Sustenna (an antipsychotic medication) intramuscular (IM) suspension 234 milligram (mg)/1.5 milliliter (ml) IM every 28 days related to schizophrenia, dated 01/13/23. (next due date 04/16/24); - March 2024 Medication Administration Record (MAR) showed the Invega due and administered on 03/19/24; - April 2024 MAR showed the Invega due date and not administered on 04/16/24. 2. Review of Resident #40's medical record showed: - admitted [DATE]; - Diagnoses of schizoaffective disorder, GAD, unspecified psychosis (a mental disorder with a severe loss of contact with reality), and impulse disorder (a group of behavioral conditions that make it difficult to control your actions or reactions); - April 2024 POS showed an order for Invega Sustenna Suspension 234 mg/1.5 ml, IM every 28 days, related to schizoaffective disorder, dated 12/21/23; - March 2024 MAR showed Invega due and administered on 03/14/24; - April 2024 MAR showed Invega due and not administered on 04/11/24. 3. Review of Resident #43's medical record showed: - admitted [DATE]; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses of autistic (a developmental condition causing an inability to relate to everyday life and adjust socially) disorder, bipolar disorder, psychotic disorder (severe mental disorder that causes abnormal thinking and perceptions) with hallucinations (where you hear, see, smell, taste or feel things that appear to be real but only exist in your mind), mood (a mental health problem that primarily affects a person's emotional state) disorder due to known physiological condition, and severe intellectual disability (a term used when there are limits to a person's ability to learn at an expected level and function in daily life); - April 2024 POS showed an order for medroxyprogesterone acetate (a hormone used in males to treat hypersexual behavior or deviant sexual behavior) suspension 150 mg/ml IM every 28 days related to mood disorder due to known physiological condition, dated 02/18/23; - March 2024 MAR showed medroxyprogesterone due and administered on 03/16/24; - April 2024 MAR showed medroxyprogesterone due and not administered on 04/13/24. During an interview on 04/15/24 at 12:00 P.M., Licensed Practical Nurse (LPN) A said the medroxyprogesterone injection wasn't given on 04/13/24, as ordered for Resident #43 because it had to be ordered from the pharmacy. Resident #40's Invega injection was due on 04/11/24, but it wasn't in the building according to the MAR so it was not administered. When LPN A entered the facility today, injection medications were not given when they were due, they still sat in the medication cart. Since they were still in the cart and not administered to the residents, he/she changed the administration due dates on the MARs. During an interview on 4/15/24 at 1:30 P M., the Administrator and Assistant Director of Nursing (ADON) said if a medication injection was missed, the physician should be notified, it should be documented why the medication wasn't given, and a counsel form with the employee should be completed if needed. Medication administration dates could be changed with physician communication and orders to ensure it was within the timeframe. 4. Review of Resident #50's medical record showed: - admitted [DATE]; - Diagnoses of schizoaffective disorder, oppositional defiant (a type of disruptive behavior disorder) disorder, GAD, attention-deficit hyperactivity disorder (ADHD - behaviors marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development), mild intellectual disabilities, and intermittent explosive disorder (repeated, sudden bouts of impulsive, aggressive, violent behavior or angry verbal outbursts); - April 2024 POS showed an order for Haldol Decanoate solution 100 mg/ml IM 100 mg every 21 days related to schizoaffective disorder and bipolar disorder, dated 03/05/24; - March 2024 MAR showed Haldol administered on 03/25/24; - April 2024 MAR showed Haldol due and not administered on 04/15/24. Observation on 04/15/24 at 11:50 A.M., showed Haldol for Resident #50 not in the facility. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #91's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, autistic disorder, borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships), oppositional defiant disorder, disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, and ADHD. Review of the resident's Behavioral Health hospitalization Discharge Instructions, dated 03/07/24, showed: - An order to change Effexor XR 225 mg every morning for anxiety to Effexor ER 75 mg one capsule once a day in the morning; - An order to stop prazosin 1 mg capsule every morning for flash backs and anxiety. Review of the resident's March and April 2024 POS showed: - An order for Effexor (an antidepressant used to treat depression, and anxiety) extended release (ER) 225 mg every morning for anxiety, dated 02/15/23; - An order for prazosin (a blood pressure medication also used to treat symptoms of PTSD and associated nightmares) 1 mg capsule every morning for flash backs and anxiety, dated 02/25/24. - An order for Effexor XR 75 mg once a day in the morning, dated 03/07/24; - An order for the prazosin 1 mg every morning for flash backs and anxiety discontinued, dated 03/07/24. Review of the resident's March and April 2024 MAR showed: - No documentation of an order for Effexor XR 75 mg once a day in the morning, dated 03/07/24; - Effexor ER 225 mg every morning incorrectly administered for 40 doses for 03/08/24 - 04/16/24; - No documentation of an order for the prazosin 1 mg every morning discontinued, dated 03/07/24; - Prazosin 1 mg every morning incorrectly administered for 40 doses for 03/08/24 - 04/16/24. During an interview on 04/16/24 at 11:05 A.M., the Administrator said she would expect the most current medication orders to be clarified with the physician and be followed. During an interview on 04/16/24 at 12:04 A.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said nursing should go through all new orders and update with the changes. It was nursing's responsibility. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/24 at 12:44 P.M., the Psychiatric Nurse Practitioner said facility staff may have notified him/her about the medication changes on the discharge instructions, he/she was unsure. He/She would expect to be notified and should address any changes. 6. Review of Resident #89's medical record showed: - admitted [DATE]; - Diagnosis of chronic obstructive pulmonary disease (COPD - a condition that constricts the airways); - A Physician's Referral Order for a new patient appointment for a visit and an initial evaluation related to shortness of breath and possible diastolic heart disease (a condition in which your heart's main pumping chamber becomes stiff and unable to fill properly), dated 02/01/24. During an interview on 04/15/24 at 3:39 P.M., Resident #89 said he/she did not get taken to an appointment with the Cardiologist, (a physician who specializes in the study and treatment of heart diseases and heart abnormalities). The appointment had been scheduled for two months, for the date of 04/15/24. During an interview on 04/15/24 at 4:20 P.M., the Central Supply and Transport Assistant said the transportation scheduler failed to get a confirmation number when originally making the appointment with Medicaid transport for Resident #89. The appointment was missed today due to the mistake. The transportation scheduler made a call today to the physician to try and reschedule a new appointment. During an interview on 04/16/24 at 10:15 A.M., the Transportation Scheduler said Resident #89 had missed an appointment yesterday that should have been scheduled with Medicaid transport and a confirmation number was not received from Medicaid transport. A new appointment has now been scheduled for the resident on 05/16/24 at 11:30 A.M. During an interview on 04/16/24 at 11:51 A.M., Licensed Practical Nurse (LPN) A said residents had missed appointments before. The appointment was made with the Cardiologist for Resident #89 and there was no confirmation number received from Medicaid transport so the resident missed the appointment. The appointment was rescheduled for 05/16/24. During an interview on 04/16/24 at 1:01 P.M., the MDS Coordinator said Resident #89 had an appointment for a Cardiologist that was missed yesterday. The appointment was his/her first scheduled appointment when the referral was made, but it was missed due to an error during transporter set up. A confirmation number for the appointment should have been given but wasn't received. The resident should have been picked up for the appointment but with no confirmation number, Medicaid transport did not know the resident needed to be picked up from the facility. During an interview on 04/16/24 at 1:59 P.M., the Administrator said Resident #89 should have been taken to an appointment with the Cardiologist yesterday but wasn't. The transporter said he/she had scheduled Medicaid transport for the resident but was not able to provide the confirmation number. Medicaid transport was contacted but they did not have a confirmation number and didn't know to pick up the resident. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bellevue Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Bellevue, MO 63623	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/24 at 2:59 P.M., the Medical Director said if the residents had orders for specialty appointments, the appointments should be scheduled and the residents should be transported to the appointments. 45693 46521		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47445 Based on observation, interview, and record review, the facility failed to ensure all residents received assistance with activities of daily living (ADLs - dressing, grooming, bathing, eating, and toileting) when staff failed to provide one resident (Resident #68) out of three sampled residents assistance with showers and shaving. The facility census was 96. The facility did not provide a policy regarding ADLs or showers. 1. Review of Resident #68's medical record showed: - admitted on [DATE]; - Diagnoses of Alzheimer's disease (progressive mental deterioration) with late onset dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) with other behavioral disturbance, Parkinson's disease (a disease of the central nervous system that affects movement, often including tremors), major depressive disorder (long-term loss of pleasure or interest in life), shortness of breath, history of falling, anxiety disorder (persistent worry and fear about everyday situations), and other symptoms and signs involving cognitive functions and awareness. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 01/30/24, showed: - Severe cognitive impairment; - Substantial/maximal assistance required for toileting, hygiene, shower/bathe self, lower body dressing, and personal hygiene; - Partial/moderate assistance required for upper body dressing; - Supervision/touching assistance for toilet transfer, and tub/shower transfers; - Always incontinent of bowel and bladder. Review of the resident's care plan, dated 02/04/24, showed ADLs were not addressed. Review of the resident's shower schedule showed the resident scheduled for showers twice a week on Wednesdays and Saturdays. Review of the resident's shower sheets, dated 02/07/24 through 04/10/24, showed: - The resident did not receive a shower on 02/10/24, 02/14/24, and 02/24/24, with a total of three out of seven missed opportunities for a shower. The resident was not shaved on 02/07/24, 02/10/24, 02/14/24, 02/17/24, 02/21/24, 02/24/24, and 02/28/24, with a total of seven out of seven missed opportunities to shave the resident's face; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident did not receive a shower on 03/09/24, 03/13/24, 03/20/24, 03/27/24, and 03/30/24, with a total of five out of nine missed opportunities for a shower. The resident was not shaved on 03/02/24, 03/06/24, 03/09/24, 03/13/24, 03/16/24, 03/20/24, 03/27/24, and 03/30/24, with a total of eight out of nine missed opportunities to shave the resident's face; - The resident did not receive a shower on 04/03/24 and 04/06/24, with a total of two out of three missed opportunities for a shower. The resident was not shaved on 04/04/24, 04/06/24, and 04/10/24, with a total of three out of three missed opportunities to shave the resident's face; - The resident did not receive a shower for nine days between 02/07/24 and 02/16/24; did not receive a shower for eight days between 02/21/24 and 03/02/24; did not receive a shower for nine days between 03/06/24 and 03/16/24; and did not receive a shower for 17 days between 03/23/24 and 04/10/24. Observations and an interview of the resident showed: - On 04/09/24 at 9:31 A.M., the resident lay in bed with an unshaven face; - On 04/09/24 at 10:45 A.M., the resident lay in bed with hair disheveled and an unshaven face; - On 04/10/24 at 12:38 P.M., the resident sat at a table in the dining room with uncombed hair and an unshaven face; - On 04/12/24 at 10:55 A.M., the resident sat on the side of the bed with uncombed hair and an unshaven face; - On 04/15/24 at 2:16 P.M., the resident sat in his/her wheelchair with disheveled hair and an unshaven face. During an interview on 04/09/24 at 10:45 A.M., the resident said he/she showered as often as he/she could. During an interview on 04/15/24 at 2:00 P.M., Certified Nursing Assistant (CNA) D said the resident needed total help with showers and was supposed to get a shower at least two to three times a week. During an interview on 04/16/24 at 2:40 P.M., the MDS Coordinator said residents should have a shower at least twice a week. Residents were scheduled for showers two or three times a week, and some daily, depending on the resident's need. Shower schedules were at the nurse's station and in the CNA's plan of care. Restorative therapy set up the shower schedule. During a telephone interview on 04/25/24 at 11:41 A.M., the Administrator said residents should have a shower three times a week. She said shaving was up to the resident if they were able to make the decision, or with every shower if the resident was unable to make the decision. During a telephone interview on 04/25/24 at 11:50 A.M., the Assistant Director of Nursing (ADON) said depending on the resident's needs, showers should be given two to three times a week, with a minimum of two showers a week for each resident. Shaving was at the resident's request.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37575 Based on interview and record review, the facility failed to ensure four residents (Resident #3, #13, #20, and #37) out of four sampled residents receiving hospice (palliative care for the terminally ill with a life expectancy of six months or less) services had a complete hospice coordinated plan of care. The facility failed to ensure one resident (Resident #37) had any hospice care documentation. The facility census was 96. The facility did not provide a hospice policy. 1. Review of Resident #3's medical record showed: - admitted to hospice on 03/20/24; - No facility staff signatures for the coordinated plan of care. 2. Review of Resident #13's medical record showed: - admitted to hospice on 06/07/22; - No facility staff signatures for the coordinated plan of care. 3. Review of Resident #20's medical record showed: - admitted to hospice on 01/13/23; - No facility staff signatures for the coordinated plan of care. 4. Review of Resident #37's medical record showed: - An order for hospice to evaluate and treat, dated 03/15/24; - Nurse's note, dated 03/21/24, the resident admitted to hospice on 03/20/24; - Nurses notes, dated 3/30/24, 3/31/24, and 4/1/24, the resident continued on hospice services. Review of the facility's hospice binder showed: - No documentation of the resident's hospice information; - The facility failed to document the resident's hospice admitted , hospice orders, the name of the hospice nurse and the specific days of the hospice nurse visits, the name of the hospice aide and the specific days of the hospice aide visits, the medical supplies provided by the hospice, and the durable medical equipment (DME) (equipment that helps complete daily activities) provided by the hospice; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The facility failed to provide a coordinated plan of care. Review of the resident's care plan dated 04/04/24, showed the resident had a terminal prognosis and was now on hospice related to chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), chronic kidney disease, Alzheimer's (progressive mental deterioration) dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), and weight loss. During an interview on 04/15/24 at 2:00 P.M., the Assistant Director of Nursing (ADON) said she was told by the hospice company there was another hospice binder. She had never seen a third binder and could not find anything on Resident #37. There should be a coordinated plan of care between the hospice and the facility. The coordinated plan of care should be signed by both the hospice and facility staff. During an interview on 04/16/24 at 1:00 P.M., the Administrator said there should be a coordinated plan of care signed by both hospice and facility staff. The ADON had looked through everything for any hospice information for Resident #37 and couldn't find anything in the building. 45693		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility failed to ensure the environment remained free of accident hazards by not appropriately assessing four residents (Resident #13, #59, #61 and #89) of four sampled residents who were identified as residents who smoke, to ensure they were able to smoke safely. The facility census was 96. Review of the facility's policy titled, Smoking, undated, showed: - The supervising staff member will notify the unit nurse when a resident's ability to smoke safely is in question; - On admission, the unit nurse will ascertain the resident's wishes about smoking and respect the resident's decision; - Assess the resident's ability to smoke safely by completing a smoking assessment that includes an evaluation of the resident's safety awareness, judgement, cognitive ability, and manual dexterity; - Instruct staff members to notify the unit nurse immediately if it is suspected the resident has violated the facility smoking policy or if the resident's clothing or skin has signs of cigarette burns; - The Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Nurse will evaluate each resident who smokes for smoking safety with every MDS assessment, and document the resident's need for supervision in the care plan, and update with any change in the resident's capabilities and needs. 1. Review of Resident #13's medical records showed: - admitted on [DATE]; - Diagnoses of a stroke affecting the left non-dominant side and hemiplegia (paralysis on one side of the body); - No documentation of a smoking assessment since 10/10/22. Review of the resident's Smoking Assessment, dated 10/10/22, showed: - Unable to light a cigarette safely; - Unable to hold a cigarette safely; - Unable to extinguish a cigarette safely; - Unable to use an ashtray to extinguish a cigarette. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 04/14/24, showed the resident required a smoking apron while smoking due to safety, and he/she refused to wear it. It should be offered with each smoke break. Observations of the resident showed: - On 04/10/24 at 6:25 P.M., the resident smoked with six additional residents and two staff present. Resident #13 held a cigarette in the right hand to smoke and did not wear a smoking apron. The resident had a small pile of ashes on his/her pants to the right side of his/her lap; - On 4/11/24 at 10:17 A.M., the resident smoked with nine additional residents and Smoke Aide (SA) O. SA O stood close to the resident. The resident did not wear a smoking apron, held the cigarette in his/her right hand and pushed the cigarette against the wheelchair frame to knock ashes off. When the resident knocked the ashes off, a pile fell into the wheelchair seat. The resident pushed the hot ash off and it fell to the ground in two piles. SA O relit the cigarette; - On 04/11/24 at 3:02 P.M., SA O passed cigarettes out to the residents that smoked and lit them. Resident #13 did not wear a smoking apron and one was not offered or encouraged. The resident sat in his/her wheelchair with a lit cigarette in his/her right hand and pushed the cigarette on the wheelchair frame to drop the ashes. Toward the end of the cigarette, the resident sat with his right foot resting on his/her left knee with the resident's right hand resting on the right heel area. The fire end of the cigarette touched the resident's sock heel and a pencil size tan/brown scorched area showed on the sock heel; - On 04/15/24 at 1:15 P.M., the resident smoked, did not wear a smoking apron, and Certified Nurse Assistant (CNA) B present. During an interview on 04/11/24 at 1:43 P.M., SA O said there were no residents that required a smoking apron. Resident #13 could probably use one, but he/she wasn't even sure if the facility had one, so he/she didn't offer it to the resident. During an interview on 04/11/24 an 1:44 P.M., CNA B said he/she was unaware of any residents that required a smoking apron. During an interview on 04/10/24 at 5:08 P.M., the MDS Coordinator said smoking assessments should be completed by a floor nurse on admission and quarterly. Resident #13 did require a smoking apron but it was refused. It should be offered and encouraged for the resident to use. 2. Review of Resident #59's medical record showed: - admitted [DATE]; - Diagnoses of encephalopathy (condition that causes brain dysfunction), post traumatic stress disorder (PTSD - disorder that occurs if a traumatic event has been witnessed or experienced), autistic (developmental disability that caused by differences in the brain) disorder, impulse (inability to control impulses and behaviors) disorder, personality disorder (behavior that deviates from accepted behavior), muscle weakness (decrease in muscle strength), and difficulty walking; (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No documentation of a smoking assessment. Review of the resident's significant change MDS, dated , 10/24/23, showed the resident used tobacco. Review of the resident's quarterly MDS, dated , 02/04/24, showed: - Cognitively impaired; - Supervision with ADLs; Review of the resident's care plan, dated, 02/02/24, showed: - Did not address the resident used tobacco; - Did not address the smoking safety or supervision during smoking; - Did not address specific interventions during smoking. Observations of the resident showed: - On 04/11/24 at 10:36 A.M., the resident smoked outside with no smoking apron and supervised by SA O. SA O lit the resident's cigarette and the resident held the cigarette in his/her right hand with 2 inches (in.) of ashes hanging off the cigarette. The resident had ashes on his/her sweatshirt and wheelchair seat; - On 04/11/24 at 1:34 P.M., the resident smoked outside with no smoking apron and supervised by SA O. SA O lit the resident's cigarette and the resident held the cigarette in his/her right hand with 3 in. of ashes hanging off the cigarette. The resident had ashes on his/her clothing and wheelchair; - On 04/12/24 at 8:33 A.M., the resident smoked, sat in a wheelchair outside, wore a smoking apron, and supervised by SA O. During an interview on 04/12/24 at 10:39 A.M., SA O said he/she kept the smoke apron in the cart with the cigarettes. SA O started putting the apron on the resident because the resident dropped ashes on him/herself yesterday. During an observation on 04/15/24 at 1:36 P.M., the resident smoked outside with no smoking apron. The resident sat in a wheelchair and wore house shoes. Ashes fell off the lit cigarette onto the resident's shirt. The resident swept off the ashes on the shirt with his/her hand. One inch (in.) of ash lay by the resident's right leg and touched the wheelchair seat and the resident's pants. Another resident told SA O that the resident needed a smoking apron. A smoking apron sat on the cart. The SA did not provide a smoking apron to the resident. The resident smoked one cigarette and another resident took the cigarette from the resident, extinguished it, and disposed of it in an appropriate container. During an observation on 04/15/24 at 3:40 P.M., the resident sat outside in the wheelchair, smoked with no smoking apron on, and supervised by CNA D. A 1/2 in. of ash sat on the resident's t-shirt. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 04/15/24 at 3:50 P.M., CNA D, said the resident told staff when he/she was finished and the staff extinguished the cigarettes. 3. Review of Resident #61's medical record showed: - admitted on [DATE]; - Diagnoses of diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), congestive heart failure (CHF - an inability of the heart to pump sufficient blood flow to meet the body's needs), lumbago with sciatica (low back pain that shoots down your legs), neuropathy (a disease of the nerves causing tingling, burning or loss of sensation), suicidal ideations, generalized osteoarthritis (a type of arthritis marked by cartilage deterioration of joints and vertebrae), psychotic disorder with hallucinations, spinal stenosis (the narrowing of one or more spaces within your spinal canal), unsteadiness on feet, and shortness of breath; - No documentation of a smoking assessment since 02/20/23. Review of the resident's Smoking Safety Evaluation, dated 02/20/23, showed: - Resident used tobacco; - Supervision required for all residents during designated smoking times; - Balance problems while sitting or standing. Review of the resident's admission MDS, dated [DATE], showed: - Moderately cognitively impaired; - Used tobacco. Review of the resident's care plan, dated 03/19/24, showed: - Did not address the resident used tobacco; - Did not address the smoking safety or supervision during smoking; - Did not address specific interventions during smoking. Observations of the resident showed: - On 04/10/24 at 1:40 P.M., the resident sat on a rollator walker (a walker with wheels and a seat) outside, smoked a cigarette and the ash from the cigarette fell on the resident's right pant leg. The resident did not wear a smoking apron, and was supervised by staff; (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 04/12/24 at 8:33 A.M., the resident sat on a rollator walker outside smoking with no smoking apron on and supervised by staff. The resident held the cigarette with the first two fingers of the right hand. The resident tapped a 1/2 in. ash off the cigarette with a finger and the ash fell down the right side of the resident's jacket onto his/her right knee of the pants. The resident's jacket had six burn holes to the bottom right area and three burn holes to the left wrist area; - On 04/12/24 at 10:30 A.M., the resident sat on a rollator walker outside smoking with no smoking apron on and supervised by staff; - On 04/15/24 at 1:30 P. M., the resident sat on a rollator walker outside smoking with no smoking apron on and supervised by staff. The resident flicked the cigarette where the ash blew back on the resident's leg and clothing; - On 04/15/24 at 1:42 P.M., the resident sat on a rollator walker outside, smoking the cigarette down to the butt and supervised by staff. The resident tapped the lit end of the butt with a fingertip and continued to smoke the butt. During an interview on 04/12/24 at 10:30 A.M., the resident said he/she had never been talked to by staff about wearing a smoking apron while smoking. 4. Review of Resident #89's medical record showed: - admitted on [DATE]; - A smoking assessment, dated 08/04/23, showed the resident a safe smoker; - No documentation of a smoking assessment since 08/24/23. - Schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), PTSD, suicidal ideations, insomnia (difficulty sleeping) due to other mental disorder, Chronic Obstructive Pulmonary Disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs); - Review of the resident's revised care plan, dated 01/30/24, showed it did not address resident smoking. Observation on 04/15/24 at 1:35 P.M. and 3:39 P.M., showed the resident smoked with other residents and supervised by staff. The resident did not wear a smoking apron. During an interview on 04/12/24 at 11:17 A.M., the resident said he/she was an independent smoker and had taken a smoke break today. During an interview on 04/10/24 at 1:40 P.M., the MDS Coordinator said smoking assessments should be completed on admission and quarterly by a nurse on the floor. There was no current evaluation for Resident #89. Care plans should indicate concerns and interventions for residents that smoke. During an interview on 4/12/24 at 11:05 A.M., SA O said that Resident #89 usually smoked outside in the afternoon and had been outside yesterday to smoke. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/24 at 1:59 P.M., the Administrator said that a smoking assessment should be completed on all residents upon admission, when required and at least quarterly. The resident care plan should indicate smoking interventions. 46521 47445 48532		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to ensure a suprapubic catheter (a tube inserted into the bladder, through an opening in the abdominal wall, to drain urine) was changed in a timely manner per physician's orders, failed to ensure the urinary drainage bag was kept off the floor, and failed to provide suprapubic catheter care as ordered and when the dressing was soiled from fecal material from a leaking colostomy for one resident (Resident #25) out of three sampled residents. The facility census was 96. The facility did not provide a suprapubic catheter policy. Facility policy titled, Urinary Catheter Care, undated showed: - Nursing assistants must do catheter and perineal care with a.m. and p.m. care, and after each of the resident's bowel movements; - Always wash your hands before and after handling the catheter, tube or bag, and wear gloves; - Clean the area where the catheter is inserted by wiping away from the insertion site, to prevent germs from being moved from the anus to the urethra; - Wash the catheter to remove any blood or other materials from the catheter, wiping downwards; - Keep the bag below the level of the resident's bladder at all times; - Use a catheter bag to cover to protect the resident's dignity. 1. Review of Resident #25's medical record showed: - admitted [DATE]; - Diagnosis of multiple sclerosis (MS - a disease of the central nervous system resulting in muscle weakness and loss of coordination). Review of the resident's Physician Order Sheet (POS), dated April 2024, showed: - An order, dated 01/25/24, to change the suprapubic catheter (surgically created connection between the urinary bladder and the skin through the abdomen used to drain urine from the bladder) with a 22 French (catheter scale measurement) Foley catheter (an indwelling catheter) monthly on the first day of the month and as needed related to MS; - An order, dated 01/17/24, for suprapubic catheter care every shift and as needed; (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bellevue Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Bellevue, MO 63623	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order, dated 01/26/24, to cleanse the suprapubic catheter site with wound cleanser, apply bacitracin (an antibiotic ointment) over the counter, cover with a split sponge, and secure with tape every day shift. Review of the resident's Treatment Administration Record (TAR), dated April 2024, showed: - An order, dated 01/17/24, for suprapubic catheter care every shift and as needed; - An order, dated 01/25/24, to change the suprapubic catheter with a 22 French Foley catheter monthly on the first day of the month and as needed related to MS (due on 04/01/24). On 04/01/24, initialed and coded by staff to see the progress note; - The suprapubic catheter changed on 04/12/24, 11 days late; - For 04/01/24 through 04/16/24, no documentation of suprapubic catheter care provided on 04/01/24, 04/06/24, 04/14/24, and 04/16/24, with four out of 16 opportunities missed; - No progress note dated 04/01/24 related to the catheter in the chart. Observation on 04/12/24 at 7:30 A.M., showed: - The resident lay in bed with the catheter drainage bag hooked to the bed frame and touching the floor and not covered with a dignity bag; - Restorative Aide (RA) I, Certified Nursing Assistant (CNA) D and Licensed Practical Nurse (LPN) K provided care for a leaking colostomy (a surgical opening for the large intestine through the abdomen) that had soaked the suprapubic catheter dressing; - CNA E did not cleanse the suprapubic catheter from the insertion point out; - LPN K did not apply a new suprapubic catheter dressing. During an interview on 04/09/24 at 9:18 A.M., Resident #25 said staff failed to change the catheter on the first of April as it was ordered. A nurse told the resident that the facility didn't have a 22 French Foley catheter to change it with. The facility didn't provide catheter care daily. Observation on 04/11/24 at 4:30 P.M., of the supply storage closet showed one 22 French urinary catheter in a box of different sized catheters. During an interview on 04/11/24 at 4:35 P.M., the Assistant Director of Nursing (ADON) and the Administrator said they expected catheters to be changed and cared for per orders. If a medically needed item is not in stock and not obtainable, then the resident could have been sent out. Resident #25 was very competent about his/her required care. The ADON and Administrator were not aware of the catheter not being changed. Any soiled dressing should be reapplied once removed and the area cleansed. Catheters should not touch the floor.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility failed to identify, assess and provide supportive interventions for seven residents (Residents #33, #38, #57, #59, #78, #89 and #91) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of seven sampled residents. The facility's census was 96. The facility did not provide a PTSD policy. 1. Review of Resident #33's medical record showed: - admitted on [DATE]; - discharged on [DATE], and readmitted on [DATE]; - Diagnoses of PTSD, major depressive disorder (MDD - long-term loss of pleasure or interest in life), schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), anxiety disorder (persistent worry and fear about everyday situations), bipolar (a mental disorder that causes unusual shifts in mood) disorder, paranoid (an unfounded and/or exaggerated mistrust of others) schizophrenia, and other seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness); - No documentation of a PTSD assessment. Review of the resident's Physician's Order Sheet (POS), dated April 2024, showed: - An order for benztropine (an anti-tremor medication) 1 milligram (mg) three times a day for schizoaffective disorder, dated 04/03/24; - An order for Celexa (an anti-depressant medication) 20 mg one tablet a day for MDD, dated 02/26/24; - An order for clozapine (an anti-psychotic medication) 50 mg two times a day for schizoaffective disorder, bipolar disorder and paranoid schizophrenia, dated 04/03/24; - An order for divalproex sodium (a seizure medication) 500 mg one tablet a day for seizures, dated 04/05/22; - An order for Haldol (an antipsychotic medication used to treat certain types of mental disorders) 5 mg every 12 hours as needed for anxiety, dated 04/03/24; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An order for hydroxyzine (an anti-anxiety medication) 25 mg every 6 hours as needed for anxiety, dated 04/03/24; - An order for Invega (an antipsychotic medication) Sustenna intramuscular (IM) 234 mg injection every 28 days for schizoaffective disorder, dated 04/03/24; - An order for lorazepam (an antianxiety medication) intenzol oral concentrate 2 mg every 6 hours for anxiety related to schizoaffective disorder, dated 03/14/24. Review of the resident's Preadmission Screening and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 07/02/18, showed: - Schizoaffective disorder, major depression, paranoid schizophrenia, anxiety and epilepsy (a disease that causes recurrent seizures); - No behaviors documented. Review of the resident's care plan, last updated 01/27/24, showed no documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 04/16/24 at 11:44 A.M., Resident #33 said he/she had not spoken with staff about PTSD triggers that included a fear of being talked about by other people. Speaking with certain nursing staff and having alone time to read helps him/her return to baseline. 2. Review of Resident #38's medical record showed: - admitted on [DATE]; - Diagnoses of schizoaffective disorder bipolar type, PTSD, MDD, and obsessive-compulsive personality disorder (OCD - a mental health condition that causes an extensive preoccupation with perfectionism, organization and control); - No documentation of a PTSD assessment. Review of the resident's POS, dated April 2024, showed: - An order for chlorpromazine (an antipsychotic medication) 25 mg by mouth twice daily for schizoaffective disorder bipolar type, dated 02/03/23; - An order for clozapine 150 mg by mouth twice daily for schizoaffective disorder bipolar type, dated 10/04/23; - An order for fluvoxamine (an anti-depressant medication) 25 mg give four tablets by mouth in the morning for schizoaffective disorder bipolar type, dated 06/22/23; - An order for Haldol injection solution 5 mg IM every six hours as needed (PRN) for agitation, dated 07/12/23; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An order for hydroxyzine 25 mg by mouth twice daily for anxiety, dated 06/01/22; - An order for Invega Sustenna Suspension 234 mg IM on day shift every 28 days for schizoaffective disorder bipolar type, dated 06/18/23; - An order for lorazepam 0.5 mg by mouth twice daily for schizoaffective disorder bipolar type, dated 01/29/24; - An order for Seroquel (an antipsychotic medication) 200 mg by mouth at bedtime for schizoaffective disorder bipolar type, dated 09/13/23. Review of the resident's PASARR, dated 12/02/21, showed: - Required secured long term care placement for safety; - Schizophrenia, command hallucinations with suicidal ideations, MDD, and borderline personality (a mental disorder characterized by unstable moods, behaviors, and relationships) disorder; - Behaviors included suicidal and homicidal tendencies, violent outburst. Review of the resident's care plan, updated 03/11/24, showed no documentation of PTSD triggers that would cause the resident to have behaviors. 3. Review of Resident #57's medical record showed: - admitted on [DATE]; - Diagnoses of delusional disorders (mental health condition which a person can't tell what's reality and imagined), MDD, anxiety disorder, PTSD, bipolar disorder, and vascular dementia (impaired thought processes caused by impaired blood flow to the brain); - No documentation of a PTSD assessment. Review of the resident's POS, dated April 2024, showed: - An order for Lexapro (an anti-depressant medication) 10 mg by mouth daily for MDD, dated 2/1/24; - An order for Seroquel 25 mg by mouth twice daily for MDD with psychosis, dated 2/1/24. Review of the resident's PASARR, dated,09/02/21, showed: - Required secured long term care placement for safety; - Unspecified psychosis, anxiety disorder, PTSD, and major neurocognitive disorder with behavioral disturbance; - History of physical and sexual abuse; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Behaviors include verbal threats and suspicion of others. Review of the resident's care plan, dated 03/11/24, showed: - PTSD not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. 4. Review of Resident #59's medical record showed: - admitted on [DATE]; - Diagnoses of encephalopathy (condition that causes brain dysfunction), PTSD, autistic disorder (developmental disability caused by differences in the brain), impulse disorder (inability to control impulses and behaviors), personality disorder (behavior that deviates from accepted behavior), muscle weakness (decrease in muscle strength), and difficulty in walking; - No documentation of a PTSD assessment; Review of the resident's POS, dated April 2024, showed: - An order for clonazepam (a sedative medication) 1 mg by mouth three times daily for anxiety/agitation, dated 2/2/24; - An order for duloxetine (an anti-depressant medication) 60 mg by mouth twice daily for depression, dated 2/2/24; - An order for Latuda (an antipsychotic medication) 80 mg by mouth two times daily for mood disorder, dated 7/13/23; - An order for lorazepam 1 mg by mouth every 12 hours PRN for anxiety, dated 1/12/24; - An order for prazosin (an anti-hypertensive medication) 1 mg by mouth at bedtime for mood disorder, dated 11/1/23; - An order for trazodone (an anti-depressant medication) 100 mg give 2 tablets by mouth at bedtime for sleep aid, dated 11/1/23. Review of the resident's PASARR, dated, 06/30/23, showed: - Required a secured long term care placement for safety; - Intellectual disability, mood disorder, borderline personality disorder, psychotic disorder, disruptive behavior disorder, and PTSD; - History of sexual abuse; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Behaviors include elopement, suicidal threats and ideations. Review of the resident's care plan, dated 02/02/24, showed: - PTSD not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. 5. Review of Resident #78's medical record showed: - admitted on [DATE]; - discharged on [DATE], and readmitted on [DATE]; - Diagnoses of PTSD, schizoaffective disorder bipolar type, OCD, and homicidal ideations (thinking about, considering, or planning, a homicide); - No documentation of a PTSD assessment. Review of the resident's POS, dated April 2024, showed: - An order for clozapine 100 mg three times a day for schizoaffective disorder, dated 12/13/22; - An order for fluvoxamine 100 mg once a day for OCD, dated 01/26/24; - An order for Haldol 10 mg every 8 hours PRN for psychosis related to schizoaffective disorder bipolar type/homicidal ideations, dated 01/12/24; - An order for Invega Sustenna 234 mg IM every 28 days for schizoaffective disorder, dated 01/12/24. Review of the resident's PASARR, dated 11/30/22, showed: - Diagnosis of schizophrenia; - No behaviors documented. Review of the resident's care plan, revised 01/27/24, showed no documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 04/16/24 at 11:46 A.M., Resident #78 said he/she had not spoken with staff about his/her PTSD triggers. Writing was helpful in returning to his/her baseline. 6. Review of Resident #89's medical record showed: - admitted on [DATE]; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- discharged on [DATE], and readmitted on [DATE]; - Diagnoses of PTSD, insomnia (a common sleep disorder) due to other mental disorder, MDD, schizoaffective disorder depressive type; - No documentation of a PTSD assessment. Review of the resident's POS, dated April 2024, showed: - An order for fluoxetine (an antidepressant medication) 40 mg 2 capsules by mouth in the morning related to schizoaffective disorder depressive type, dated 03/18/24; - An order for Seroquel 300 mg at bedtime related to schizoaffective disorder depressive type, dated 01/01/24. Review of the resident's PASARR, dated 07/31/23, showed: - MDD and antisocial personality disorder (a mental health disorder characterized by a disregard for other people); - No behaviors documented. Review of the resident's care plan, revised 02/16/24, showed: - Psychotropic (medications that affects behavior, mood, thoughts, or perception) medications related to PTSD and depression used; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 04/12/24 at 11:17 A.M., Resident #89 said no one had talked with him/her about his/her PTSD triggers. The triggers were mainly loud noises and loud talkers. Most help came from the medications and they were effective in the treatment of his/her PTSD, but talking to staff was also helpful. 7. Review of Resident #91's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, autistic disorder, borderline personality disorder, oppositional defiant disorder (a disorder marked by defiant and disobedient behavior to authority figures), disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, attention deficit hyperactivity disorder (ADHD - a chronic condition including attention difficulty, hyperactivity and impulsiveness). Review of the resident's Trauma informed Care Assessment, completed on 04/12/24, showed: - The resident experienced a frightening, horrible or traumatic event; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- In the past month, the resident had nightmares or thought about the event when he/she didn't want to; tried hard not to think about it or went out of the way to avoid situations that reminded him/her of the event; been constantly on guard; watchful or easily startled; had felt numb or detached from people, activities or surroundings; and had felt guilty or unable to stop blaming him/herself or others for the events or problems the events may have caused; - Did not identify the resident's triggers. Review of the resident's POS, dated April, 2024, showed: - An order for Effexor (an antidepressant medication) extended release (XR) 225 mg every morning for anxiety, dated 2/15/23; - An order for Haldol 5 mg tablet every eight hours PRN for behaviors related to oppositional defiant disorder, dated 04/04/24; - An order for Haldol 5 mg tablet give two tablets two times a day for disruptive mood disorder, dated 04/09/24; - An order for lorazepam 0.5 mg one tablet two times a day for anxiety, dated 04/10/24; - An order for oxcarbazepine (an anticonvulsant medication) 300 mg three tablets two times a day for borderline personality disorder, dated 11/29/23; - An order for Invega Sustenna 234 mg IM in the afternoon every 28 days, dated 02/02/24; - An order for prazosin 1 mg every morning for flash backs and anxiety, dated 02/05/24; - An order for prazosin 5 mg at bedtime for frightening dreams/PTSD, dated 11/29/23; - An order for trazodone (an antidepressant medication) 50 mg tablet give two tablets PRN at bedtime for trouble sleeping. dated 02/01/24. Review of the resident's PASARR, dated 11/27/23, showed: - Needs can be met in a nursing facility; - PTSD; - PASARR related disability, serious mental illness, intellectual developmental disability; - Supports and services to be provided by the nursing facility: behavioral support services, structured environment, and crisis intervention services; - Behaviors include impatience, demanding, and physically threatening; (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Extensive history of aggression, self-injurious behaviors, suicide attempts, attention seeking behavior, mood liability, anxiety, depression, impulse control issues, limited insight and judgement, poor decision making skills, and inability to keep self safe; - Needs a provision of services to address the individuals mental health and behavioral needs; - Obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), and Behavioral Support Plan (BSP) from the Department of Mental Health (DMH) Community Mental Health Center and/or Developmental Disability Regional Office; - Requires a structured environment, provide instruction at the individuals level of understanding, environmental supports to prevent elopement, assess and plan for the level of supervision required to prevent harm to self or others, provide individual personal space, provide sensory support, establish consistent routines, and provide schedule of daily tasks/activities; - Crisis intervention services - assess and plan for crisis intervention that provides emotional support, education and safety. It should create clear steps that are taken to support the resident during a behavioral crisis, including who to contact for assistance, how to work together, how to determine when a crisis is over. The plan should also identify a physician and emergency medical services that should be contacted, the facility may also wish to utilize the DMH Behavioral Health Crisis Hotline; - Suicide precautions, assault precautions, and elopement precautions; - The crisis plan is warranted due to the resident has an extensive history of aggression, suicidal ideation, self injurious behaviors and elopements; - Long term care placement recommended for the resident's safety. Review of the resident's care plan, dated 03/22/24, showed: - Did not identify the resident's triggers; - Did not address suicidal ideations, elopements, or self-harm with interventions; - Did not address a crisis plan. During an interview on 04/12/24 at 4:40 P.M., the Social Service Designee (SSD) said there were no PTSD assessments completed. There should have also been care plans completed that address triggers and interventions for PTSD. During an interview on 04/12/24 at 4:44 P.M., the Medical Records Director said there were no PTSD assessments completed. Residents with PTSD should have an assessment upon admission. There should have also been care plans completed that address triggers and interventions for PTSD. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/24 at 11:51 A.M., Licensed Practical Nurse (LPN) A said residents were supposed to be seen by the psychiatrist routinely. PTSD concerns like triggers, interventions and medication information should be in the care plan so it could be reviewed by all staff. The care plan would be checked in order to know how to deal with a triggered resident. The PTSD assessments should be completed and used to help complete care plans. During an interview on 04/16/24 at 1:01 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said residents with a PTSD diagnosis should have a care plan that addressed the triggers with individualized interventions. Residents with PTSD should also have an assessment. Staff should know what triggers a resident with PTSD and so it should be identified on the care plan. The resident interventions should be on the care plan that speaks on how a resident was brought back to a baseline. There were no PTSD assessments completed and care plans will need to be corrected. During an interview on 04/16/24 at 1:59 P.M., the Administrator said residents with PTSD did not have proper care plans or assessments completed. A PTSD assessment should have been completed on admission. The assessment should determine the best path for the resident. There was no PTSD policy at this time. There should be a plan of care that was individualized to the resident. Care plans should cover PTSD concerns including triggers for the resident, interventions that should be resident specific and help them calm and return to baseline when triggered. 46521 48532		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview and record review, the facility failed to appropriately assess the use of bed rails, review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to using bed rails, and appropriately plan care, for two residents (Resident #3 and #13) out of two sampled residents and one additional resident (Resident #20) outside of the sample. The facility census was 96. Review of the Federal Drug Administration (FDA) documents entitled, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated [DATE], showed 413 people died as a result of entrapment events in the United States. Further review revealed those among the most vulnerable for these entrapment type events are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Review of the FDA document entitled, Practice Hospital Bed Safety, dated February 2013, showed seven different potential zones of entrapment. The guidance characterizes the head, neck, and chest as key body parts that are at risk for entrapment. Review of the FDA document entitled, Guide to Bed Safety Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, showed the potential risks of bed rails may include: - Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress; - More serious injuries from falls when patients climb over rails; - Skin bruising, cuts, and scrapes; - Inducing agitated behavior when bed rails are used as a restraint; - Feeling isolated or unnecessarily restricted; - Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. 1. Review of Resident #3's medical record showed: - admitted on [DATE]; - Diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone or posture) and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and other mental function); (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bellevue Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Bellevue, MO 63623	
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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of an informed consent signed by the resident and/or representative explaining the risks and benefits. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility staff, dated [DATE], showed: - Severe cognitive impairment; - Impairment to both sides of the upper and lower extremities; - Dependent for bed mobility; - Bed rails not used. Review of the resident's Bed Safety Assessment, dated [DATE], showed bed rails not required. Observations of the resident showed: - On [DATE] at 04:16 P.M., [DATE] at 9:31 A.M., and 1:12 P.M., the resident lay in a low bed with a fall mat in the floor and the upper ,d+[DATE] bed rails in the raised position on the right and left sides of the bed; - On [DATE] at 2:51 P.M., [DATE] at 9:12 P.M., [DATE] at 9:42 A.M., and [DATE] at 1:15 P.M., the resident lay in a low bed with a fall mat in the floor and the upper right ,d+[DATE] bed rail in the raised position on the left side of the bed against the wall. Review of the resident's care plan, dated [DATE], showed it did not address the use of bed rails. 2. Review of Resident #13's medical record showed: - admitted on [DATE]; - Diagnoses of stroke affecting the left non-dominant side and hemiplegia (paralysis on one side of the body); - No documentation of an informed consent signed by the resident and/or representative explaining the risks and benefits. Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Impairment to the left upper and both sides of the lower extremities; - Substantial to maximal (helper does more than half) assistance for all activities of daily living (ADL's); - Bed rails not used. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Bed Safety Assessment, dated [DATE] showed bed rails not required at this time. Review of the resident's Nurses Notes, dated [DATE] at 11:07 P.M., showed the resident sat on the floor with left arm twisted behind him/her and stuck between the bed and the bed rail. The resident complained of pain to his/her left shoulder. The resident was assisted to untangle his/her arm from between the bed and the bed rail and sat on the bed with assist of two staff. The resident said he/she was trying to get up to change clothes. The resident said he/she did not fall and sat on the floor because he/she could not get his/her arm out. Review of the resident's care plan, dated [DATE], showed it did not address the use of bed rails. Observations of the resident showed: - On [DATE] at 4:19 P.M., and [DATE] at 2:57 P.M., the resident lay in a low bed with the upper ,d+[DATE] bed rails in the raised position on both sides of the bed; - On [DATE] at 9:27 A.M., the resident sat on the bedside with both upper ,d+[DATE] bed rails in the raised position; 3. Review of Resident #20's medical record showed: - admitted on [DATE]; - Diagnosis of Huntington's disease (a rare inherited disease causing progressive breakdown of brain nerve cells, having an impact on functional abilities, usually resulting in movement, cognitive and psychiatric disorders); - No documentation of an informed consent signed by the resident and/or representative explaining the risks and benefits. Review of the resident's significant change MDS, dated [DATE], showed: - Severe cognitive impairment; - Impairment to both sides of the upper and lower extremities; - Dependent on bed mobility; - Bed rails times two used daily. Review of the resident's Bed Safety Assessment, dated [DATE], showed: - Bed rail times one was used to keep the resident from falling out of bed and helped with positioning; - Potential safety issues of the bars within the bed rails were not closely spaced to prevent entrapment. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated [DATE], showed: - The resident with a bedrail to help with positioning and safety; - No documentation of additional interventions. Observations of the resident showed: - On [DATE] at 9:34 A.M., the resident lay in bed with both upper ,d+[DATE] bed rails in the upright position on both sides of the bed. The resident's left lower leg crossed over the right leg with his/her left foot between the inside bars of the right upper ,d+[DATE] bed rail. The resident unable to remove his/her foot from the right upper ,d+[DATE] bed rail in the raised position. Certified Nursing Assistant (CNA) L entered the resident's room and removed the resident's foot out of the raised ,d+[DATE] bed rail; - On [DATE] at 1:12 P.M., [DATE] at 2:54 P.M., and [DATE] at 1:15 P.M., the resident lay in a low bed with a fall mat in the floor and the left upper ,d+[DATE] bed rail in the raised position on the wall side of bed; - On [DATE] at 3:10 P.M., the resident sat in a wheelchair with the left upper ,d+[DATE] bed rail in the raised position on the wall side of the bed. During an interview on [DATE] at 1:10 P.M., the Administrator and the MDS Coordinator said the facility had no residents with bed rails in use. During an interview on [DATE] at 1:10 P.M., the Assistant Director of Nursing (ADON) said he/she was not aware of any residents with bed rails. During an interview on [DATE] at 9:47 A.M., the MDS Coordinator said he/she thought hospice staff had brought new beds in and was unaware there were bed rails on them. During an interview on [DATE] at 11:02 A.M., the Administrator said she would expect bed rail assessments and consents with risks and benefits to be accurately completed. The bed rails should also be addressed on the care plan if they were used.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45693 Based on observation, interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day, seven days a week, and the facility failed to designate a RN to serve as the Director of Nursing (DON) on a full-time basis. This deficiency had the potential to affect all residents residing in the facility. The facility census was 96. Review of the facility's policy titled, Nursing Staff, undated, showed: - The facility must use a RN for at least eight consecutive hours a day, seven days a week; - The facility must designate a RN to serve as the DON on a full time basis. The DON can serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Review of the facility's Facility Assessment Tool, last reviewed 02/12/23, showed: - The facility required three RN's; - The facility required a full time DON. Review of the Nursing Schedules for 12/26/23 through 04/16/24, showed: - No documentation of a RN scheduled for eight consecutive hours on 12/26/23 - 04/07/24, 04/12/24, and 04/13/24; - No documentation a RN worked eight consecutive hours on 12/26/23 - 04/07/24, 04/12/24, and 04/13/24, with 106 out of 112 days missed; - No documentation of a DON scheduled 04/01/24 - 04/16/24; - No documentation a DON worked 04/01/24 - 04/16/24, with 16 out of 16 days missed. Review of the current Nursing Assignment Sheets, dated 04/12/24 and 04/13/24, showed no documentation a RN worked eight consecutive hours. Review of the facility's time sheets, dated 12/26/23 through 04/15/24, showed no documentation a RN worked eight consecutive hours on 12/26/23 - 04/07/24, 04/12/24 and 04/13/24. Review of the DON's Termination Notice, dated 04/01/24, showed: - Last day worked of 03/29/24; - Termination date of 04/01/24. (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations of the facility on 04/09/24 through 04/12/24, 04/15/24 and 04/16/24, showed no DON worked in the facility. During an interview on 04/11/24 at 11:30 A.M., the Assistant Director of Nursing (ADON) and Administrator said they did not have a DON. The last one last worked on 03/29/24, and had a termination date of 04/01/24. The company had an advertisement for a new DON. They recently hired two RN's who just started orientation, but they need at least one more RN to cover all of the days.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 45693 Based on interview and record review, the facility failed to provide the nurse aides an annual individual performance review or evaluation and failed to provide regular in-service education based on these reviews for two certified nursing assistants (CNAs) (CNA G and CNA M) out of two sampled CNAs. The facility census was 96. Review of the facility's policy titled, Nursing Staff, undated, showed the facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. 1. Review of CNA G's employee file showed: - Hire date of 03/02/23; - No documentation CNA G received any in-service education for 03/02/23 to 03/02/24; - No documentation CNA G received an annual individual performance review or evaluation for 03/02/23 to 03/02/24. 2. Review of CNA M's employee file showed: - Hire date of 01/26/23; - No documentation CNA M received an annual individual performance review or evaluation for 01/26/23 to 01/26/24. Review of the facility's in-service records showed: - No documentation CNA M received any in-service education for 01/26/23 to 01/26/24; - No documentation CNA M received an annual individual performance review or evaluation for 01/26/23 to 01/26/24. During an interview on 04/16/24 at 10:15 A.M., CNA E said he/she had worked at the facility about one and one-half years. He/she should have received a performance evaluation but was told the facility wasn't doing them right now. During an interview on 04/16/24 at 10:19 A.M., CNA C said he/she had not heard about performance evaluations and had not received one. CNA C had worked there over a year. During an interview on 04/16/24 at 10:24 A.M., CNA N said he/she had received a performance evaluation in 02/23, but did not receive one in 02/24. CNA N had worked there over a year. (continued on next page)		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/15/23 at 1:30 P.M., the Assistant Director of Nursing (ADON) said they could not find the in-services from the last Director of Nursing (DON) and the DON before that destroyed a bunch of paper work when he/she quit. They did in-services at least once a month. During an interview on 04/16/23 at 10:30 A.M., the Administrator said they had not started performance reviews for the nurse aides yet.		

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide a crisis plan for one resident (Resident #91) of 20 sampled residents, as directed from the Pre-Admission Screening and Resident Review (PASRR) (a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care). Resident #91, who required supervision due to physical aggression, self-harming behaviors, and mental illness, was observed to have escalating behaviors which resulted in the resident: cutting him/herself with sharpened pencil 01/25/24; laying on top of a closed razor so the staff couldn't confiscate it on 02/16/24; cutting him/herself with a dull piece of broken plastic on 02/25/24; cutting him/herself with a razor on 02/29/24; cutting his/her finger by placing it in an open soda can on 03/27/24; attempting to harm him/herself with a broken piece of a cooler lid on 04/04/24; ingesting hair conditioner on 04/05/24; escaping out of the facility door and running towards the road as a truck drove by the facility on 04/07/24, and cutting him/herself with a screw and a razor on 04/11/24. The facility did not put any interventions into place after each behavior and staff were not aware of or trained on any interventions to intercede in these behaviors. The facility census was 96 residents. The administrator was notified on 04/12/24 at 9:00 A.M., of an Immediate Jeopardy (IJ) which began on 04/11/24. The IJ was removed on 04/12/24, as confirmed by surveyor onsite verification. Review of the facility assessment, dated 02/12/23, showed: - Facility assessment not reviewed annually since 2023; - No documentation the Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committee reviewed the facility assessment; - The number of residents with intellectual and/or developmental disability not accurate; - The behavioral healthcare needs (Including Trauma/PTSD) who have an individualized care plan to be zero and inaccurate; - The competencies required by the facility did not include behavior health (including PTSD and Trauma History), or meeting the needs of individuals with mental illness/intellectual disability or development disability. The facility did not provide a policy on Crisis Intervention. 1. Review of Resident #91's Preadmission Screening and Resident Review (PASRR) (a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 11/27/23, showed: - The PASRR Level II indicated the resident's needs can be met in a nursing facility; (continued on next page)		

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident with Post-Traumatic Stress Disorder (PTSD) (a mental health condition triggered by a terrifying event); - PASRR related disability, serious mental illness, intellectual developmental disability; - The PASRR Level II indicated the following supports and services are to be provided by the nursing facility, behavioral support services, structured environment, crisis intervention services; - Behaviors include, impatient, demanding, physically threatening; - Extensive history of, aggression, self-injurious behaviors, suicide attempts, attention seeking behavior, mood liability, anxiety, depression, impulse control issues, limited insight and judgement, poor decision making skills, and inability to keep self safe; - The individual needs a provision of services to address the individuals mental health and behavioral needs, obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), Behavioral Support Plan (BSP), from Department of Mental Health (DMH) Community Mental Health Center and/or Developmental Disability Regional Office; - Provision of a structured environment, provide instruction at the individuals level of understanding, environmental supports to prevent elopement, assess and plan for the level of supervision required to prevent harm to self or others, provide individual personal space, provide sensory support, establish consistent routines, provide schedule of daily tasks/activities; - Crisis intervention services, assess and plan for crisis intervention that provides emotional support, education and safety, it should create clear steps that are taken to support the resident during a behavioral crisis, including who to contact for assistance, how to work together, how to determine when a crisis is over. The plan should also identify a physician and emergency medical services that should be contacted, the facility may also wish to utilize Department of Mental Health Behavioral Health Crisis Hotline; - Suicide precautions, assault precautions, and elopement precautions; - The crisis plan is warranted due to the resident has an extensive history of aggression, suicidal ideation, self injurious behaviors and elopements; - Long term care placement recommended for the resident's safety. Review of Resident #91's medical record showed: - admitted on [DATE]; (continued on next page)		

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diagnoses of PTSD, autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), borderline personality disorder (a mental disorder characterized by unstable moods, behavior and relationships), oppositional defiant disorder (a disorder marked by defiant and disobedient behavior to authority figures), disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, attention deficit hyperactive disorder (a chronic condition including attention difficulty, hyperactivity and impulsiveness). - Medications prescribed and administered for behavior management; - No crisis management plan. Review of Nurse's progress notes, dated 01/25/24 through 04/11/24 showed: - On 01/25/24, the resident cut him/herself with sharpened pencils; - On 02/03/24, the resident found with a dull, broken piece of plastic; - On 02/16/24, the resident noted to be more sad than usual for two days. Resident asked for a razor to shave legs. The nurse was going to go with the resident to supervise but the resident ran to room with the razor. The resident lay on top of a closed razor so the staff couldn't confiscate it; - On 02/25/24, the resident cut him/herself with a dull piece of broken plastic; - On 02/29/24, the resident asked if he/she could shave. A Certified Nurse Aide (CNA) was sent to assist the resident with shaving. The resident went into the shower room with a razor and cut him/herself on the arm with a razor. It was witnessed by a CNA, Certified Medication Technician (CMT) and another resident. The CMT obtained the razor and the resident told the CNA he/she did not want to live anymore. Staff spoke with the resident who said if he/she would be sent to the hospital then he/she would say it was an accident. The resident was offered 1:1, but the resident calmed down. - On 03/12/24, the resident walked down the hall sniffing a marker. Staff requested the marker be handed over to staff so the resident wouldn't [NAME] the marker; - On 03/13/24, resident #91 initiated an altercation with another resident; - On 03/14/24, resident #91 interrupted a conversation between a nurse and the other resident involved in the altercation on 03/13/24. Resident #91 became aggressive toward staff, walked down the hall and became aggressive toward the other resident. Due to being the 4th altercation during day shift the resident was sent out to the hospital. On 03/27/24, the resident put his/her finger in an open soda can and cut his/her finger; - On 03/29/24, during an Epsom salt foot soak the resident independently removed his/her toe nail from the nail bed of his/her left greater toe. The resident stated the toe nail was loose and was bothering him/her; - On 04/01/24, the resident rolled out of bed onto the floor hitting his/her head on the floor; (continued on next page)		

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 04/03/24, the resident threw dining room chairs against walls in the sitting room; - On 04/04/24, the resident threw hangers at the Assistant Director of Nursing (ADON), hit CNA in chest and ran to room slamming the door shut and hitting the door repeatedly. Prior to this incident the resident grabbed an ice chest cooler lid with a crack and stated he/she wanted to hurt herself/himself. The resident was sent to the hospital due to wanting to harm self. The resident returned from the hospital. The resident reported he/she turned over in bed and hit his/her head against the bedside table; - On 04/05/24 the resident wanted to harm him/herself with a broken piece of a cooler lid; - On 04/05/24 the resident ingested hair conditioner and, after telling staff, moved electric bed into hallway blocking the path to the resident. The resident later told staff he/she had vomited in the toilet but flushed. The resident complained of his/her stomach being upset; - On 04/07/24 the resident left out of the facility door and ran towards the road as a truck drove by the facility. The resident fought Emergency Medical Services (EMS) staff and sheriff about getting into the ambulance. - On 04/09/24 the resident had several behaviors. The resident said he/she is not ok; - On 04/10/24 the resident stated he/she hates feeling like this. Resident asked for an as needed (PRN) medication which was administered. The resident walked into bathroom, given a few minutes for privacy and entered. The resident was tearful saying he/she hates feeling like this. The resident went behind the shower curtain then handed staff a straightened out paperclip. The resident had a superficial scrape to the skin. The resident later ran out of the door into the enclosed courtyard crying that the medication doesn't work; - On 04/11/24 Resident #91 kicked open a locked supply room closet door. The resident pulled a screw from the wall and wedged self between shelving and wall beginning to scratch self with the screw. The resident said staff shouldn't care about him/her or try to help. The resident injured self with a safety razor obtained from the storage room. The resident refused to allow nurse to apply pressure, but agreed to hold gauze him/herself. The resident was sent out to the hospital. Review of the resident's care plan, updated 03/22/24, showed: - Resident #91 has behavior problems (history of manipulation, aggression, aggressive toward other); - Intervene as necessary to protect the rights and safety of others; - Approach/speak in a calm manner; divert attention; - Resident #91 has potential to be physically aggressive; - When resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation; (continued on next page)		

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- If response is aggressive, staff is to walk calmly away and approach later; - Did not identify the residents triggers; - Did not address, suicidal ideations, elopements, or self harm with interventions; - Did not address a crisis plan. The facility did not put interventions into place after Resident #91's aggressive and self-harming behaviors began to escalate. During an interview on 04/12/24 at 2:20 P.M., CNA E said the facility can't provide the care that Resident #91 requires. They are not trained to care for someone with those types of behaviors. During an interview on 04/12/24 at 2:24 P.M., CNA C said Resident #91 needs more care than the facility can provide. During an interview on 04/12/24 at 2:27 P.M., LPN K said he/she is familiar with Resident #91. Resident #91 doesn't belong at the facility because they can't keep him/her safe and provide the care needed. During an interview on 04/12/24 at 3:10 P.M., the Assistant Director of Nursing (ADON) and Administrator said the facility can't provide the care needed for Resident #91. They had tried sending the resident to the hospital, but the hospital sends him/her right back, saying the behaviors should be handled at the facility. They have done medication changes and are currently seeking other placement. The staff isn't trained to care for a resident like this and they can't keep Resident #91 safe. During an interview on 04/16/24 at 2:59 P.M., the Medical Director (MD) said he/she did not think the facility could adequately care for some residents with these behaviors. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). 48532		

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NAME OF PROVIDER OR SUPPLIER Bellevue Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Bellevue, MO 63623	
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance of the required provision of services to address the individuals mental health and behavioral needs, for one resident (Resident #91) from a sample of 20 residents. The facility census was 96. The facility did not provide a policy regarding behaviors. Review of Resident #91's Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes), dated 11/27/23, showed: - The resident's needs can be met in a nursing facility; - Resident with post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event); - Disabilities of serious mental illness and intellectual developmental disability (a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors); - Supports and services to be provided by the nursing facility: behavioral support services, structured environment, and crisis intervention services; - Behaviors of impatience, demanding, and physically threatening; - Extensive history of aggression, self-injurious behaviors, suicide attempts, attention seeking behaviors, mood lability (rapid, often exaggerated changes in mood, where strong emotions or feelings (uncontrollable laughing or crying, or heightened irritability or temper) occur), anxiety, depression, impulse control issues, limited insight and judgement, poor decision making skills, and inability to keep self safe; - Requires a provision of services to address the individuals mental health and behavioral needs, obtain an Individual Support Plan (ISP), and Individualized Treatment Plan (ITP), a Behavioral Support Plan (BSP) from the Department of Mental Health (DMH) Community Mental Health Center and/or the Developmental Disability Regional Office; - Provision of a structured environment, provide instruction at the individual's level of understanding, environmental supports to prevent elopement, assess and plan for the level of supervision required to prevent harm to self or others, provide individual personal space, provide sensory support, establish consistent routines, and provide a schedule of daily tasks/activities; (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Crisis intervention services to assess and plan for crisis intervention that provides emotional support, education and safety. It should create clear steps that are taken to support the resident during a behavioral crisis, including who to contact for assistance, how to work together, and how to determine when a crisis is over. The plan should also identify a physician and emergency medical services that should be contacted. The facility may also wish to utilize DMH Behavioral Health Crisis Hotline; - Provide suicide precautions, assault precautions, and elopement precautions; - The crisis plan is warranted due to the resident has an extensive history of aggression, suicidal ideation, self injurious behaviors and elopements; - Long term care placement recommended for the resident's safety. Review of the resident's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, autistic disorder (a developmental condition causing an inability to relate to everyday life and adjust socially), borderline personality disorder (a mental illness that severely impacts a person's ability to regulate their emotions), oppositional defiant disorder (a disorder marked by defiant and disobedient behavior to authority figures), disruptive mood disorder (a condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), anxiety, attention and deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity and impulsiveness). Review of the resident's Nurse's Progress Notes, dated 01/25/24 through 04/11/24, showed: - On 01/25/24, the resident cut him/herself with sharpened pencils; - On 02/03/24, the resident found with a dull, broken piece of plastic; - On 02/16/24, the resident more sad than usual for two days. Resident asked for a razor to shave legs. The nurse was going to go with resident to supervise, but the resident ran to the room with the razor. The resident lay on top of a closed razor so the staff couldn't confiscate it; - On 02/25/24, the resident cut him/herself with a dull piece of broken plastic; - On 02/29/24, the resident asked if he/she could shave. A Certified Nurse Aide (CNA) was sent to assist the resident with shaving. The resident went into the shower room with a razor. The resident cut him/herself on the arm with a razor which was witnessed by a CNA, a Certified Medication Technician (CMT) and another resident. The CMT obtained the razor and the resident told the CNA he/she did not want to live anymore. The resident said if he/she would be sent to the hospital, then he/she would say it was an accident. Resident offered one-to-one (1:1) care, but the resident calmed down. This resident threw shoes at another resident who witnessed him/her using the razor. Resident removed from the other resident's room, placed on 1:1 and an order was obtained to send the resident out to the hospital; (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/13/24, the resident initiated an altercation with another resident; - On 03/14/24, the resident interrupted a conversation between a nurse and the other resident involved in the altercation on 03/13/24. Resident #91 became aggressive toward the staff, walked down the hall and became aggressive toward the other resident. Due to being the fourth altercation during the day shift, the resident was sent out to the hospital; - On 03/27/24, the resident put his/her finger in an open soda can and cut his/her finger; - On 04/03/24, the resident threw dining room chairs against the walls in the sitting room; - On 04/04/24, the resident threw hangers at the Assistant Director of Nursing (ADON) and hit a CNA in the chest. The resident ran to his/her room, slammed the door shut and hit the door repeatedly. Prior to this incident, the resident grabbed an ice chest cooler lid with a crack in it and said he/she wanted to hurt him/herself. The resident was sent to the hospital. The resident returned from the hospital; - On 04/05/24, the resident wanted to harm him/herself with a broken piece of a cooler lid; - On 04/05/24, the resident ingested hair conditioner, told staff, and moved an electric bed into the hallway blocking the path to the resident. The resident told staff he/she had vomited in the toilet and flushed it. The resident complained of an upset stomach; - On 04/07/24 the resident left out of the facility door and ran towards the road as a truck drove by the facility. The resident fought Emergency Medical Services (EMS) staff and the sheriff about getting into the ambulance, but eventually got into the ambulance; - On 04/09/24, the resident had several behaviors today and said he/she was not okay; - On 04/10/24, the resident said he/she hated feeling like this. The resident asked for an as needed (PRN) medication and it was administered. The resident walked into the bathroom and a few minutes later, staff entered the bathroom. The resident was tearful and said he/she hated feeling like this. The resident went behind the shower curtain and scratched at his/her arm with a straightened out paper clip which he/she gave the staff. The resident had a superficial scrape to the skin. The resident later ran out of the door into the enclosed courtyard crying that the medication didn't work; - On 04/11/24, the resident kicked open a locked supply room closet door, pulled a screw from the wall, wedged him/her self between shelving and the wall, and began to scratch him/herself with the screw. The resident said staff shouldn't care about him/her or try to help. The resident injured him/herself with a safety razor obtained from the storage room. The resident refused to allow the nurse to apply pressure, but agreed to hold gauze him/herself over the wound. The resident was sent out to the hospital. Review of the resident's care plan, updated 03/22/24, showed: - Behavior problems (history of manipulation, aggression, aggressive toward other); - Intervene as necessary to protect the rights and safety of others; (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Approach/speak in a calm manner and divert attention; - Potential to be physically aggressive; - When agitated, intervene before agitation escalates, guide away from source of the distress, and engage calmly in conversation; - If resident's response was aggressive, staff to walk calmly away and approach later; - Did not identify the resident's specific triggers to avoid that would cause increased anxiety and behaviors; - Did not address suicidal ideations, elopements, or self-harm behaviors with interventions; - Did not address a crisis plan. The facility failed to provide the resident with a crisis plan with interventions, an IPS, an ITP, a BSP, a plan for the level of supervision required to prevent harm to self or others, suicide precautions, assault precautions, and elopement precautions per the resident's PASRR. During an interview on 04/12/24 at 3:10 P.M., the ADON and the Administrator said the facility can't provide the care needed for the resident. They had tried sending the resident to the hospital, but the hospital sent the resident right back and said the behaviors should be handled at the facility. They had done medication changes and were currently seeking another placement. The staff wasn't trained to care for the resident and they couldn't keep the resident safe. During an interview on 04/15/24 at 1:30 P.M., the ADON said they provided in-services with staff once a month, but did not know what the specific training for the behavioral residents was, or when it had last been done. She was in charge of the training until a new DON could be hired. During an interview on 04/16/24 at 2:59 P.M., the Medical Director (MD) said he/she did not think the facility could adequately care for residents with this kind of behavior. During an interview on 04/16/24 at 10:10 P.M., the Administrator said she did not feel the facility could provide the behavioral needs of the resident. The facility did not have the staff to do 1:1 care, as it would take away care from the other residents.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48532 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for four out of four medication carts. This practice had the potential to affect all residents. The facility census was 96. Review of the facility's policy titled, Medications, Narcotics, undated, showed: - Narcotics will be counted at the beginning and end of every shift by the Unit Nurse ending the shift and the Unit Nurse beginning the shift; - Both nurses will date and sign the narcotics count record; - The Charge Nurse will be notified immediately if there is any discrepancy in the narcotics count; - If the Unit Nurse must leave before the end of the shift, he/she will count the narcotics with the Charge Nurse before leaving the facility. The Charge Nurse will then count with the Unit Nurse from the oncoming shift. 1. Review of the A Hall Certified Medical Technician (CMT) Narcotic Count Log for Controlled Substances showed: - For 02/21/24 through 03/03/24, the staff missed 25 out of 36 opportunities to reconcile the narcotics; - For 03/04/24 through 03/16/24, the staff missed 32 out of 39 opportunities to reconcile the narcotics; - For 03/17/24 through 03/31/24, no documentation provided. The staff missed 45 out of 45 opportunities to reconcile the narcotics; - For 04/01/24 through 04/10/24, the staff missed 28 out of 29 opportunities to reconcile the narcotics; - For 02/21/24 through 04/10/24, the staff missed a total of 130 out of 149 opportunities to reconcile the narcotics. 2. Review of the B Hall Nurses Narcotic Count Log for Controlled Substance showed for 04/03/24 through 04/09/24, the staff missed 12 out of 14 opportunities to reconcile the narcotics. 3. Review of the B Hall CMT Narcotic Count Log for Controlled Substances showed for 03/27/24 through 04/10/24, the staff missed 41 out of 44 opportunities to reconcile the narcotics. 4. Review of the Secured Units CMT Narcotic Count Log for Controlled Substances showed: (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- For 02/21/24 through 03/27/24, the staff missed 72 out of 72 opportunities to reconcile the narcotics; - For 03/28/24 through 04/10/24, the staff missed 28 out of 28 opportunities to reconcile the narcotics; - For 02/21/24 through 04/10/24, the staff missed a total of 100 out of 100 opportunities to reconcile the narcotics. During an interview on 04/10/24 at 4:30 P.M., CMT E said narcotic reconciliation log was signed on shift change by oncoming and off going CMT and/or Nurses. He/She said the narcotics should be counted together by both staff and for B hall, the off going CMT should count with the day shift nurse and the nurse should count with the night shift nurse. During an interview on 04/10/24 at 4:49 P.M., CMT T said no one counted the secured unit cart with him/her because he/she followed him/herself on most days. One other CMT and him/herself were the only two that worked the secured unit medication cart. He/She came in, counted the cart, and if it had no discrepancies with the count, he/she started passing medications. If there was a discrepancy, he/she went to the nurse, the count was redone, and the error was found. A lot of times when he/she was done with medication pass, the nurses were in report, which could last two hours, and he/she didn't wait around until 9:00 P.M., to count. He/She hung the keys in the locked medication room. During an interview on 04/10/24 at 4:54 P.M., Licensed Practical Nurse (LPN) A said narcotic counts were completed at shift change, the oncoming and off going staff counted together. He/She said the night CMT counted with the night nurse, the day nurse CMT counted with the night nurse, and off going nurse counted with the day nurse. He/She said there were no narcotics in the nurse cart at this time. During a phone interview on 04/25/24 at 11:41 A.M., the Administrator said narcotic counts should be completed anytime there was a change in staff. If an employee left mid shift, the narcotic count should be completed with whoever took the keys to the cart. The narcotic log should be signed at that time. Discrepancies during the narcotic count should be reported to the nurse. The nurse should check the cart and double check the electronic medication administration record was correct. The Nurse and/or CMT should notify the supervisor, then the Assistant Director of Nursing (ADON) or the Director of Nursing (DON), and then the Administrator. If the discrepancy was not found at that point, an investigation would begin. During a phone interview on 04/25/24 at 11:50 A.M., the ADON said narcotic counts should be completed before and after each shift by the on and off going staff. The narcotic count should be completed any time the keys to the medication cart were exchanged. Documentation in the narcotic log book should be completed at that time, and should show the number of medication cards, and number of narcotics in each card/bottle.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on interview and record review, the facility failed to limit the use of an as needed (PRN) order for psychotropic (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviors) medication to 14 days for three residents (Resident #38, #59, and #92) and failed to ensure one resident (Resident #92) was free from an unnecessary antipsychotic (a medication to treat a mental disorder characterized by a disconnection from reality) medication out of seven sampled residents. The facility also failed to ensure an appropriate diagnosis for the use of a psychotropic medication and to attempt a gradual dose reduction (GDR) for one resident (Resident #51) outside the sample. The facility census was 96. The facility did not provide policies for the limited use of PRN medications, unnecessary antipsychotic medication use, appropriate diagnosis, use of psychotropic medication, and GDRs. 1. Review of Resident #38's April 2024 Physician's Order Sheet (POS) showed: - Diagnoses of schizoaffective disorder (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), major depressive disorder (MDD - long-term loss of pleasure or interest in life), obsessive-compulsive personality disorder (OCD - characterized by unreasonable thoughts and fears (obsessions) that lead to compulsive behaviors); - An order for Haldol (an antipsychotic medication) 5 milligram per milliliter (mg/ml), inject 1 ml intramuscularly (IM) every six hours as needed for agitation, dated 07/12/23, and no stop date; - No 14 day stop date order for the Haldol PRN order. 2. Review of Resident #51's April 2024 POS showed: - admitted [DATE]; - Diagnoses of anxiety disorder (persistent worry and fear about everyday life), MDD, and bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels and concentration); - An order for nortriptyline (an antidepressant medication) 10 mg by mouth in the evening for nerve pain, dated 9/12/23; - An order for duloxetine (an antidepressant medication) 60 mg by mouth twice daily for MDD, dated 9/8/23; - An order for olanzapine (an antipsychotic medication) 5 mg by mouth twice daily for bipolar disorder, dated 2/12/24; (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for quetiapine (an antipsychotic medication) 50 mg by mouth at bedtime for bipolar disorder, dated 9/8/23; - An order for quetiapine 25 mg by mouth in the afternoon for anxiety, dated 2/1/24; - No documentation of an appropriate diagnosis for the quetiapine 25 mg dose; - No attempt by the physician for a GDR of the nortriptyline, duloxetine, and quetiapine 50 mg medications. 3. Review of Resident #59's April 2024 POS showed: - Diagnoses of encephalopathy (any brain disease that alters brain function or structure), post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event), autistic disorder (a developmental condition causing an inability to relate to everyday life and adjust socially), anxiety, schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions) bipolar type; - An order for lorazepam (an antianxiety medication) 2 mg/ml, give 0.5 ml by mouth every 12 hours PRN for anxiety, dated 1/12/24, and no stop date; - No 14 day stop date order for the lorazepam PRN order. 4. Review of Resident #92's April 2024 POS showed: - Diagnoses of alcohol dependence with alcohol-induced dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), dementia with other behavioral disturbance, insomnia (difficulty sleeping), and anxiety; - An order for lorazepam 1 milligram (mg) by mouth every eight hours PRN for anxiety, dated 02/02/24, with no stop date; - An order for Risperdal (an antipsychotic medication) 1 mg by mouth three times daily as needed for agitation related to dementia, severe, with other behavioral disturbance, dated 02/02/24, with no stop date; - An order for olanzapine (an antipsychotic medication) intramuscularly (IM) 10 mg one time only for aggression, anxiety for one day, dated 04/14/24; - No 14 day stop date order for the lorazepam and the Risperdal PRN orders. Review of the resident's nurse's note, dated 04/14/24, showed: - Episodes of aggressive behavior throughout the shift, directed towards staff; - Wandered into other resident rooms and not easily redirected; - Pushed and punched staff to get back into another resident's room; (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Grabbed a nurse's wrists and pulled the nurse down the hall; - Assaulted staff with closed fists when redirected from entering other resident rooms; - Another nurse obtained an order for a PRN olanzapine injection; - When the nurse stepped in between the staff and the resident, the resident grabbed the nurse and walked to his/her room and said he/she wanted to go to bed; - Once in the room, the resident yelled at staff and grabbed the nurse's wrists; - A second nurse gave the resident an injection, olanzapine; - The resident punched one nurse and Certified Nurse Aide (CNA). Review of the resident's April 2024 MAR showed: - Lorazepam 1 mg by mouth every eight hours as needed for anxiety, dated 02/02/24, and not administered on 04/14/24; - Risperdal 1 mg by mouth three times a day as needed for agitation, dated 02/02/24, and not administered on 04/14/24; - Olanzapine IM 10 mg one time only for aggression, anxiety, start date of 04/14/24 and end date of 04/14/24, administered on 04/14/24; - No PRN medications attempted prior to obtaining the order for the olanzapine IM injection. Review of the resident's care plan, dated 02/14/24, showed the resident received psychotropic (a medication that affects how the brain works) medications without an appropriate diagnosis. During an interview on 04/15/24 at 10:20 A.M., the Assistant Director of Nursing (ADON) said a PRN antipsychotic should only be ordered for 14 days at a time. The medication should then be stopped at the 14th day, or a new order should be obtained from the physician on the 14th day. An appropriate diagnosis should be included and GDRs should be completed in a timely manner. During an interview on 04/16/24 at 10:30 A.M., the Administrator said staff should try deescalating residents and administer the PRN medications prior to calling for an antipsychotic medication IM one time order. If a resident was starting to have behaviors, then PRNs should be administered before a big event occurred requiring an actual one time injection of usually stronger medications. During an interview on 04/16/24 at 1:30 P.M., the Administrator said PRN antipsychotic medications should only be ordered for 14 days at a time. All medication should have an approved diagnosis and GDRs should be completed. 48532		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46521 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 96. Review of the facility's policy titled, Cleaning Rotation, dated 2020, showed: - Equipment and utensils will be cleaned and sanitized according to the following guidelines, or manufacturer's instructions; - Items cleaned and sanitized after each use included can opener, utensils, worktables, and counters, pots and pans, dishes, dining room tables and chairs; - Items cleaned daily included kitchen and dining room floors, steam table, hand washing sink, and exterior of large appliances; - Items cleaned weekly included hoods, filters, trash barrels, storerooms, drawers, shelves, ovens, and cupboards; - Items cleaned monthly included refrigerators, freezers, ingredient bins, ice machines, food containers, and walls; - Items cleaned annually included ceilings and windows. Review of the facility's policy titled, Food Storage Dry, Refrigerated, and Frozen, dated 2020, showed: - Food shall be stored on shelves in a clean, dry area free from contaminants; - Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety; - General storage guidelines to be followed, all food items will be labeled; - The label must include the name of the food and the date by which it should be sold, consumed, or discarded; - Poisonous materials, medications, and chemicals will be stored separately from food in a designated medication refrigerator, cleaning closet, or cabinet which can be locked; - Place a thermometer in the warmest part of the refrigerator to monitor the air temperature in the refrigerator; - Defrost freezers regularly to improve their efficiency; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Store dry food on shelves two inches (in.) away from walls to allow ventilation, six in. off the floor to allow for proper sanitation, and 18 in. from the ceiling to ensure fire safety. 1. Observation on 04/09/24 at 8:20 A.M., 04/10/24 at 1:27 P.M., and 04/12/24 at 08:35 A.M., of the kitchen showed: - Food debris and oily film build-up on the floor beneath the range; - The commercial dishwasher exterior with flaky white grime (dirt ingrained on the surface of something) build-up, and a connected 1 in. water line leak; - A 5-foot (ft.) section of wall baseboard with damage behind the commercial dishwasher and white grime build up on the floor below; - Two 4 in. x 4 in. ceramic tiles missing on each wall section left and right of the door passage from the kitchen to the dishwashing area; - A window mounted air conditioning unit with black grime and dust buildup above the dishwashing area counter; - The commercial style can opener with a worn cutting edge, oily film and a black grime buildup; - Four connected ceiling lights over the food preparation areas with black grime buildup and one broken fluorescent light fixture cover; - Three ceiling diffusers (one of the few visible parts of an air conditioning system) with dust buildup and a brown substance on the front exterior surfaces and between the ventilation louvers; - The floor below the reach-in freezer with scattered debris in the rear kitchen exit area; - The reach-in refrigerator interior with scattered debris and no separate thermometer in the rear kitchen exit area; - The chest freezer with 1 in. frost buildup and a damaged gasket along the upper interior surface in the rear kitchen exit area; - One large and one small cookie sheet with brown carbon buildup; - Four flies in the kitchen food prep area. 2. Observation on 04/09/24 at 8:30 A.M., 04/10/24 at 1:37 P.M., and 04/12/24 at 08:45 A.M., of the dry food storage room showed: - Scattered debris below the food storage shelves; - Undated, unlabeled onions stored in an uncovered plastic bin; - Two non-intact floor tiles and black grime buildup on the floor; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Two undated, unlabeled plastic zipper bags with chocolate chips and crackers on the storage cart; - A food wrapper and debris below the food shelving; - The chest freezer with 1 in. frost buildup and a damaged gasket along the upper interior surface; - One light fixture without a plastic cover; - Three flies flew around the storage shelves. 3. Observations on 04/09/24 at 8:40 A.M., 04/10/24 at 1:47 P.M., and 04/12/24 at 08:55 A.M., of the dining room showed: - A buildup of dried white grime on the upper part of the left and right-side corner crevices of the ice dispenser machine located in the steam table serving area; - An uncovered 32 gallon trash can partially filled near the kitchen entrance; - A buildup of brown grime on the clear plastic dispensing area of the ice dispenser machine located in the steam table serving area; - The ice dispensing machine drain with debris along the sides and the floor below, and the drain with no visible air gap; - The ice dispensing machine exterior front and side surfaces with white grime buildup; - The dining serving area with black grime on the floor; - The dining area floor with scattered debris; - The steam table shields with film buildup; - The faucet and sink basin with white grime buildup in the steam table serving area; - The countertop with a 2 ft non-intact Formica (a hard durable plastic laminate used for countertops) in the steam table serving area; - A wooden cabinet with one missing cabinet door and drawer front in the steam table serving area; - Twelve flies flew around the dining tables, the trash receptacle, the windows and steam table serving area. 4. Observation of the meal preparation on 04/10/24 at 12:32 P.M., showed: - An uncovered one-half gallon red bucket with a dish cloth and gray liquid sat on the serving area counter near the steam table; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Dietary Aide (DA) Q served salad and loaded the food trays without a proper restraint of exposed facial hair; - DA R touched and opened a hot dog bun with his/her bare hand and placed a hot dog inside the bun with a utensil; - A cart with unwrapped individual carrot cake desserts sat in the dining area while four flies circled the cart. During an interview on 04/10/24 at 1:04 P.M., the Assistant Dietary Manager said the kitchen had several issues that should be addressed, including flies. The facility policy should be followed by dietary workers. The dishwashing sanitizer was used for cleaning tables in between dining and it was kept in a small red bucket in the serving area for emergency cleanings during the meals. Ready to eat foods should not be handled by staff with bare hands and staff should wear restraints over beard hair. Walls, floors, and counters should be clean and in good repair. Each refrigerator and freezer should have separate thermometers. During an interview on 04/10/24 at 1:25 P.M., DA S said they had two workers quit recently and cleaning had been a challenge. The can opener was supposed to be cleaned after each use. Dietary workers were expected to follow the facility policy. During an interview on 04/16/24 at 12:21 P.M., the Interim Maintenance Director said there should not be flies in the facility, including the kitchen and dining area. The Regional Maintenance Director was contacted to see what could be put in place to help with the flies in the kitchen. Kitchen repairs should be made by maintenance including plumbing leaks, replacing filters, fixing walls and cleaning vents. The facility should be kept in good repair. During an interview on 04/16/24 at 1:59 P.M., the Administrator said she was aware the kitchen had several issues that should be addressed and had done her own tour recently. Dietary workers should be following facility policy. Overhead vents should be clean in the kitchen and dining areas. The dishwasher should be clean and leak free. Food should not be handled by staff with bare hands and staff should wear hair nets and cover beards. Deep cleaning was a concern and should be done more often. Lighting and ventilation should be clean and intact. All appliances should be clean. Walls, floors, and counters should be clean and intact. There should not be flies in the kitchen and dining area.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 45693 Based on interview and record review, the facility failed to review and update the facility assessment (an assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies) at least annually. The facility census was 96. Review of the facility assessment, dated 02/12/23, showed: - Annual update due 02/12/24, not completed; - No documentation the Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committees reviewed the facility assessment; - The number of residents with intellectual and/or developmental disability not accurate; - The assessment indicated no residents had behavioral healthcare needs (including trauma/post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event)) with an individualized care plan; - The competencies required by the facility did not include catheter care, falls, communication, behavioral health (including PTSD and trauma history), or meeting the needs of individuals with mental illness/ intellectual disability or development disability. During an interview on 04/15/24 at 10:15 A.M., the Administrator and Assistant Director of Nursing (ADON) said they would expect the facility assessment to be completed and reviewed annually. They did it together sometime in February, but must not have changed the date. The facility did have intellectually disabled residents, multiple residents with PTSD, and most residents in the facility had behaviors. All the competencies listed should have been included as they had residents that fall in those categories.		

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 45693 Based on interview and record review, the facility failed to ensure the medical director worked with the facility's clinical team to assure residents attain or maintain their highest practicable physical, mental and psychosocial well-being and failed to ensure the medical director participated and was involved in conducting the Facility Assessment, implementation of resident care policies, and attending the Quality Assessment and Assurance (QAA) Committee. This deficient practice had the potential to affect all residents of the facility. The facility census was 96. The facility did not provide a policy regarding the responsibilities of the Medical Director (MD). Review of the Facility Assessment, dated 02/12/23, showed: - Annual update due 02/12/24, not completed; - No documentation that the QAA and the Quality Assurance Performance Improvement (QAPI) committees reviewed the Facility Assessment. Review of the signature sheets for the QAPI meetings, dated 12/19/23 through 03/19/24, showed no MD signature for the QAPI meetings on 12/19/23, 01/16/24, 02/20/24 and 03/19/24. During an interview on 04/16/24, the Administrator said she became the facility administrator in February 2024. She said the MD did not attend the QAA committee meetings. During an interview on 04/16/24 at 2:59 P.M., the MD said the new administration scheduled the QA meetings on days he could not attend. He previously had attended when the meetings were not on clinical days. He did not participate in the completion of the Facility Assessment. It had been at least 2020 since he participated in the review of the facility's policies and procedures.		

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 45693 Based on record review and interview the facility failed to provide written notice to the State agency responsible for licensing the facility when their Director of Nursing (DON) was no longer employed. This had the potential to affect all resident. The facility census was 96. Review of the facility's policy titled, Nursing Staff, undated showed: - The facility must designate a Registered Nurse (RN) to serve as the DON on a full time basis. Review of the Facility Assessment Tool, last reviewed 02/12/23, showed the facility required a full time DON. Review of the facility Nursing Schedule for 04/01/24 through 04/16/24, showed: - No documentation of a DON scheduled 04/01/24 - 04/16/24; - No documentation a DON worked 04/01/24 - 04/16/24, with 16 out of 16 days missed. Review of the DON's Termination Notice, dated 04/01/24, showed: - Last day worked 03/29/24; - Termination date of 04/01/24. Observations of the facility on 04/09/24 through 04/12/24, 04/15/24 and 04/16/24, showed no DON worked in the facility. During an interview on 04/11/24 at 11:30 A.M., the Administrator said they did not have a DON. The last DON worked on 3/29/24 for the last time, and was terminated effective 04/01/24. They had an advertisement for a new DON. They had not sent in the notice to the State agency about the DON no longer working there because they did not have a new DON to fill the job title yet.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 45693 Based on interview and record review, the facility failed to have a Quality Assurance and Performance Improvement (QAPI) (a program to improve the processes for the delivery of health care and quality of life for the residents) program in place with policies and protocols describing how the facility will identify and correct its own quality deficiencies. This deficient practice had the potential to affect all residents in the facility. The facility census was 96. The facility's policy titled, Policy and Procedure Quality Assurance and Improvement Plan (QAPI), dated, 04/10/19 showed: PURPOSE: The primary purpose of the QAPI program is to establish data-driven facility wide processes that improve the quality of care, quality of life, and clinical outcomes of our residents; - The QAPI program will be developed with governance and leadership; - Members of the facility leadership are accountable for QAPI efforts; - Adverse events will be tracked, monitored and investigated as they occur; - Action plans will be implemented to prevent recurrence of adverse events; - A summary of the reports and findings from meetings; - A summary of any approaches, action plans to be implemented, conclusions and recommendations. Review showed the facility did not follow their QAPI plan that contained the necessary policies and protocols describing how they would identify and correct their quality deficiencies, track and measure performance, and establish goals and thresholds for performance measurement. During an interview on 04/16/24 at 11:30 A.M., the Administrator said the facility had no documentation showing what needed to be improved on, or outcomes of working on issues. The facility had a tracking tool of data, but nothing past that point.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45693 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI - the coordinated application of two mutually-reinforcing aspects of a quality management system): Quality Assurance (QA) and Performance Improvement (PI)) committee developed and implemented policies and procedures that included how it collects and uses data, and monitors concerns for all departments. The facility failed to ensure the QAA committee developed and implemented action plans to correct identified quality deficiencies and failed to conduct at least one Performance Improvement Project (PIP) annually that focused on a high risk area identified by the facility. This had the potential to affect all residents in the facility. The facility census was 96. The facility's policy, Policy and Procedure Quality Assurance and Improvement Plan (QAPI), dated, 04/10/19, showed: - Performance Improvement Projects (PIPs) will be initiated when problems are identified; - PIPs will involve systematically gathering information to clarify issues and to intervene for improvements; - Root cause analysis (RCA) will be used to determine whether identified issues are exacerbated by the way care and services are organized or delivered and if so how; -RCA serves as a highly structured approach to fully understanding the nature of an identified problem, its cause and implications of making changes to improve the problem. During an interview on 04/16/24 at 1:30 P.M., the Administrator said the facility had not done a PIP since she started in February and there was no record of a PIP prior. The Administrator said the facility had an approved waiver for not having a RN for the required amount of time, but when the last Director of Nursing left, the waiver became null and void.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45693 Based on interview and record review, the facility failed to maintain quarterly Quality Assessment and Assurance (QAA) committee meetings with the required members. These practices had the potential to affect all staff and residents. The facility census was 96. The facility's policy, Policy and Procedure Quality Assurance and Improvement Plan (QAPI), dated 04/10/19, showed: - QAPI Committee Members will include at minimum: The Administrator, Director of Nursing, Medical Director, Activities Director, Social Service Director, Dietary Manager, Housekeeping and Laundry Supervisor, Maintenance Director, additional facility staff, contracted staff including but not limited to Pharmacy consultant, Dietician, Rehab Director; - The Committee will meet monthly at an appointed time. The Quality Assurance Director Job Description, undated, showed: - Schedule meetings of the Quality Assurance Committee, whose membership consists of: Director of Nursing (DON), Medical Director or designee, Administrator, owner, a board member or other individual in a leadership role, infection control and prevention officer. Review of the signature sheets for the Quality Assurance meetings dated 12/19/23 through 03/19/24, showed: - No signature from the Medical Director on the 12/19/23, 01/16/24, 02/20/24 or 03/19/24 signature sheets; - No signature from the DON on the 01/16/24, 02/20/24 or 03/19/24 signature sheets; - No signature from the Administrator or other administrative personnel on the 01/16/24 signature sheet; - No signature from the IP on the 01/16/24, 02/20/24 or 03/19/24 signature sheets. During an interview on 04/16/24 at 1:30 P.M., the Administrator said the medical director does not attend the meetings. Not everyone attends the meetings every time. The only way to track attendance is to go by who signed the signature sheets. The Minimum Data Set ((MDS) a federally mandated assessment tool) Coordinator compiles all the data into the QAPI form. They go over the form during the meeting. There is no documentation showing issues found or plans to resolve issues. During an interview on 04/16/24 at 02:59 P.M., the Medical Director said he/she has not attended a QAPI meeting since last year.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45693 Based on observation, interview and record review, the facility failed to maintain proper infection control practices during colostomy (an opening for the colon through the abdomen) and suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow) care for one resident (Resident #25) out of one sampled resident. The facility failed to maintain proper infection control practices during blood sugar checks for three residents (Residents #22, #38, and #60) out of five sampled residents and insulin administration for one resident (Resident #22) of one resident, when staff failed to perform hand hygiene between each resident and tasks. The facility census was 96. Review of the facility's policy titled Standard Precautions undated, showed: - Wash hands before having direct contact with resident, putting on gloves, and preparing or eating food; - Wash hands after removing gloves or other personal protective equipment, contact with body substances or articles/surfaces contaminated with body substances, contact with resident's intact skin (taking pulse, lifting resident); - It may be necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites; - Remove gloves promptly after use, before touching non-contaminated items and surfaces, and before going to another resident; - Wash hands as soon as possible after glove removal; - Needles-take care to prevent injuries when disposing of used needles, place used disposable needles and other sharp items in appropriate puncture-resistant containers. Review of the facility's policy titled, Urinary Catheter Care, undated showed: - Nursing assistants must do catheter and perineal care with a.m. and p.m. care, and after each of the resident's bowel movements; - Always wash your hands before and after handling the catheter, tube or bag, and wear gloves; - Clean the area where the catheter is inserted by wiping away from the insertion site, to prevent germs from being moved from the anus to the urethra; - Wash the catheter to remove any blood or other materials from the catheter, wiping downwards; - Keep the bag below the level of the resident's bladder at all times; - Use a catheter bag to cover to protect the resident's dignity. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Observation on 04/12/24 at 7:30 A.M., of colostomy and suprapubic catheter care for Resident #25 showed: - Restorative Aide (RA) I and Certified Nursing Assistant (CNA) D did not perform hand hygiene upon entering the room; - Resident lay in bed on his/her back; - CNA D and RA I put on gloves and pulled the sheet back; - RA I removed the gloves, failed to perform hand hygiene, touched the door knob to leave the room to gather supplies, and told a nurse the colostomy needed changed; - CNA D removed the colostomy bag and the suprapubic catheter dressing soiled with fecal material from the leaking colostomy; - CNA D removed the gloves, did not perform hand hygiene, and left the room to discard the waste; - RA I entered the room without performing hand hygiene and put on gloves; - RA I cleansed the resident's abdomen around the colostomy toward the suprapubic catheter insertion site; - CNA D entered the room, did not perform hand hygiene, put on gloves, and rolled the resident to his/her side; - RA I cleansed the resident's right side, removed the gloves, did not perform hand hygiene, and left the room with soiled wash cloths; - Licensed Practical Nurse (LPN) K entered the room, put on gloves, did not perform hand hygiene, applied skin prep (wipes that forms a barrier between the patient's skin and adhesives to help preserve skin integrity) around the stoma (a surgically made hole in the abdomen that allows body waste to be removed from the body directly through the end of the bowel into a collection bag), and applied the new colostomy bag; - LPN K removed the gloves, did not perform hand hygiene, and left the room; - RA I entered the room, put on gloves, did not perform hand hygiene, and placed the catheter bag on top of the resident's abdomen with the urine flowing back towards the resident's bladder. - RA I and CNA D transferred the resident from the bed to the wheelchair by the hooyer lift (a mechanical lift); - RA I and CNA D removed their gloves. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/12/24 at 8:10 A.M., RA I said fecal material should be cleansed away from the suprapubic catheter opening. Hands should be sanitized between glove changes, but he/she didn't have hand sanitizer during the resident's care. Catheter bags should always remain below the bladder so urine does not flow back to the bladder. 2. Observation on 04/15/24 at 11:26 A.M., of the blood sugar check and the insulin administration for Resident #38 showed: - LPN H put on gloves, did not perform hand hygiene, and obtained the resident's blood sugar with a lancet (used to make a tiny prick in the skin to obtain a few drops of blood for testing); - LPN H threw the used lancet away in the open trash container on the side of the medication cart; - LPN H failed to perform hand hygiene when he/she changed, administered insulin, and removed the gloves; - LPN H failed to place the used lancet in a sharps container. Observation on 04/15/25 at 11:40 A.M., of the blood sugar check for Resident #22 showed: - LPN H put on gloves and failed to perform hand hygiene; - LPN H obtained the resident's blood sugar with a lancet; - LPN H threw the used lancet away in the trash can in the resident's room; - LPN H failed to place the used lancet in a sharps container. Observation on 04/15/24 at 4:45 P.M., of the blood sugar check for Resident #60 showed: - LPN A put on gloves and failed to perform hand hygiene; - LPN A obtained the resident's blood sugar with a lancet; - LPN A removed the gloves and failed to perform hand hygiene. 3. During an interview on 04/15/24 at 11:41 A.M., LPN H said only syringes go in the sharps container and insulin vials, meter strips and lancets can be thrown away in the regular trash because there was not enough blood on the strips, and the used lancets retracted. During an interview on 04/15/24 at 1:30 P.M., the Assistant Director of Nursing (ADON) and the Administrator said hands should be sanitized between glove changes and when going from dirty to clean care. The catheter bag should always remain below the resident's bladder. Fecal material should not have been cleansed toward the suprapubic catheter site but away from it and the tubing should then be cleansed from the insertion point down. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Bellevue Valley Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23144 Highway 32 Bellevue, MO 63623	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/24 at 10:30 A.M., the Administrator said hand hygiene should be completed between residents and tasks when performing blood sugars and insulin administration. Lancets should go in the biohazard container. 47445 48532		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility staff failed to conduct regular inspections of all bed frames, mattresses and side rails as part of a regular maintenance program for three residents (Residents #3, #13, and #20) out of 20 sampled residents. The facility census was 96. Review of the Federal Drug Administration (FDA) documents entitled, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated [DATE], showed 413 people died as a result of entrapment events in the United States. Further review revealed those among the most vulnerable for these entrapment type events are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Review of the FDA document entitled, Practice Hospital Bed Safety, dated February 2013, showed different potential zones of entrapment. The guidance characterizes the head, neck, and chest as key body parts that are at risk for entrapment. 1. Review of Resident #3's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident showed: - On [DATE] at 04:16 P.M., [DATE] at 9:31 A.M. and 1:12 P.M., the resident lay in a low bed with a fall mat on the floor and upper ,d+[DATE] bed rails in raised position on right and left sides of the bed; - On [DATE] at 2:51 P.M., [DATE] at 9:12 P.M., [DATE] at 9:42 A.M., and [DATE] at 1:15 P.M., the resident lay in a low bed with a fall mat on the floor and the upper right ,d+[DATE] bed rail in raised position on the left side of the bed against the wall. 2. Review of Resident #13's medical record showed: - admitted on [DATE]; - No documentation of a maintenance assessment for side rails. Observations of the resident showed: - On [DATE] at 4:19 P.M., and [DATE] at 2:57 P.M., the resident lay in a low bed with upper ,d+[DATE] bed rails in raised position on upper both sides of the bed; (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 9:27 A.M., the resident sat on the bedside, with the left upper ,d+[DATE] bed rail in the raised position to the left side of resident, upper ,d+[DATE] bed rail in raised position on the right side of the bed; - On [DATE] at 01:12 P.M., [DATE] at 03:10 P.M., [DATE] at 09:35 P.M., and [DATE] at 01:15 A.M., the resident sat in a wheelchair in hall, upper ,d+[DATE] bed rails in raised position on right and left sides of the bed. 3. Review of Resident #20's medical record showed: - admitted on [DATE]; - No documentation of maintenance assessment for side rails. Observations of the resident showed: - On [DATE] at 9:34 A.M., the resident lay in bed with the left lower leg crossed over the right leg with his/her left foot between the inside bars of the upper raised ,d+[DATE] bed rail on the right side of the bed, upper , d+[DATE] bed rails in raised position on both right and left sides of the bed; - Resident unable to remove his/her foot from the upper ,d+[DATE] bed rail in raised position on right side of the bed. Certified Nursing Assistant (CNA) L entered the resident's room and moved his/her foot out of the raised ,d+[DATE] bed rail; - On [DATE] at 1:12 P.M., [DATE] at 2:54 P.M., and [DATE] at 1:15 P.M., the resident lay in a low bed with a fall mat in the floor and left upper ,d+[DATE] bed rail up in raised position on the wall side of bed; - On [DATE] at 3:10 P.M., the resident sat in a wheelchair, left upper ,d+[DATE] bed rail up in raised position on the wall side of bed. During an interview on [DATE] at 09:47 A.M., the Minimum Data Set (MDS - a federally mandated assessment completed by the facility) Coordinator said he/she thought hospice brought new beds. He/She was unaware there were side rails and they have been removed. During an interview on [DATE] at 11:02 A.M., the Administrator said there were no assessments/inspections completed on the bed rails, and no documentation that she is aware of.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 45693 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the insect population in the facility. The facility census was 96. The facility did not provide a policy on pest control. Review of the monthly pest control invoices provided for 2024 showed: - January service targeted the German roach, the house mouse, and the Norway rat; - February service targeted the German roach, the house mouse, and the Norway rat; - March service targeted the German roach, the house spider, the house mouse, and house ants; - April service targeted the German roach, house ants, and the house mouse. Review showed the monthly pest control invoices did not include any services targeting flies. Observations on 04/09/24 at 8:20 A.M., 04/10/24 at 1:27 P.M., and 04/12/24 at 8:35 A.M., of the kitchen showed four flies in the kitchen food prep area. Observations on 04/09/24 at 8:30 A.M., 04/10/24 at 1:37 P.M., and 04/12/24 at 8:45 A.M., of the dry food storage room showed three flies flew around the storage shelves. Observations on 04/09/24 at 8:40 A.M., 04/10/24 at 1:47 P.M., and 04/12/24 at 8:55 A.M., of the dining room showed 12 flies flew around the dining tables, the trash receptacle, the windows and the steam table serving area. Observation of the meal preparation on 04/10/24 at 12:32 P.M., showed: - A cart with unwrapped individual carrot cake desserts sat in the dining area while four flies circled the cart; - Six flies flew around and crawled on the food debris in an open 32 gallon trash barrel partially filled. Observation of room A17 on 04/16/24 at 9:43 A.M., showed two flies flew around the room. Observation of A Hall nurses' office on 04/16/24 at 11:51 A.M., showed four flies flew around the room. During an interview on 04/12/24 at 9:43 A.M., the resident in room A17 said flies were a problem in the room and made it hard to sleep. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/24 at 1:04 P.M., the Assistant Dietary Manager said the kitchen had several issues that should be addressed, including flies. During an interview on 04/16/24 at 11:51 A.M., Licensed Practical Nurse (LPN) A said it was normal for flies to be in the nurses' office and it had gotten worse in the last two weeks. They were noticed more inside the office than outside. Corporate was contacted about the flies and they were looking for options on fly control. The flies were also reported to maintenance and the pest control service was called but nothing was helping. During an interview on 04/16/24 at 12:21 P.M., the Interim Maintenance Director said there should not be flies in the facility including the kitchen and the dining area. The Regional Maintenance Director was contacted to see what can be put in place to help with flies in the kitchen. They had gotten worse since it warmed up. The insect problem should be addressed. During an interview on 04/16/24 at 1:59 P.M., the Administrator said there should not be flies in the kitchen and dining area. They were working on solutions to solve the problem including sprays to the outside windows and doors. 46521 48532		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 45693 Based on record review and interview, the facility failed to develop, implement and maintain an effective training program for all new and existing staff consistent with their expected roles, including keeping records of the trainings received by staff. This had the potential to affect all staff and residents. The facility census was 96. The facility did not provide a training program policy, records of completing the training, nor performance evaluations/appropriate return practice of the following required training programs: - The abuse, neglect, and exploitation prevention and dementia management training program; - The Quality Assurance and Performance Improvement ((QAPI) the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving) program and the elements of the program including the goals and the roles played by various staff; - The required in-service training for Nurse Aides; - Behavioral Health training. During an interview on 04/15/24 at 1:30 P.M., the Assistant Director of Nursing (ADON) said they could not find the in-services from the last Director of Nursing (DON), and the DON before that destroyed a bunch of paperwork when he/she quit. The ADON said he/she was in charge of the training until a new DON could be hired. During an interview on 04/16/24, the Administrator said the facility should have documentation of all required trainings and should have policies in place for those programs.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 37575 Based on record review and interview the facility failed to ensure all facility staff participated in an abuse, neglect, and exploitation prevention program and a dementia management training program, with a process in place to track attendance. This had the potential to affect all residents. The facility census was 96. The facility did not provide abuse, neglect, and exploitation prevention and dementia management training records. On 04/15/24 at 1:30 P.M., the Assistant Director of Nursing (ADON) said they could not find the in-services from the last Director of Nursing (DON), and the DON before that destroyed a bunch of paper work when he/she quit. The ADON said they do inservices with staff once a month, but did not know when the abuse, neglect, and exploitation prevention and dementia management training program training had last been done. The ADON said he/she was in charge of the training until a new DON could be hired. During an interview on 04/16/24, the Administrator said the facility should have documentation of the abuse and neglect training for all staff. 45693		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 45693 Based on record review and interview, the facility failed to conduct mandatory training for all staff on the facility's Quality Assurance and Performance Improvement ((QAPI) the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving) program and the elements of the program including the goals and the roles played by various staff. This had the potential to affect all resident and staff. The facility census was 96. The facility's policy titled, Policy and Procedure Quality Assurance and Improvement Plan (QAPI), dated, 04/10/19 showed: PURPOSE: The primary purpose of the QAPI program is to establish data-driven facility wide processes that improve the quality of care, quality of life, and clinical outcomes of our residents; - The QAPI program will be developed with governance and leadership; - Members of the facility leadership are accountable for QAPI efforts; - Adverse events will be tracked, monitored and investigated as they occur; - Action plans will be implemented to prevent recurrence of adverse events; - A summary of the reports and findings from meetings; - A summary of any approaches, action plans to be implemented, conclusions and recommendations; - Providing frequent leadership and staff training on the QAPI plan and its underlying principles, including the concept that systems of care and business practices must support quality care or be changed. The facility did not provide records of staff receiving training on the QAPI program. Interviews with all levels of staff, throughout the survey showed none had received any information or training on a QAPI program. During an interview on 04/15/24, the Assistant Director of Nursing (ADON) said the facility does not currently have a DON. The ADON has had to assume many of the DON's duties, including her role in the QAPI program. The ADON could not locate any training records regarding QAPI. During an interview on 04/16/24, the Administrator said she could not find any records of training all staff members on the QAPI program.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37575 Based on record review and interview the facility failed to develop, implement and permanently maintain a nurse aide (NA) in-service training program that is appropriate and effective as determined by nurse aide performance reviews and the facility assessment. This deficient practice had the potential to affect all residents and staff of the facility. The facility census was 96. The facility did not provide a policy regarding nurse aide training or performance reviews. The facility did not provide any nurse aide training records or performance reviews. Review of the facility assessment, dated 02/12/23, showed: - Facility assessment not reviewed annually since 2023; - No documentation that the Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committee reviewed the facility assessment; - The number of residents with intellectual and or developmental disability not accurate; - The behavioral healthcare needs (Including Trauma/PTSD) who have an individualized care plan to be zero and inaccurate; - The competencies required by the facility did not include catheter care, falls, communication, behavioral health (including PTSD and Trauma History), or meeting the needs of individuals with mental illness/intellectual disability or development disability. During interviews: - On 04/16/24 at 10:15 A.M., Certified Nurse Aide (CNA) E said he/she had worked at the facility for about one and one-half years. He/she should have received a performance evaluation but was told the facility wasn't doing them right now; - On 04/16/24 at 10:19 A.M., CNA C said he/she had not heard about performance evaluations and had not received one. CNA C had worked there over a year; - On 04/16/24 at 10:24 A.M., CNA N had received a performance evaluation in 02/23, but did not receive one in 02/24. CNA N had worked there over a year; - On 04/15/23 at 1:30 P.M., the Assistant Director of Nursing (ADON) said they could not find the in-services from the last Director of Nursing (DON), and the DON before that destroyed a bunch of paper work when he/she quit. There is no current DON. The ADON said he/she is in charge of the NA inservice training, but did not know about the documentation of the training. The ADON said she has had to take a lot of the DON's responsibilities until they can hire a new one; (continued on next page)		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 04/16/23 at 10:30 A.M., the Administrator (ADM) said they had not started performance reviews for the nurse aides yet. 45693		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 45693 Based on interview and record review the facility failed to develop, implement and maintain an effective training program for all staff which included an effective behavioral health care and services training, as determined by staff need and the facility assessment. This deficient practice affected two sampled employees hired within the last year. The facility census was 96. The facility failed to provide a policy regarding behavioral health training. Review of the facility assessment, dated 02/12/23, showed: - Facility assessment not reviewed annually since 2023; - No documentation showing the Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committee reviewed the facility assessment; - The number of residents with intellectual and or developmental disability not accurate; - The behavioral healthcare needs (Including Trauma/PTSD) who have an individualized care plan to be zero and inaccurate; - The competencies required by the facility did not include catheter care, falls, communication, behavior health (including PTSD and Trauma History), or meeting the needs of individuals with mental illness/ intellectual disability or development disability. Review of the medical diagnoses (dx) of the 96 residents present during the on-site survey, as provided by the facility, showed: - Thirty-one residents had dx of schizophrenia (disorder that affects a person's ability to think, feel and behave clearly); - Eighteen residents had a dx of bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs); - Sixty-five residents had a dx of anxiety (intense, excessive and persistent worry and fear about everyday situations); - Forty-six residents had dx of depression (loss of pleasure or interest in activities for long periods of time); - Sixty-seven residents had dx of schizoaffective disorder (mental health condition including a combination of schizophrenia and a mood disorder like depression or bipolar); - Eleven residents had dx history of suicide attempt/suicidal ideations (thoughts); (continued on next page)		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Twenty-one residents had dx of personality disorder (condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems); - Twenty residents had dx of post traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); - Twenty-seven residents had dx of psychosis (mental disorder characterized by disconnection from reality). 1. Review of Certified Nurse Aide (CNA) G's employee file showed: -A hire date of 03/02/23; -No documentation of behavioral health training. 2. Review of CNA M's employee file showed: -A hire date of 01/26/23; -No documentation of behavioral health training. During an interview on 04/15/24 at 1:30 P.M., the Assistant Director of Nursing (ADON) said they could not find the in-services from the last Director of Nursing (DON,) and the DON before that destroyed a bunch of paper work when he/she quit. The ADON said they do inservices with staff once a month, but did not know what the specific training for behavioral residents was, or when it had last been done. The ADON said he/she was in charge of the training until a new DON could be hired. During an interview on 04/16/24 at 10:30 A.M., the Administrator said facility needed to offer behavioral health training.		