

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Nixa Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1104 North Main Street Nixa, MO 65714	
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 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** 48534 Based on interview and record review, the facility failed to ensure all allegations of possible misappropriation were reported to the State Survey Agency (Department of Health and Senior Services, DHSS) within the required 24-hour time frame when staff failed to report an allegation of misappropriation of property made by one resident (Resident #122). The facility census was 65. Review of the facility's policy titled Reporting - Abuse Policy, undated, showed the following: -It is the policy of the facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties; -Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator; -The nursing some administrator or designee will report abuse to the state agency per State and Federal requirements. 1. Review of Resident #122's face sheet (resident's information at a quick glance) showed the following information: -admitted [DATE] with readmitted [DATE]; -Diagnoses included sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age) and hyperlipidemia (high levels of fat in blood). Review of the resident's significant change Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 04/30/24, showed the resident was cognitively intact. During an interview on 07/15/24, at 10:07 A.M., the resident said the following: -He/she did not want to answer any questions because he/she was upset; -An aide took his/her embroidery scissors from him/her a couple of weeks ago; (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The scissors were taken by an aide that worked the night shift and the resident did not know the aides name; -The resident spoke with the Administrator and Social Service Director (SSD) this morning and they were not aware that the resident's scissors had been taken by an aide; -He/she likes to crochet and used the scissors to cut yarn; -The scissors had a yellow, plastic handle and the blades were very small and short; -The scissors were a gift from his/her family that had visited from out of state; -He/she had not been told he/she could not have scissors. During an interview on 07/16/24, at 10:30 A.M., the resident said the following: -He/she does not participate in activities and prefers to stay in his/her room and crochet; -No one has followed up with him/her about his/her scissors; -The resident had no scissors to cut his/her yarn. Review of the facility's July 2024 Grievance Log showed no grievances had been filed for the month of July 2024. During an interview on 07/16/24, at 11:40 A.M., the SSD said the resident came to the SSD on 07/15/24 stating that an aide had taken his/her embroidery scissors. The SSD asked the resident if he/she wanted to file a formal grievance and the resident said no. During an interview on 07/18/24, at 1:20 P.M., the Housekeeping Supervisor said the following: -The staff were told in morning meeting that the resident's scissors had been taken by an aide; -The residents aren't allowed to have regular scissors, but can have safety scissors; -The Housekeeping Supervisor gave the resident his pair of safety scissors until administration finds which aide took the resident's scissors. During an interview on 07/18/24, at 1:24 P.M., the Activities Director said the following: -The resident does not participate in group activities; -The resident crochets in his/her room; -The staff were told in morning meeting that the resident's scissors had been taken by an aide; -There was no risk associated with the resident having scissors. (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 resident's record showed staff did not document reporting the allegation of misappropriation. Review of DHSS records showed the home did not self-report the allegation of misappropriation. During an interview on 07/23/24, at 2:00 P.M., Certified Nurse Aide (CNA) A said the following: -Misappropriation is a form of abuse and should be reported to administration; -If misappropriation was reported to CNA A, he/she reported it to the charge nurse and the chain of command; -The state required allegations of abuse, neglect, and misappropriation be reported to the state within two hours. During an interview on 07/23/24, at 2:15 P.M., Certified Medical Technician (CMT) B said the following: -If a resident reported abuse, neglect, or misappropriation to him/her, CMT B would tell the charge nurse immediately; -The state required allegations of abuse, neglect, or misappropriation to be reported to the state within two hours. During an interview on 07/23/24, at 2:11 P.M., SSD said the following: -If a resident reported abuse, neglect, or misappropriation to him/her, SSD would report it to the Administrator; -The Administrator and Director of Nursing (DON) investigate allegations; -The state required allegations of misappropriation be reported to the state within 24 hours; -There have not been any allegations of misappropriation; -The resident did report to her on 07/15/24, that an aide took his/her scissors; -He/she ask the resident if he/she wanted to file a formal grievance and the resident said no; -Staff were looking for the resident's scissors; -She did not report the misappropriation allegation to the state. During an interview on 07/23/24, at 3:45 P.M., the DON said the following: -The resident had been at the home for over a year; -The resident had scissors to use for crocheting; (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no risk associated with the resident having scissors; -The SSD should document the allegations made by the resident; -The allegation of misappropriation should have been reported to the stated within 24 hours. During an interview on 07/23/24, at 3:52 P.M., the Administrator said the following: -During his morning rounds on 07/15/24, he was told by the resident that an aide had taken his/her scissors; -He referred the resident to the SSD to file a grievance; -Staff was made aware of the missing scissors in a morning meeting; -Staff would look for the scissors; -Reports of items taken by staff would be considered misappropriation and should be reported to the state within 24 hours.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on interview and record review, the facility failed to complete investigations of all allegations of misappropriation when staff failed to investigate one resident's (Resident #122) allegation of misappropriation. The facility census was 65. Review of the facility's policy titled Investigation, undated, showed the following: -It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated; -The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed; -The facility staff will complete an active search for missing item(s) including documentation of investigation; -The investigation will consist of at least the following: a review of the completed complaint report; an interview with the person or persons reporting the incident; interviews with any witnesses to the incident; a review of the resident medical record if indicated; a search of resident room (with resident permission); an interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident; and interviews with the resident's roommate, family members and visitors. 1. Review of Resident #122's face sheet (resident's information at a quick glance) showed the following information: -admitted [DATE] and readmitted [DATE]; -Diagnoses included sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age) and hyperlipidemia (high levels of fat in blood). Review of the resident's significant change Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 04/30/24, showed the resident was cognitively intact. During an interview on 07/15/24, at 10:07 A.M., the resident said the following: -He/she did not want to answer any questions because he/she was upset; -An aide took his/her embroidery scissors from him/her a couple of weeks ago; -The scissors were taken by an aide that worked the night shift and the resident did not know the aides name; (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident spoke with the Administrator and Social Service Director (SSD) this morning and they were not aware that the resident's scissors had been taken by an aide; -He/she likes to crochet and used the scissors to cut yarn; -The scissors had a yellow, plastic handle and the blades were very small and short; -The scissors were a gift from his/her family that had visited from out of state; -He/she had not been told he/she could not have scissors. During an interview on 07/16/24, at 10:30 A.M., the resident said the following: -He/she does not participate in activities and prefers to stay in his/her room and crochet; -No one has followed up with him/her about his/her scissors; -The resident had no scissors to cut his/her yarn. Review of the resident's record showed staff did not document investigating the allegation of misappropriation of the resident's scissors. During an interview on 07/16/24, at 11:40 A.M., the SSD said the resident came to the SSD on 07/15/24 stating that an aide had taken his/her embroidery scissors. The SSD asked the resident if he/she wanted to file a formal grievance and the resident said no. During an interview on 07/18/24, at 1:24 P.M., the Activities Director said the following: -The resident does not participate in group activities; -The resident crochets in his/her room; -The staff were told in morning meeting that the resident's scissors had been taken by an aide; -There was no risk associated with the resident having scissors. Review of the facility's July 2024 Grievance Log showed no grievances had been filed for the month of July 2024. Review of the facility records showed the facility did not provide a timely written investigation of the resident's allegation of misappropriation. During an interview on 07/23/24, at 2:00 P.M., Certified Nurse Aide (CNA) A said administration is responsible for investigating allegations of misappropriation. During an interview on 07/19/23, at 1:42 P.M., Certified Medication Tech (CMT) C said the Director of Nursing (DON) investigated allegations of misappropriation and the state would send someone to investigate. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/23/24, at 2:11 P.M., SSD said the administrator and Director of Nursing (DON) investigate allegations of abuse, neglect, and misappropriation. There had not been any allegations of misappropriation. The resident did report to her on 07/15/24, that an aide took his/her scissors. During an interview on 07/23/24, at 3:45 P.M., the DON said she and the Administrator were responsible for completion of investigations of abuse, neglect, exploitation, and misappropriation. The resident had been at the home for over a year and had scissors to use for crocheting. There was no risk associated with the resident having scissors. The SSD should document the allegations made by the resident. During an interview on 07/23/24, at 3:52 P.M., the Administrator said the following: -The Administrator said that during his morning rounds on 07/15/24, he was told by the resident that an aide had taken his/her scissors; -The Administrator said reports of items taken by staff were considered misappropriation.		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28865 Based on interview and record review, the facility failed to ensure each resident's choice of to receive Cardiopulmonary Resuscitation (CPR - an emergency treatment that's done when someone's breathing or heartbeat has stopped) or not was consistently and clearly documented when staff documented conflicting CPR choice information for 10 residents (Resident #11, #12, #17,#23, #26, #30, #40, #41, #46 and #58) out of a sample of 16 residents. The facility census was 65. Review of the facility's policy and procedure titled, Advanced Directives from the Nursing Guidelines Manual, undated, showed the following: -The facility will respect advance directives in accordance with state law; -Upon admission of a resident to the facility, the Social Services Designee (SSD) will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive; -Upon admission of a resident, the social services designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives; -Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record under the advance directive tab; -Advance directives include, but are not limited to, living will (a document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis) and do not resuscitate (DNR - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy or representative has directed no CPR or other life saving methods are to be used; -Inquiries concerning advance directives should be referred to the SSD. 1. Review of Resident #11's face sheet (a document that gives a resident's information at a quick glance) showed the following information: -admitted [DATE]; -The resident's code status was full code (wished to receive CPR). Review of the resident's [DATE] Physician Order Sheet (POS) showed and order, dated [DATE], for DNR status Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR. (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was purple DNR sheet, dated [DATE], which directed staff to not provide CPR. 2. Review of Resident #12's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident's [DATE] POS showed an order, dated [DATE], for DNR status. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -Resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated [DATE], which directed staff to not complete CPR. 3. Review of Resident #17's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident's [DATE] POS showed an order, dated [DATE], for DNR status for the resident. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple (DNR) sheet, dated [DATE], which directed staff to not provide CPR. 4. Review of Resident #23's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's [DATE] POS showed an order, dated [DATE], for full code status . Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated [DATE], that directed staff to not provide CPR. 5. Review of Resident #26's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident [DATE] POS showed an order, dated [DATE], for DNR status for the resident. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated [DATE], which directed staff to not provide CPR. 6. Review of Resident #30's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident's [DATE] POS showed an order, dated [DATE], for DNR status. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated [DATE], that directed staff to not perform CPR. (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #40's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident's [DATE] POS showed an order, dated [DATE], for DNR code status. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR code status. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind this resident's admission face sheet was a purple DNR sheet, dated [DATE], which directed staff to not perform CPR. 8. Review of Resident #41's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident's [DATE] POS showed an order, dated [DATE], for DNR status. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR code status. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple (DNR) sheet, dated [DATE], which directed staff to not perform CPR. 9. Review of Resident #46's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the resident's [DATE] POS showed an order, dated [DATE], for DNR code status. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR code status. Review of the facility's Code Status Book located at the nurses' desk showed the following: (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated [DATE], which directed staff to not perform CPR. 10. Review of Resident #58's face sheet showed the following information: -admitted [DATE]; -The resident's code status was full code. Review of the [DATE] POS showed an order, dated [DATE] for DNR code status. Review of the resident's care plan, dated [DATE] and reviewed on [DATE], showed the resident chose to be a DNR code status. Review of the facility's Code Status Book located at the nurses' desk showed the following: -The resident's admission face sheet showed the resident was a full code; -Behind the resident's admission face sheet was a purple DNR sheet, dated [DATE], which directed staff to not perform CPR. 11. During an interview on [DATE], at 3:00 P.M., the SSD said she was responsible for keeping each resident's code status up to date. She kept three binders with residents from A Hall, B Hall, and C Hall at the nurses' station with all residents from each of those halls code status, to include DNR or a full code status. The resident's face sheet and the purple advanced health directive sheet were placed in the book in alphabetical order. The book was up to date. The book was where the nurses would go to in case of an emergency to find code status. All residents' face sheets, POS, care plans, and purple sheets should be the same code status, either full code or DNR. During an interview on [DATE], at 3:25 P.M., Licensed Practical Nurse (LPN) E said the residents' advanced health care directive and code status were on the computer, on the residents' face sheets, and on the residents' physicians orders. The face sheet, the care plan, the POS, and the purple sheet should all match with either DNR or full code status. There is a book at the nurses' station that has hard copies of the residents' face sheets and DNR purple sheets which tells the nurses each resident's code status. They should match to be a full code or a DNR. He/she would look on the resident's door for a green (CPR) or red dot (DNR) or in the code status book in an emergency. During an interview on [DATE], at 3:40 P.M., the Administrator and Director of Nursing (DON) both said code status on the residents' face sheets and DNR purple sheets should match to either a full code or a DNR status. The SSD is responsible for keeping the code status books up to date. The DON and Administrator were not aware the books were not updated. Nobody was monitoring the SSD to ensure the code status books were up to date for all residents.		