STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43327 Based on observation, interview, and record review, facility staff failed to revise a comprehensive person-centered care plan for four (Resident #2, #13, #14, and #18) out of six sampled residents who had a fall. The facility census was 56. 1. Review of the facility's Care Plan Comprehensive policy, undated, showed: -Assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition; -The interdisciplinary team (IDT) is responsible for the periodic review and updating of care plans when a significant change has occurred or when changes occur that impact the resident's care. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 3/11/24 showed staff assessed the resident as: -Cognitively impaired; -History of falls one month prior to admission; -Two or more non-injury falls since prior assessment; -History of falls. Review of the nurse notes, dated 04/08/24 at 03:24 P.M., showed the resident found on the floor in the bathroom on back between toilet and wall, knees bent. Review of the care plan, dated 3/12/24, showed staff assessed the resident at risk for falls. Review showed the care plan did not contain new fall interventions or review of the care plan for the fall that occurred on 4/8/24. During an interview on 4/17/24 at 2:00 P.M., the Director of Nursing (DON) said he/she is responsible to ensure the care plans are updated with new interventions after a fall. He/She said the resident's intervention was to place a sign in the restroom reminding the resident to call for assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/19/24 at 11:55 A.M., the DON said the fall intervention was not placed in the care plan for the resident. He/She said the intervention is in the event investigation, however the floor staff do not have access to the event investigation. 3. Review of Resident #13's Quarterly MDS, dated [DATE] showed staff assessed the resident as: -Cognitively intact; -Two or more non-injury falls since prior assessment; -Diagnosis of seizure disorder and traumatic brain dysfunction (brain injury caused by violent force to the head). Review of the nurse notes, dated 03/09/2024 at 06:49 A.M., showed staff documented the resident walked back to bed from the bathroom with his/her wheeled walker. He/She says the tennis ball was coming off the walker causing him/her to lose his/her balance. He/She fell to his/her knee and then sat on the floor. He/She said he/she did not hit his/her head. Denies any pain. Review of the nurse notes recorded as Late Entry on 04/01/24 at 10:42 A.M., showed on 03/31/24 at 12:39 P. M., the resident was found by Certified Nurse Aide (CNA), who called nurse to room. Resident lying face down on the floor with bilateral legs extended. [NAME] laying over him/her on floor with part of it lying under residents leg. Denied hitting head or pain. Review of the residents care plan dated 2/22/24 showed: -The resident has a history of seizures and sustained a closed head injury from a motor vehicle accident; -He/She has a history of falls and is a risk for further injuries related to falls due to poor safety awareness and impulsive nature; -He/She has attention seeking behaviors where he/she will intentionally sit down on the floor; -The care plan did not contain new fall interventions or review of the care plan for the fall 3/9/24 or 3/31/24. During an interview on 4/17/24 at 2:00 P.M., the DON said he/she is responsible to ensure the care plans are updated with new interventions after a fall. During an interview on 4/19/24 at 11:55 A.M., the DON said the new intervention for the resident was to replace the tennis ball on the walker. He/She said the intervention is in the event investigation, however the floor staff do not have access to the event investigation. 4. Review of Resident #14's Quarterly MDS, dated [DATE] showed staff assessed the resident as: -Cognitively intact; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Two or more non-injury falls since prior assessment; -Diagnosis of multiple falls. Review of the nurse notes, dated 4/6/24 at 08:41 A.M., showed staff documented when CNA entered the room to give resident his/her breakfast, he/she on his/her knees in front of his/her wheelchair. He/She attempted to get into bed without assistance. Denies new complaints of pain. Assisted into bed. Review of the residents care plan, dated 2/22/24, showed staff assessed the resident at risk for falls related to decreased cognition and impaired safety awareness. The care plan did not contain new fall interventions or review of the care plan for the fall that occurred on 4/6/24. During an interview on 4/17/24 at 2:00 P.M., the DON said he/she is responsible to ensure the care plans are updated with new interventions after a fall. During an interview on 4/19/24 at 11:55 A.M., the DON said the new intervention was the change of pain medication. He/She said pain was not in the care plan, but it should be. 5. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -No falls since prior assessment; -Diagnosis of Schizophrenia (disorder effects a person's ability to think, feel, and behave clearly). Review of the nurse notes, dated 3/3/24 at 11:46 P.M., showed at 11:30 P.M., called by staff and reported resident observed on floor. Resident claimed he/she slid from bed, resident's bed is leaning on his/her right side. Complaint of hitting his/her head, resident transferred in bed using mechanical lift. As needed Tylenol (pain medication) given. No injury observed, complaint of headache. No dizziness, nausea, vomiting. Pupils equal round reactive to light and accommodation (PERRLA). Neurological checks initiated. Review of the care plan, dated 2/22/24, showed: -Resident at risk for falls related to increased weakness, use of psychotropic medications, and exacerbations of Bipolar Disorder (disorder associated with mood swings); The care plan did not contain new fall interventions or review of the care plan for the fall that occurred on 3/3/24. During an interview on 4/17/24 at 02:00 P.M., the DON said he/she is responsible to ensure the care plans are updated with new interventions after a fall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/24 at 11:55 A.M., the DON said the resident had an increase in his/her antipsychotic medication. He/She said since antipsychotics were already addressed in the care plan, he/she did not update it. 5. During an interview on 4/19/24 at 09:55 A.M., CNA A said CNA's do not have access to the event reports. During an interview on 4/19/24 at 11:55 A.M., the DON said the CNA's are notified of changes in the care plans or new interventions via report from the nurses. He/She said the CNA's have access to the care plans but not the event investigations. He/She said if the nurses don't pass on the information then they would not know what the new interventions for falls were. During an interview on 4/19/24 at 12:02 P.M., the administrator said the MDS nurse is responsible to ensure the care plan interventions are up to date and should be updated after each fall with new interventions. He/She said the new interventions should be relayed to the staff verbally by the charge nurses. The administrator said the CNA's have access to the care plans. MO00234539

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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. 43327 Based on observation, interview, and record review, facility staff failed to ensure one resdident (Resident #3) of three sampled dependent residents received the necessary services to remain clean and dry, when staff failed to provide timely toileting assistance and incontinence care. The facility census was 56. 1. Review of the facility's Perineal Care policy, undated, showed: -The purpose is to cleanse the perinium and prevent infection and odor; -Use a wet lightly soaped washed cloth to wash from front to back; -Rinse and pat dry; -The policy did not contain direction on when/how often to provide perineal care. 2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 3/11/24 showed staff assessed the resident as: -Cognitively impaired; -Did not have behaviors or rejection of care; -Functional impairment on one side; -Required partial to moderate toilet assistance; -Required substantial to maximal assistance for toilet transfers; -Frequently incontinent of bladder and occasionally incontinent of bowel; -Diagnosis of hemiplegia (paralysis on one side). Review of the resident's care plan, dated 3/12/24, showed staff are to assist with completion of Activities of Daily living (ADL)'s related to right-side weakness from a stroke. The resident required the assist of one staff for toileting and occasionally incontinent of bowel and bladder. The residents care plan did not contain direction for staff with how often to encourage/offer to toilet or refusal of toileting/toileting assistance or how often to provide incontinence care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/17/24 at 11:45 A.M., showed Certified Nurse Aide (CNA) D transferred the resident to the toilet, the pad to the wheelchair saturated, the resident's pants were saturated, and the brief saturated. Observation showed the CNA did not wash the resident's buttocks, inner thighs, lower back or perineum after the resident used the restroom. The CNA applied a clean brief, pants and pad to the wheelchair and transferred the resident into the wheelchair. Observation showed a smell of urine. During an interview on 4/17/24 at 11:52 A.M,. CNA D said the resident is very paculiar about how they want things done and does not always allow staff to clean him/her up or toilet him/her. He/She said the resident was restless and he/she was in a hurry but normally would wash a resident when they have been incontinent. He/she said resident's should be toileted at least every two hours or they could get skin breakdown. During an interview on 4/19/24 at 11:55 A.M., the Director of Nursing (DON) said staff should toilet residents at least every two to three hours depending on the resident and as needed or it could lead to skin breakdown and/or infection. He/She said the facility did not have anyone that was care planned as a heavy wetter but would not expect a resident to be wet through to the wheelchair and that pericare includes washing the resident. He/She said the CNA's are responsible to ensure the residents are toileted as care planned. During an interview on 4/19/24 at 12:02 P.M., the administrator said residents should be toileted every two hours to help decrease skin breakdown and urinary infections. He/She said if the resident is not toileted, it looks like they are not cared for and unacceptable. MO00234682 MO00234878

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43327 Based on observation, interview, and record review, facility staff failed to provide safe transfers with a mechanical lift for one resident (Residents #3) of two sampled residents in a manner to prevent accidents. The facility census was 56. 1. Review of the facility's Hydraulic Lift policy, undated, showed to follow manufacturer's instructions when using any type of hydraulic lift: . Review of the hydraulic lift manual, dated September 2023, showed: -Residents should be able to bear some weight, have upper body strength and able to follow simple commands; -For safety of resident, securely fasten the safety strap around the residents torso, secure the buckle and pull the strap to tighten; -Position the resident's arms on the outside of the harness and have them place their hands on the paddle handles; -If a caregiver deems it necessary to keep a resident's shins or feet on the footplate, secure the shin straps around the resident's legs; -As the resident is being raised, simultaneously tighten the safety strap buckled around their torso. 2. Review of Resident #3s Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 3/11/24, showed staff assessed the resident as: -Cognitively impaired; -Did not have behaviors or rejection of care; -Functional impairment on one upper and one lower extremity; -Required partial to moderate assistance for toileting; -Required substantial to moderate assistance for sit to stand and toileting transfers; -Diagnosis of hemiplegia (paralyzed on one side). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/17/24 at 11:45 A.M., showed Certified Nurse Aide (CNA) D assisted the resident with a transferred and placed a waist strap around the back and sides of the resident and attached the loops to the lift. The CNA did not secure the safety strap around the resident's torso. The CNA placed the residents feet onto the base. The shin strap was missing from the lift. The CNA instructed the resident to put hand on the lift. The resident placed his/her left hand on the lift and the right hand hung to his/her side and not on the lift. CNA D raised the lift and transferred the resident from the wheelchair to the toilet and did not secure the torso strap. The resident's right arm hung by the residents side and he/she did not hold onto the lift. CNA D transferred the resident from the toilet to his/her wheelchair. Observation showed the safety strap not secured around the resident's torso and his/her right hand did not hold onto the lift. During an interview on 4/17/24 at 11:52 A.M., CNA D said the resident is very particular about things and does not always allow staff to provide care. He/she said the strap for the feet might be on another lift in the facility, but the resident was able to keep his/her feet in place and should secure the strap around the chest in case the resident slips down. During an interview on 4/17/24 at 02:00 P.M., the Director of Nursing (DON) said the chest buckle should be secured or the resident could fall. He/She said staff just had transfer training in January and would expect staff to use the lift as instructed. He/She said if there is a foot/shin strap for the lift, it should be used. He/She was not aware the lift did not have a shin strap. During an interview on 4/19/24 at 12:02 P.M., the administrator said he/she has not ever used a mechanical lift but would expect staff to use it as intended by the manufacturer or the resident could fall or cause injury to the resident. He/She was not aware the shin strap was missing for the lift. MO00234539

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 43327 Based on observation, interview, and record review, facility staff failed to ensure the wireless call light system was fully operational twenty-four hours per day, seven days a week when direct care staff failed to carry and utilize the wireless nurse call pagers at all times. This failure had the potential to affect 56 residents who resided in the facility. The facility census was 56 residents. 1. Review of the facility's Call Light, answering policy, undated, showed some residents may not be able to use their call light. Be sure to check these residents frequently and answer the resident's call as soon as possible. The policy did not contain direction on when to obtain pagers, what to do if the pager did not work, and how to utilize the pager. Review of the facility's approved exemption, dated August 2023, showed the operator will ensure all direct care staff carry and utilize the wireless nurse call pagers at all times and resident care and services are not adversely affected in any way by the exemption. 2. Review of the facility's Call Light report, from 4/18/24 at 12:00 A.M. through 4/19/24 at 10:01 A.M., showed: -On 4/18/24 at 01:53 A.M., Room B4, 40 minutes; -On 4/18/24 at 02:22 A.M., Room C1, 57 minutes; -On 4/18/24 at 02:34 A.M., Room B4, 40 minutes; -On 4/18/24 at 03:20 A.M., Room C1, 57 minutes; -On 4/18/24 at 04:07 A.M., Room C8, 161 minutes; -On 4/18/24 at 04:27 A.M., Room B1, 59 minutes; -On 4/18/24 at 05:26 A.M, Room B4, 136 minutes; -On 4/18/24 at 05:27 A.M., Room B1, 59 minutes; -On 4/18/24 at 05:45 A.M., Room C3, 65 minutes; -On 4/18/24 at 06:07 A.M., Room B3, 84 minutes; -On 4/18/24 at 06:48 A.M., Room C8, 161 minutes; -On 4/18/24 at 06:50 A.M, Room C3, 65 minutes; -On 4/18/24 at 07:31 A.M., Room B3, 84 minutes; -On 4/18/24 at 07:40 A.M., Room D8, 71 minutes; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 4/18/24 at 07:43 A.M., Room B4, 136 minutes; -On 4/18/24 at 07:44 A.M., Room D6, 67 minutes; -On 4/18/24 at 07:48 A.M., Room A7, 166 minutes; -On 4/18/24 at 08:41 A.M., Room B4, 83 minutes; -On 4/18/24 at 08:41 A.M., Room B1, 70 minutes; -On 4/18/24 at 08:50 A.M., Room A6, 119 minutes; -On 4/18/24 at 08:51 A.M., Room A5, 99 minutes; -On 4/18/24 at 08:51 A.M., Room D8, 71 minutes; -On 4/18/24 at 08:51 A.M., Room D6, 67 minutes; -On 4/18/24 at 09:51 A.M., Room B1, 70 minutes; -On 4/18/24 at 10:03 A.M., Room D2, 36 minutes; -On 4/18/24 at 10:05 A.M., Room B4, 83 minutes; -On 4/18/24 at 10:28 A.M., Room C8, 34 minutes; -On 4/18/24 at 10:31 A.M., Room A5, 99 minutes; -On 4/18/24 at 10:34 A.M., Room A7, 166 minutes; -On 4/18/24 at 10:39 A.M., Room D2, 36 minutes; -On 4/18/24 at 11:02 A.M., Room C8, 34 minutes; -On 4/18/24 at 11:53 A.M., Room D2, 37 minutes; -On 4/18/24 at 12:30 P.M., Room D2, 37 minutes; -On 4/18/24 at 01:08 P.M., Room A6, 31 minutes; -On 4/18/24 at 01:40 P.M., Room A6, 31 minutes; -On 4/18/24 at 02:25 P.M., Room C3, 67 minutes; -On 4/18/24 at 02:31 PM., Room C14, 41 minutes; -On 4/18/24 at 03:12 P.M., Room C14, 41 minutes; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 4/18/24 at 03:13 P.M., Room D2, 58 minutes; -On 4/18/24 at 03:17 P.M., Bathroom D7-D9, 62 minutes; -On 4/18/24 at 03:32 P.M., Room C3, 67 minutes; -On 4/18/24 at 04:12 P.M., Room D2, 58 minutes; -On 4/18/24 at 05:03 P.M., Room A6, 64 minutes; -On 4/18/24 at 05:15 P.M., Room B8, 36 minutes; -On 4/18/24 at 05:29 P.M., Room A1, 36 minutes; -On 4/18/24 at 05:52 P.M., Room B8, 36 minutes; -On 4/18/24 at 05:54 P.M., Room D2, 108 minutes; -On 4/18/24 at 05:59 P.M., Room D9, 52 minutes; -On 4/18/24 at 06:06 P.M., Room A1, 36 minutes; -On 4/18/24 at 06:08 P.M., Room A6, 64 minutes; -On 4/18/24 at 06:33 P.M., room D1, 48 minutes; -On 4/18/24 at 06:51 P.M., Room D9, 52 minutes; -On 4/18/24 at 06:52 P.M., Room A7, 91 minutes; -On 4/18/24 at 07:19 P.M., Room A6, 84 minutes; -On 4/18/24 at 07:22 P.M., Room D1, 48 minutes; -On 4/18/24 at 07:43 P.M., Room D2, 108 minutes; -On 4/18/24 at 08:43 P.M., Room A6, 84 minutes; -On 4/18/24 at 10:29 P.M., Room B4, 44 minutes; -On 4/18/24 at 10:48 P.M., Room A6, 77 minutes; -On 4/18/24 at 11:13 P.M., Room B4, 44 minutes; -On 4/19/24 at 03:16 A.M., Room D14, 35 minutes; -On 4/19/24 at 03:52 A.M., Room D14, 35 minutes; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 4/19/24 at 08:04 A.M, Room A4, 32 minutes; -On 4/19/24 at 08:08 A.M., Room C1, 55 minutes; -On 4/19/24 at 08:19 A.M., Room B4, 35 minutes; -On 4/19/24 at 08:36 A.M., Room A4, 32 minutes; -On 4/19/24 at 08:38 A.M., Room D6, 66 minutes; -On 4/19/24 at 08:54 A.M., Room B4, 35 minutes; -On 4/19/24 at 08:57 A.M., Room B1, 63 minutes; -On 4/19/24 at 09:04 A.M., Room C1, 55 minutes; -On 4/19/24 at 09:44 A.M., Room D6, 66 minutes. Observation on 04/19/24 at 08:35 A.M., showed a call light computer station located centrally for all hallways and scrolling ticker (a continuous stream of text that scrolls) screen at the end of each hallway. The resident rooms did not have indicator lights above the corridor entrance to the resident rooms. During an interview on 04/19/24 at 09:49 A.M., Certified Nurse Aide (CNA) A said he/she is not wearing a pager because he/she had not had a chance to pick it up yet. CNA A said he/she has been using the ticker screen at the end of the hall and computer station to know if a light is going off. He/She said call lights should be answered within 15 minutes or sooner to ensure the resident is safe. He/She said the shift started at 07:00 A.M. During an interview on 04/19/24 at 09:50 A.M., CNA B said he/she is not wearing a pager because he/she had not had time to put it on yet. CNA B said he/she used the ticker screen and computer to know if the call light was sounded. He/She said there is also a beep on the ticker screen when a light goes off. He/She said 15 minutes is an appropriate time to get call lights answered. He/She said his/her shift started at 07:00 A.M. During an interview on 04/19/24 at 09:51 A.M., Certified Medication Technician (CMT) C said he/she was not wearing his/her pager and does not usually wear one. He/She said pagers are often lost or taken home with other staff members. Call light indicators are at the end of each hallway and there is a computer that is used to let staff know when a call light is going off. He/She said call lights should be answered within 30 minutes and has had residents complain about the time it takes for call lights to be answered before. During an interview on 04/19/24 at 11:55 A.M., the Director of Nursing (DON) said staff should grab a pager when arriving for their shift so staff are alerted right away if the resident sounds the call lights. He/She said call lights should not sound longer than 30 minutes but would expect them to be answered within 15 minutes or falls, skin breakdown, or unmet needs could result. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/19/24 at 12:02 P.M., the adminstrator said he/she was aware some of the staff did not wear pagers due to being lost or taken home with team members. He/She said it is hard to police the pagers and staff have been edcucated multiple times regarding the importance of wearing them. He/She said call lights should be answered as soon as possible and greater than 30 minutes is unacceptable and could result in potential harm to the resident. MO00234878