STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265347	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adair Village	1801 North Gaines Drive Clinton, MO 64735

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review the facility failed to provide care per standards of practice when staff failed to identify, assess, document, monitor, obtain orders for treatment of, and notify the physician of wounds for one resident (Resident #1). The census was 34. Review of the facility's policy titled Wound and Skin Care Protocols and Procedures, dated June 2021, showed the following: -The facility would include the orders on the physician's order sheet (POS); -May use facility skin and wound care protocols. Each resident's personal physician must approve of orders at the time of admission and then sign the order sheets monthly; -Each individual resident required treatment and specific telephone orders would be written based on protocols. -If a wound was not making progress, it was important to attempt to reduce the bioburden and manage infection. -Treatment included cleansing with sterile water, select appropriate type of alginate with silver property, moisten the alginate with sterile water, and cover, change every three days and ensure the alginate (assists with wound healing) stays moistened. Contact physician for the consideration of a negative pressure pump (wound vac). 1. Review of Resident #1's face sheet (brief look at resident information), showed the following information: -admitted [DATE]; -Diagnoses included kidney failure, type two diabetes, high blood pressure, and chronic pulmonary embolism (long term condition that occurs when a clump of material, most often a blood clot gets stuck in an artery in the lungs, blocking the flow of blood). Review of the resident's care plan, revised on 07/15/24, showed the following information: -Required skin to be observed daily during routine care for irritation and redness. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Adair Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 North Gaines Drive Clinton, MO 64735	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required a full skin evaluation weekly with showers. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool that is filled out by facility staff), dated 07/18/24, showed the following information: -Cognitively intact; -Required substantial to maximum assistance from staff for dressing, bathing, and mobility, and completely dependent on staff assistance for toileting; -At risk for pressure ulcers with no current pressure, venous (wounds that are due to vein and blood flow issues), or arterial (wounds that are due to poor circulation) ulcers; -Required pressure reducing devices for chair and bed, and required a turning and repositioning program. Review of the resident's weekly Skin Only Evaluation sheets showed the following information: -Staff did not document skin evaluations from 07/11/24 through 08/01/24; -On 08/02/24, staff noted the resident had no skin issues, aside from a current healing hematoma (a collection of blood that pools in an organ, tissue, or body space) to the left knee, measuring 5 centimeters (cm) by 5 cm, with 0 cm depth. Review of the resident's care plan, updated 08/07/24, showed open area to left knee with daily dressing changes as directed. Staff to notify physician if no improvements in two weeks. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review sheets showed the following information: -On 08/09/24, no skin issues documented (two days after care planned updated with open are to knee requiring dressing changes); -On 08/13/24, shower was rescheduled to 08/14/24 with no skin issues documented; -On 08/15/24, staff noted open area to left knee, and redness and open areas to the backs of both legs in the calf regions; -On 08/16/24, resident refused a shower; -On 08/20/24, staff noted sore to left knee, and sores to the backs of both legs. Review of the resident's care plan, updated 08/20/24, showed a new order to refer resident to wound care. Staff did not care plan related to the new sores to the back of the resident's legs. Review of the resident's care plan, updated 08/21/24, showed open areas to buttocks added. Staff to encourage resident to reposition, provide incontinent care, and apply barrier cream each shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's weekly Skin Only Evaluation sheets showed the following information: -On 08/21/24, staff noted resident had no skin issues, aside from an opened scab on the left knee, measuring 2 cm by 2 cm with bloody drainage.(Staff did not document area on buttocks requiring treatment noted on the same day.) -On 08/23/24, staff noted the resident had no skin issues, aside from a pressure ulcer injury to the posterior (back side) left thigh that measured 6 cm by 2 cm with a 0.2 cm depth with bloody drainage. Staff also noted the resident had multiple pinpoint areas on the buttocks with bloody drainage. Review of the resident's Physician Order Sheet (POS) showed the following: -A current order for an appointment with wound care clinic on 08/28/24 for left knee wound; -A order, dated 08/27/24, to change wound dressing every three days and as needed with island dressing to left knee. (The orders did not include orders to address the wounds on the resident's buttocks, thigh, or calf.) During an interview on 08/27/24, at 10:08 A.M., the resident said he/she did have wounds. He/she had one on his/her left knee and he/she is supposed to be going out to have it treated at a wound clinic soon. The staff change the bandage every couple days. During an interview on 08/27/24, at 1:02 P.M., the Director of Nursing (DON) said if a resident were to have wounds, he/she would expect to see documentation of that in the progress notes and skin assessments. If the staff are aware that a resident has wounds, the facility outsourced and worked with a wound company and/or will send the resident across the street to be treated in a wound care clinic. The floor nurses complete wound treatments daily and there should be orders within the physician's order sheet as well as care plan for them to follow. The DON said the resident does have wounds. The resident had a wound on the left knee, on his/her bottom, and on the backs of both legs in the thigh area. The DON said the resident's physician was aware of all wounds. The DON looked the resident's record and said there were technically no doctor orders at this time for the areas. He/she is just keeping a dry patch on them for now. She expects staff treat the wounds without the physician orders following the facility protocol book for wounds. Review showed the facility did not provide a facility protocol book for wounds signed off on by the physician or medical director. Observation and interview on 08/27/24, at 3:10 P.M., showed the resident had 4 x 4 gauze squares on top of left knee wound that were secured with paper tape with dried red substance, appearing to be blood, on the gauze. The resident's his/her left knee had a yellow and red substance seen on the pad underneath the residents' legs. The resident said none of his/her treatments have been done in a couple days. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Observation on 08/27/24, at 3:30 P.M., showed the resident transferred into his/her bed. Upon assessment of the resident, two wounds were located on the back of the upper legs. One wound on the left appearing as an open area with a red wound bed approximately 5 cm long with some bruising alongside of the wound and yellow drainage coming from wound. One wound on the right appearing as an open area with a red and yellow wound bed approximately golf ball sized, with yellow drainage. The Assistant Director of Nursing (ADON) sprayed both areas with wound cleanser and left open. The resident also had two open areas on the left knee. Both areas had black and yellow tissue inside, draining a red and yellow substance, with the surrounding tissue was red. ADON sprayed this area with wound cleanser and covered with a dry dressing.

During an interview on 08/27/24, at 3:54 P.M., the DON said the wounds to the resident's backs of legs had been there approximately a week and intervention of encouraging the resident to get off of his/her bottom had been put in place. As far as treatments for all the resident's wounds, she followed the nursing protocols book. If a new wound was found for any resident, she expected staff to assess the area, measure it, notify the doctor, and family, follow the wound care protocol, and document.

During an interview on 08/28/24, at 10:42 A.M., Registered Nurse (RN) G said the following:

-The computer system notified nursing staff when a skin assessment or wound care was due to be completed;

-The aides also do skin assessments with baths and bring skin concerns to the nurse, often having the nurse come evaluate the skin while still in the shower;

-Nursing staff should document all skin concerns;

-The RN was not aware of any areas on the back of the resident's leg or bottom;

-He/she was only aware of the wound on the left knee.

During an interview on 08/28/24, at 11:56 A.M., the Social Services Director (SSD) said wounds and wound treatments should be included in the care plan. If there was no improvement in a wound within two weeks, the physician should be notified. There should also be wound care orders in the physician orders sheet. Those orders should be followed. Any staff member can add information to the care plan, and she will then review it. The resident does have wounds, one on the knee and one on the bottom. The bottom wound is being treated with barrier cream and the wound to the knee is being treated with a dry dressing.

During an interview on 08/27/24, at 3:10 P.M., DON said the resident did not like to move out of his/her recliner. The staff encourage him/her to get off his/her bottom. The resident had an upcoming appointment with the wound care clinic. The nursing staff should see the resident's bottom at least once per day. The resident had a couple of random open areas on his/her bottom and thighs. There was no treatment order, staff were only putting barrier cream and encouraging to get into the bed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24, at 10:49 A.M., the resident's physician said she saw the resident a few weeks ago. At that time, the resident had a wound to his/her left knee. She referred to it as a popped hematoma and the wound bed was clean. The physician referred the resident to the wound care clinic for treatment. The physician believed she made specific in-house wound care orders, but could not verify them at this time. She did tell a nurse to be treating the area with the in house wound care protocol. The physician said she was not aware of any other wounds to the resident. The physician expected nursing staff to assess new wounds, measure, notify her, begin treatment, and document. During an interview on 08/28/24, at 9:00 A.M., the Corporate Nurse said that staff should use the wound protocol and should add to the physician's orders for nurses to know the treatment plan. During an interview on 08/28/24, at 12:11 P.M., with the DON and Regional Nurse Consultant, the DON said if a new wound was brought to her attention or another nurses attention, they should go down and assess the wound, measurements should be obtained, and it should be documented. The staff are to be completing treatments on all wounds, staff should use the wound care protocol for those treatment orders, and those orders should be found in the POS. The Regional Nurse Consultant said there are weekly skin assessments for all residents. Once Wound Care Plus or wound care clinic is established, the facility used their measurements. Otherwise, wounds were monitored with skin assessments and the electronic medical record should trigger this every seven days for all residents. During an interview on 08/27/24, at 1:35 P.M., the Administrator the resident had some wounds on his/her left knee and buttock area. The resident was going to see the wound clinic soon. The nursing staff should be treating the wounds until seen at the clinic and received new orders. The staff was probably treating the areas per facility protocol. There should be an order for the nurses to know when a treatment was to be done. During an interview on 08/28/24, at 12:28 P.M., the Administrator, DON, Regional Nurse Consultant, and Director of Regional Consulting said wounds should be documented and monitored. The wound care treatment protocol should be activated, and those orders should be found in the POS. MO00239310 41787

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review the facility failed to ensure residents were as free from accident hazards as possible when staff failed to transfer one resident (Resident #1) in a safe manner and failed to follow-up on possible injury from the transfer. The facility census was 34. Review of the facility's policy titled Bath, Shower/Tub, dated February 2018, showed the following: -The purpose of the procedure was to promote cleanliness, promote comfort, and to observe the condition of the resident's skin; -Staff should observe the skin for any rashes, reddened areas, and swelling and document all assessment data including reddened areas, and sores on the resident's skin. 2. Review of Resident #1's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included kidney failure, type two diabetes, high blood pressure, and chronic pulmonary embolism (long term condition that occurs when a clump of material, most often a blood clot gets stuck in an artery in the lungs, blocking the flow of blood). Review of the resident's care plan, revised on 07/15/24, showed the following information: -Required skin to be observed daily during routine care for irritation and redness; -Required a full skin evaluation weekly with showers; -Potential for bruises due to anticoagulant (medicines that help prevent blood clots) therapy; -Staff to be gentle in working with the resident; -Staff to inspect skin daily for bruises; -Assistance of one staff for all ambulation. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool that is filled out by facility staff), dated 07/18/24, showed the following information: -Cognitively intact; -Required substantial to maximum assistance from staff for dressing, bathing, and mobility, and completely dependent on staff assistance for toileting; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No current skin conditions. Observation and interview on 08/27/24, at 10:08 A.M., showed the following: -The resident said he/she was in pain due to something that happened on Friday (08/23/24); -The resident pulled up his/her left shirt sleeve and showed his/her arm. The resident's skin was red and swollen starting at his/her inner elbow, and moving up the arm. In the bicep region, there was a dark blue to purple golf ball sized area. Past the bruise was more redness and swelling up to and including the resident's armpit. -The resident said this occurred during an improper transfer. He/she was supposed to be transferred with a mechanical lift called a sit-to-stand (helps a resident into a standing position with the use of a sling). The resident said he/she was sitting on the side of his/her bed and requested to be assisted into the recliner. Certified Nursing Assistant (CNA) A grabbed his/her arm when transferring him/her to the recliner and pulled at the arm roughly leaving the bruising and redness. -The resident said he/she reported this to Licensed Practical Nurse (LPN) B as well as the therapy department. During an interview on 08/28/24, at 8:30 A.M., CNA A said on 08/23/24, he/she helped another aide transfer the resident with the sit-to-stand. The resident let go of the handles and let his/her body drop in the sling. The CNA reported this to the Assistant Director of Nursing (ADON). The CNA did not know if the nurse evaluated the resident. If at any time saw any skin issues on a resident, he/she would notify the charge nurse and if they did not check the resident, he/she would tell the Administrator. During an interview on 08/27/24, at 2:31 P.M., Physical Therapist (PT) D said he/she had not been made aware of any bruising that would affect therapy. The resident had mentioned to him/her that his/her left shoulder was hurting. The resident did report to him/her that the pain was from an improper transfer the side of the bed to the recliner. PT D said the resident was a sit-to stand lift and sometimes the resident would let go and go limp on the lift, unable to stand. In those cases staff should advance to a different mechanical lift called a Hoyer (a mechanical lift that lifts a resident up off the ground with a sling). Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review sheets, dated 08/09/24 to 08/27/24, showed staff did not document regarding bruising to the resident's arm. The resident refused a shower on 08/23/24. Review of the resident's weekly Skin Only Evaluation sheets, dated 08/02/24 to 08/27/24, showed staff did not document regarding bruising to the resident's arm. Review of the resident's progress notes, dated 08/23/24 to 08/27/24, showed staff did not document regarding the bruising or an investigation into the bruising or transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/24, at 5:37 P.M., LPN B said the expectation when a bruise was reported, was for the nurse to assess the area, and notify the Administrator so she can report it to the state if it is suspicious. New bruising should be documented in the skin assessment notes and progress notes in the electronic medical record. The resident was difficult and didn't like to stand or help when using the sit-to stand, but that's what should be used for transfer. No new bruising to the resident had been reported to him/her. The resident did complain of left shoulder pain on 08/23/24. LPN B assessed the resident's arm at that time and said the resident had good range of motion and he/she didn't see a new bruise at the time. He/she did see a bruise that was quarter size, but believed it to be in the healing process and not related. During an interview on 08/27/24, at 12:34 P.M., CNA C said he/she wasn't aware of any bruising to the resident. If he/she seen or was reported to him regarding new bruising to a resident he/she would report it to the charge nurse, and the charge nurse would take it from there. During an interview on 08/27/24, at 1:02 P.M., the Director of Nursing (DON) said she has not had any bruising to the resident reported to her. Bruising should be documented on the weekly skin assessments. She would expect new bruising to be reported to her. The resident is transferred with a sit-to stand so she is unsure of how a CNA could have caused the bruising. During an interview on 08/28/24, at 9:50 A.M., Certified Medication Tech (CMT) H said he/she would let the charge nurse know of any skin issues, bruises, redness, or open areas on a resident especially if unaware if the nurse was aware of the area. The CMT was aware that the resident had a bruise on his/her left arm that was from the sit-to-stand lift. He/she did not notify the nurse as this was not a new bruise. When staff transfer the resident, the resident would lean back and his/her arms rest on the lift sling. The resident complained of pain in his/her arm area to the CMT on Monday 8/26/24 and he/she notified the nurse. During an interview on 08/28/24, at 10:42 A.M., Registered Nurse (RN) G said the following: -Nursing staff should document all skin concerns; -The resident had told the RN of the bruise over the weekend, however he/she did not document any information about the bruise because he/she thought it was a pre-existing concern; -The RN did not look at the resident's arm or document any information related to the bruise. During an interview on 08/27/24, at 2:10 P.M., the Assistant Director of Nursing (ADON) said that nursing staff should look at resident skin, measure and document when notified of new areas. If staff were unable to document under the skin assessment portion of the chart, the staff should at least document a progress note. The ADON said on 08/23/24 she and CNA A transferred the resident with the sit-to-stand lift at about 3:00 P. M. The resident was not compliant and would not try to hold self-up and let go of the handles. The resident's arms were resting on the lift pad. During an interview on 08/28/24, at 11:56 A.M., the Social Services Director said that she updates the care plans. Care plans should include a good overview of the resident including any skin issues. If she was aware of any new bruising, that is something she would include in the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24, at 10:49 A.M., the resident's doctor said she had seen the resident a few weeks ago and wasn't aware of any new bruising, but the resident was on anticoagulants (a medication that prevents blood from clotting) and bruises easily. Staff should report new skin issues her. During an interview on 08/27/24, at 1:36 P.M., the Administrator said he/she wasn't aware of any bruising on the resident and none had been reported to her. She expected staff to report, assess, and monitor bruising. There have never been any other issues with CNA A. During an interview on 08/28/24, at 12:28 P.M., the Administrator, Director of Regional Consulting, Regional Nurse Consultant, and Director of Nursing said expectations for bruising include the charge nurse assessing the bruise, reporting it to the DON and Administrator. The Administrator said she was not aware of the bruising to the resident. Regardless, it should be documented on daily and investigated. The physician and family should be notified and there should be a 72-hour follow up per the Director of Regional Consulting.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review the facility failed to provide effective pain management consistent with professional standards of practice when staff failed to administer requested pain medication timely, failed to assess the resident's pain level, failed document the administration of pain medication, and failed to follow-up with the resident regarding the effectiveness of the pain mediation for one resident (Resident #1) who displayed physical verbal signs of pain. The facility census was 34. Review of the facility's policy titled Medication and Treatment Orders. dated July 2016, showed the following information: -Drug and biological orders must be recorded on the physian's order sheet in the resident's chart; -Orders for medication must include, name and strength, dose, duration, number of doses, route of administration, clinical condition or symptoms for which the medication is prescribed, and any interim follow up related to the medication. Review showed the facility did not provide a policy regarding pain management. 1. Review of Resident #1's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses include kidney failure, type two diabetes, high blood pressure, and chronic pulmonary embolism (long term condition that occurs when a clump of material, most often a blood clot gets stuck in an artery in the lungs, blocking the flow of blood). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool that is filled out by facility staff), dated 07/18/24, showed the following information: -Cognitively intact; -Required substantial to maximum assistance from staff for dressing, bathing, and mobility, and completely dependent on staff assistance for toileting; -Received as needed pain medication and received non-medication pain intervention. Review of the resident's care plan, revised on 07/22/24, showed the following information: -Evaluate pain daily by using 1 to 10 pain scale; -Administer pain medications as ordered; -Assist with positional changes slowly; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Monitor for worsening of symptoms and report them to the physician. Review of the resident's Physician Order Sheet (POS), dated 08/24/24, showed the following orders for pain: -A current order for lidocaine external gel 4% (used to treat pain), apply to area of pain topically (on skin) one time a day; -A current order for tramadol 50 milligram (mg) tablet (used to treat chronic pain or moderate/severe pain), give one tablet by mouth every six hours as needed. During an interview on 08/27/24, at 10:08 A.M., the resident said often times, when he/she asked for pain medication, he/she had to wait two to three hours before someone would administer the medication. He/she was always told it will be a few minutes, or we're busy. Observation and interview on 08/27/24, at 12:24 P.M., showed the resident sat in his/her recliner. The resident was visually uncomfortable with grimacing and asked the surveyor if he/she had brought him/her a pain pill. The resident said he/she had requested a pain pill this morning and pressed his/her call light. Observation on 08/27/24, at 12:27 P.M., showed Certified Nursing Assistant (CNA) C entered the resident's room. The resident asked the aide if he/she minded asking the nurse if the resident could have some pain medication. CNA C said yes and exited the room. During an interview on 08/27/24, at 12:34 P.M., CNA C said if a resident was in pain he/she would let both the certified medication technician (CMT) and charge nurse know. The Director of Nursing (DON) was the charge nurse on this day. The CMT passed some pain medications while the charge nurse passed others, so it was best to notify them both. A resident should not have to wait two to three hours for pain medication. Observation on 08/27/24, at 1:24 P.M., showed the DON observed the resident's arm and the resident told the DON that he/she was in pain and had requested a pain pill. The DON did not ask the resident where his/her pain was or what his/her pain level, and exited the room. (Fifty minutes after the resident asked staff for pain medication.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Adair Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 North Gaines Drive Clinton, MO 64735	

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 08/27/24, at 3:22 P.M., showed the resident in the same position, in his/her recliner, visually uncomfortable with grimacing. The DON, Assistant Director of Nursing (ADON), and CNA F were present in the room. The resident said he/she was still waiting for pain medication. At this time, surveyor asked the DON if the resident had been administered any pain medication. The DON said no and the DON would go get it now. The DON did not ask the resident where his/her pain was, or pain level. The ADON and CNA F transferred the resident from the recliner to the bed with a sit to stand mechanical lift (a device that helps people who have difficulty standing up from a seated position). During the transfer, the resident was observed grimacing, moaning, and voicing pain. The resident told the staff that the lift swing was causing additional pain to his/her left arm which was visibly red, swollen, and bruised. The resident continued to voice his/her pain while laying on the bed. At 3:44 P.M., the DON re-entered the resident's room with pain medication. The ADON and CNA F transferred the resident back to his/her recliner. The DON administered the pain medication, said to be tramadol, to the resident at 3:48 P.M. (Over three hours after the resident requested pain medication from staff.) Review of the Stat Lock (a safe containing several different types of on-hand medications that can be pulled from when a resident is out of medication) form titled Sterling Pharmacy, dated 08/27/24, showed one tablet of Ultram (tramadol) for the resident obtained from the stat lock at 3:27 P.M. Review of the resident's Medication Administration Record (MAR), on 08/27/24 at 3:54 P.M., showed the DON had not documented the administration of the tramadol or the resident's pain level. Review of the resident's MAR on 08/28/24, at 9:15 A.M., showed staff did not document tramadol 50 mg as administered on 08/27/24 at 3:48 P.M. Review of the resident's medical record showed staff did not document follow-up regarding the effectiveness of the pain medication. Review on the resident's pain scale assessments, dated 08/27/24, showed staff completed one pain assessment for the resident on 08/27/24, at 10:51 P.M. The resident rated his/her pain at a 5 out of 10. During an interview on 08/28/24, at 9:50 A.M., CMT H said that nurses give all as needed pain medications. The nurse should evaluate the resident's pain. If resident complained of pain the CMT would notify the nurse. If returned and the nurse had not evaluated and provided pain medication, staff would return to the nurse or go to the DON if the nurse was busy. During an interview on 08/28/24, at 10:42 A.M., Registered Nurse (RN) G said that nursing staff should provide pain medications in a timely manner when resident requests and with the appropriate orders. The resident should not have to wait three hours for pain medication. During an interview on 08/27/24, at 12:20 P.M., the ADON said that the nurses give as needed pain medications because they will complete an assessment of the resident's pain. The CMT only gives routine ordered pain medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265347	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adair Village	1801 North Gaines Drive Clinton, MO 64735

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/28/24, at 10:14 A.M., DON said that he/she had given the resident tramadol 50 mg on the afternoon of 08/27/24. The medication was signed out from the E-Kit because the resident needed the pain medication right away. She was unable to locate the order to document the administration of the pain medication. She did not make a progress note related to the pain medication. She knew the resident needed the pain medication right then. The administration of pain medication was passed on verbally to the next shift. The DON was not aware that the resident needed pain medication prior to 3:30 P.M. The DON said no staff notified the DON previously. During an interview on 08/28/24, at 10:49, the resident's doctor said if a resident was complaining of pain, the resident should be given whatever was ordered for that pain. He/she wouldn't expect two to three hours to be an acceptable wait time for pain medication. During an interview on 08/28/24, at 12:28 P.M., the Administrator, DON, Regional Nurse Consultant, and Regional Director of Consultants said a resident should not have to wait two to three hours to receive pain medication. The nurse should perform a pain assessment, administer the medication if it is within the allotted time frame, and document the administration. MO00238842, MO00239423, & MO00239941 41787