| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265360 | A. Building<br>B. Wing | 11/17/2025 |

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| Lewis County Nursing Home District | 17528 State Highway 81<br>Canton, MO 63435 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to maintain the can opener blade to be free of debris, failed to maintain the range hood to be free of grease and debris, failed to properly label, date, seal/cover/close food items, failed to discard expired food items, failed to maintain the ice machine and ensure the unit was equipped with an appropriate air gap, failed to ensure staff properly wore hair restraints, failed to ensure staff properly handled ready to eat food items, failed to utilize proper handwashing techniques, failed to cover trash cans when not in use, and failed to ensure the SCU refrigerator/freezer unit was equipped with thermometers to ensure temperatures were appropriate for storing cold/frozen food items. The facility census was 45.1. Review of undated facility policy, Cleaning the Can Opener, showed the can opener will be maintained in clean sanitary condition. Clean can opener at least after each use. Observation on 9/22/25 at 10:01 A.M. showed brown crusty and stringy debris on the can opener blade. (The can opener was not in use.) During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said staff should clean the can opener after each use. 2. Review of the undated facility policy, Cleaning Vent Hoods and Filters or Extractors showed venting equipment will be clean and free of grease. Clean vent hoods monthly and as needed to prevent accumulation of dirt and grease. Wash filters or extractors weekly/monthly. Observation on 9/22/25 at 10:03 A.M. in the kitchen, showed a range hood, equipped with three baffle filters, located over a six-burner stove and flat-top griddle. The filters had a heavy buildup of debris and yellow grease. The other side of the range hood was located over a four-burner stove and a double fryer and was equipped with three baffle filters. The filters had a heavy buildup of yellow and clear grease and drips/runs were visible on the outside of the filters. Stickers on the outside of both range hoods showed the hoods were professional cleaned on 6/12/25. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said staff should clean the range hood monthly, and the range hood was professionally cleaned every six months. She was not sure when staff last cleaned the range hood and filters. 3. Review of the undated facility policy, Food Preparation and Service, showed leftovers will not be held for longer than seven days unless at freezing temperatures. Observation on 9/22/25 at 10:11 A.M. of the three-door reach-in refrigerator showed the following:-A medium steamtable pan labeled gravy was undated;-A small steamtable pan labeled gravy was undated;-A small steamtable pan labeled ground was undated;-A small steamtable pan labeled puree was undated;-A large plastic container, dated 9/22, was not labeled and contained a yellowish liquid. The container was partially covered with plastic wrap;-A tray held eight small bowls of chopped peaches, four small bowls of pureed peaches, and eight small bowls of stewed tomatoes. Neither the tray nor the bowls were dated;-Two trays held bowls of condiments (tomato, lettuce and onion). Neither the trays nor the bowls were dated;-Two blue trays held 12 bowls of sliced grapes. The tray and bowls were undated;-A clear container with a green lid contained chocolate pudding and was dated 9/9;-A large zipper bag held slices of American cheese (no original packaging included). The bag was unsealed and open to air and was undated;-A zipper bag of sliced turkey (no original packaging included) was not labeled or dated;-A zipper bag of sliced bologna (no original packaging included) was not labeled or dated;-A zipper bag of sliced ham (still in an open original package) was<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | not dated when opened;-Two individual slices of white cheese were wrapped in plastic wrap and not dated;-A glass bowl contained berry cobbler dessert and was not dated;-A package of sliced Braunschweiger was labeled with a resident's name and dated 8/29;-Three small zipper bags held four orange slices each and were not dated. Observation on 9/22/25 at 10:25 A.M. in the kitchen chest freezer showed a box of pork and vegetable egg rolls was open. The egg rolls were in an opened plastic bag inside the box. The plastic bag was not sealed. Observation on 9/22/25 at 10:46 A.M. in the kitchen above the metal preparation counter showed the following:-The lid on an 18-ounce container of paprika was open;-The lid on a 40-ounce container of seasoned salt was open;-The lid on a 1-pound 5-ounce container of garlic powder was open;-The lid on a 10-ounce container of poultry seasoning was open. Observation on 9/22/25 at 11:47 A.M. showed a loaf of white bread sat near a cereal box on a counter above the microwave. The bread had areas of green mold (with the largest area the size of nickel) on the loaf. Observation on 9/22/25 at 2:51 P.M. inside the kitchen refrigerator showed a bowl of cooked carrots was undated, and a hamburger patty on a plate was undated. Observation on 9/22/25 at 2:58 P.M in the dry storage room showed a large open bag of graham cracker crumbs stored inside a zipper bag and was undated. Observation on 9/22/25 at 3:22 P.M. showed a large zipper bag of cereal sat inside a white plastic tub below the microwave and was undated. Observation on 9/22/25 at 3:17 P.M. of activity refrigerator/freezer unit in the Activity Room showed the following:-In the refrigerator: A 32-ounce container of liquid whole eggs had a manufacturer's expiration date of 8/21/25. A pint of heavy whipping cream had a manufacturer's expiration date of 9/15/25 and a disposable plate was covered with foil and held a piece of cake. The plate was undated and Activities Do Not Touch was written with marker on the foil;-In the freezer: A foam cup with a lid/straw had a frozen dark substance inside and was not labeled or dated. Observation on 9/22/25 at 3:20 P.M. of the Activity Room cabinets showed a disposable plastic container was labeled pumpkin bars by the manufacturer. The words pumpkin bars had a black line drawn through them and the words Ch. Chip Banana Cookies was written in black marker. The container was undated. Observation on 9/22/25 at 3:22 P.M. of the outside of the Activity Room refrigerator/freezer unit, showed a sign had been placed on the door that read For Activities and Residents Use Only!! Everything must be dated with use by date (Seven days from opening). No staff drinks or food allowed. Observation on 9/23/25 at 4:50 P.M. inside the Activity Kitchen showed the following:-A 3.25-pound carton of grape cotton candy mix was open to air and not sealed. The mix had a best by date of 4/29/22. The mix was hard and dried into a block at the bottom of the carton;-An opened container of apple juice with a best by date of 7/9/26. The manufacturer directions showed to Refrigerate after opening for best quality. The container was half-full and was not refrigerated. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said the following:-Leftover food items were good for seven days. The date written on the item should be the date the item was placed in the refrigerator. All staff was responsible for checking food items every day or every other day;-Staff forgot to date the steam table pans. The items were prepared the previous weekend;-The yellow liquid was probably pancake mix and staff forgot to label the item;-The bowls of relish plates, peaches, tomatoes were being used for the next meal, so those items were not dated;-The chocolate pudding should have been used by 9/9 or discarded;-Staff should date bags of cheese when opened; -The lunch meat and cheese should be used up in seven days or discarded;-The cobbler should have been dated from the previous Sunday;-The Braunschweiger belonged to a resident. She was unsure how long this item was good for; -The lids on the spice containers should be closed;-Bread came in twice weekly on a truck. She was unaware this loaf had mold;-All food items should be dated;-Dietary staff was responsible for the refrigerators in the activity room and the SCU, but staff in those areas should also assist with checking food items;-The two items in the activity refrigerator should be discarded. The activity staff made the banana cookies and should have dated them. During an interview on 9/24/25 at 2:50 P.M., Activity Director said staff completed random checks of the activity room refrigerator and freezer every week. The cotton candy was used for the last Fourth of<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | July holiday. She was unaware there was apple juice in the activity room that wasn't refrigerated. 4. Observation on 9/22/25 at 10:35 A.M. of the kitchen ice machine showed two small areas of a brown substance were on the interior surface on the side wall. Black debris and white crusty debris were located on the exterior sides of the ice machine. The ice machine drain sat directly on the floor drain grate and did not have an appropriate air gap. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said staff should wipe down the exterior of the ice machine twice weekly. She was unaware the ice machine needed an air gap. During an interview on 9/24/25 at 1:47 P.M., the Maintenance Supervisor said he was unaware the ice machine in the kitchen needed an air gap. 5. Observation on 9/22/25 between 10:36 A.M. and 10:50 A.M. showed Dietary Staff U entered the kitchen, did not wash his/her hands, and put on a hair restraint. Approximately 2 inches of his/her hair was not contained inside the hair restraint. Dietary Staff U began removing clean plates and bowls from the dish machine and carried the items to the steam table. Observation on 9/22/25 at 10:40 A.M. showed Dietary Staff X wore a hair restraint and approximately 4-inch-long section of hair hung outside of the hair restraint. He/She prepared residents' beverages for lunch. Observation on 9/22/25 at 10:59 A.M. showed Dietary Staff W entered the kitchen and wore a hair restraint. A few long sections of hair were not contained inside the hair restraint. He/She placed pans of food on the steam table. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said all hair should be tucked inside the hair restraint. 6. Review of the untitled and undated procedure for handwashing showed employees must wash their hands: a. Before going on duty;b. After a visit to the restroom;c. After smoking;d. After touching hair, nose or other parts of the body;e. After handling fresh produce or uncooked foods; f. When going from a soiled job (mopping, sweeping, washing dishes, handling garbage) to a clean job (handling clean dishes, handling food, pouring beverages);g. After handling money;h. When returning to the kitchen for any reason. Observation on 9/22/25 between 10:36 A.M. and 10:50 A.M. showed Dietary Staff U entered the kitchen and did not wash his/her hands. He/She rolled a large trash can out of the kitchen. He/She returned to the kitchen and rolled/pushed the trash can with his/her hand touching the inside of the can. He/She placed a clean trash bag inside the can in the dish room. He/She repositioned the floor mat in the dish room with his/her hands and then began to spray dirty dishes with the sprayer in the dish room. He/She started the dish machine. Dietary Staff U did not wash his/her hand and began removing clean plates and bowls with his/her soiled hands and carried the items to the steam table. He/She scratched his/her face and then picked up a clean coffee mug and a clean cutting board with his/her bare hands, placed the mug on a tray near the coffee station and placed the cutting board in a rack under the food preparation table. Observation on 9/22/25 at 10:58 A.M. showed Dietary Staff W entered the kitchen and washed his/her hands. He/She turned off the faucets with his/her hands and then obtained paper towels to dry his/her hands. Observation on 9/22/25 at 10:59 A.M. showed Dietary Staff U left the kitchen. He/She did not wash his/her hands upon returning to the kitchen and began to place tray tickets on resident meal trays. Observation on 9/22/25 at 11:05 A.M. showed Dietary Staff W entered the kitchen, washed his/her hands, turned off the faucets with his/her hands and then obtained paper towels to dry his/her hands. Observation on 9/22/25 between 11:21 A.M. and 12:32 P.M. during the lunch service showed Dietary Staff V began to plate lunch trays. He/She did not wash his/her hands and did not wear gloves prior to the start of meal service. He/She handled each resident's hamburger bun and a slice of cheese with his/her bare hands throughout the lunch meal service. Dietary Staff V handled serving utensil handles for food items in the steam tables pans to add food to the resident's trays. Observation on 9/22/25 at 12:15 P.M. showed during the lunch service, Dietary Staff V momentarily left the steam table, opened the refrigerator door with his/her bare hands, obtained a slice of cheese and carried it back to the steam table with his/her bare hands and placed it on a resident's hamburger bun. Observation on 9/22/25 at 12:02 P.M., showed the Dietary Manager entered the kitchen and washed her hands. She turned off the faucets with his/her hands and then obtained paper towels to dry her hands. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | staff should wear gloves when handling ready to eat food or staff should use tongs. Staff should wash their hands, scrub well, rinse, and turn off the faucet with a paper towel. 7. Observation on 9/22/25 at 2:50 P.M. showed no staff was working in the kitchen. A garbage can in the dish room contained cardboard food containers and food debris and was not covered. Observation on 9/22/25 at 2:55 P.M. showed no staff was working in the kitchen. A gray garbage can near the preparation counter was not covered and contained large food cans, paper trash and food debris. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said the trash cans should be covered when not in use. 8. Observation on 9/22/25 at 3:08 P.M. of the Special Care Unit (SCU) refrigerator and freezer unit showed the unit was not equipped with a thermometer in the refrigerator or in the freezer. No temperature log sheets were visible for either portion of the unit. Miscellaneous resident food items were stored in the refrigerator and the freezer. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said there used to be thermometers in the SCU refrigerator and freezer. She was unsure what happened to them. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not have documentation of a detailed water flow map for the facility that identified areas in the water system that could encourage the growth and spread of Legionella (a type of bacteria found in [NAME] that causes legionnaires' disease, a severe form of pneumonia, when inhaled in water droplets or mist) or other waterborne bacteria and did not have an assigned water management team or documentation of the program to show meeting minutes or that required members attended meetings. The facility failed to ensure nursing staff washed their hands and changed soiled gloves after each direct resident contact and when indicated by professional standards of practice during care for three residents (Resident #2, #3 and #7), in a review of 13 sampled residents and failed to provide appropriate infection control measures for one resident (Resident #2) when staff did not utilize enhanced barrier precautions (EBP, an infection control strategy in nursing homes that expands the use of personal protective equipment (PPE), specifically gowns and gloves, for high-contact care activities to prevent the spread of multidrug-resistant organisms (MDROs)), as directed in the facility policy and when completing personal care. The facility also failed to ensure proper infection control was utilized for blood glucose testing (finger prick procedure that checks the level of sugar in the blood) for three residents (Resident #3, Resident #38, and Resident #47) to prevent the spread of contaminates (bacteria and viruses) that cause infection. The facility census was 45. Review of the facility policy, Legionella Water Management Program, dated 2001 and last revised July 2017, showed the following:-As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team;-The water management team consists of at least the following personnel: the infection preventionist, the administrator, the medical director (or designee), the director of maintenance and the director of environmental services;-The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease;-The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program;-The water management program includes the following elements: -a. An interdisciplinary water management team (see above); -b. A detailed description and diagram of the water system in the facility, including the following: receiving, cold water distribution, heating, hot water distribution and waste; -c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: water heaters; filters; showerheads and hoses; personal humidifiers; fountains; and medical devices such as CPAP machines etc.; -d. The identification of situations that can lead to Legionella growth, such as: construction; water main breaks; changes in municipal water quality; the presence of biofilm, scale or sediment; water temperature fluctuations; water pressure changes; water stagnation; and inadequate disinfection; -e. Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants); -f. The control limits or parameters that are acceptable and that are monitored; -g. A diagram of where control measures are applied; -h. A system to monitor control limits and the effectiveness of control measures; - i. A plan for when control limits are not met and/or control measures are not effective and -j. Documentation of the program. 1. Review of facility provided documentation, showed the facility provided a Quality Assurance (QA) meeting agenda, dated May 2025, that included a topic regarding Legionella. There was no documentation of notes or who attended the meeting. During an interview on 09/25/25 at 2:00 P.M., the Maintenance Director said the following:-The facility does not have a specific water management team; it was whoever was at the QA meetings; -The facility had not had a water management meeting specifically, but discussed Legionella at the QA meetings;-He was not familiar with ASHRAE;-He did not have a water flow map.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 09/25/25 at 3:30 P.M., the Infection Preventionist (IP) said the following:-She had not attended a water management meeting;-The facility does not have a water management team; -Legionella was discussed at QA meetings and she attended QA meetings. During an interview on 09/25/25 at 5:15 P.M., the Director of Nursing (DON) said the following:-They talked about Legionella at QA meetings;-The facility did not have a specific water management team that she knew of. During an interview on 09/25/25 at 5:40 P.M., the Administrator said the following:-Everyone on the QA team was part of the water management team (the Administrator, Maintenance, housekeeping, Infection Preventionist, Director of Nursing, dietary, pharmacist, medical records and MDS); (the medical director (or designee) was not included); -She did not know about a water flow map until the maintenance director asked her about it. 2. Review of the facility policy, Handwashing/Hand Hygiene, revised October 2023, showed the following:-This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections;-All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections;-All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors;-Hand hygiene products and supplies (sinks, soaps, towels, alcohol-based hand rub (ABHR), etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies;-Hand hygiene is indicated:a. Immediately before touching a resident;b. Before performing an aseptic task (for example, placing an indwelling device or handling an invasive device);c. After contact with blood, body fluids or contaminated surfaces;d. After touching a resident;e. After touching the resident's environment;f. Before moving from work on a soiled body site to a clean body site on the same resident;g. Immediately after glove removal;-Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations;-Wash hands with soap and water:a. When hands are visibly soiled;b. When anticipating contact with blood or body fluids;c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions;-The use of gloves does not replace hand washing/hand hygiene. 3. Review of the facility policy, Personal Protective Equipment (PPE)-Using Gloves, revised September 2010, showed the following:-Wash hands after removing gloves. (Note: Gloves do not replace handwashing);- Use gloves when touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin and whenever in doubt. 4. Review of an undated facility document, EBP for Nurses, showed the following:-You must wear PPE (gown and gloves) for the following activities if they are performed in the resident's room or shower room:d. Changing linens;e. Providing hygiene;f. Changing briefs or assisting with toileting;-Sanitize your hands, sanitize your hands, sanitize your hands, sanitize your hands. 5. Review of the undated facility document, EBP for Certified Nurse Aides (CNAs) and Certified Medication Technicians (CMTs), showed the following:-You must wear PPE (gown and gloves) for the following activities if they are performed in the resident's room or shower room:a. Dressing;b. Bathing/showering;d. Changing linens;e. Providing hygiene;f. Changing briefs or assisting with toileting;-Sanitize your hands. 6. Review of Resident #2's Prospective Payment System (PPS) 5-day Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/23/25, showed the following:-Lower extremity impairment in range of motion on both sides;-Dependent on staff for toileting hygiene;-Required substantial/maximal assistance to roll left and right;-Indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine continuously);-Always continent of bowel;-Has a Stage I or greater pressure ulcer (localized area of skin damage that develops when prolonged pressure is applied to the body);-Two Stage II pressure ulcers (partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present)-present on admission/re-entry;-Pressure ulcer care;-Applications of ointments/medications other than to feet. Review of the resident's Care Plan, revised 09/09/25, showed the following:-The resident has a urostomy (surgical procedure that<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | creates an opening (stoma) in the abdomen to divert urine from the bladder to an external bag or pouch) and nephrostomy tube (a thin, flexible tube inserted into the kidney to drain urine directly into a collection bag);-The resident is currently on EBP for his/her nephrostomy (an artificial opening created between the kidney and the skin which allows for the urinary diversion directly from the upper part of the urinary system) and urostomy;-Signage is placed on the door to inform staff what PPE to use;-Please wear gown and gloves when doing personal care with resident either in his/her room or in the tub room;-PPE was in the plastic drawers by each door;-Please use proper hand hygiene both before and after taking care of the resident. Observation on 09/23/25 at 8:18 P.M. outside the resident's room showed the following:-A plastic cart with drawers. The drawers contained various PPE including gloves, gowns and face masks;-A red Centers for Disease Control (CDC) sign which read:ENHANCED BARRIER PRECAUTIONS EVERYONE MUST:-Clean their hands, including before entering and when leaving the room;PROVIDERS AND STAFF MUST ALSO:Wear gloves and a gown for the following High-Contact Resident Care Activities:-Providing hygiene;-Changing briefs or assisting with toileting;-Device care or use: indwelling catheter. Observation on 09/23/25 at 8:18 P.M., in the resident's room, showed the following:-The resident lay awake in bed;-The resident was incontinent of a small amount of feces;-Certified Nurse Aide (CNA) R and CNA S applied gloves and entered the resident's room;-CNA R and CNA S did not apply gowns;-The resident had vomited a moderate amount of yellow-green liquid in his/her basin;-With gloved hands, CNA S emptied the basin into the toilet; -The resident told CNA R and CNA S that his/her linens would need to be changed because his/her urostomy was leaking;-The resident removed his/her stoma dressing (an ostomy pouching system, which includes a skin barrier (wafer) that adheres to the skin around the stoma) and urinary drainage pouch (a medical device used to collect urine when the bladder has been removed or is no longer functioning properly) and handed them to CNA S;-There was milky-looking tan drainage in the urinary drainage pouch;-CNA S placed the stoma dressing and urinary drainage pouch in a trash bag, removed his/her gloves and without washing his/her hands or using ABHR, exited the resident's room; -The resident placed a clean stoma dressing and urinary drainage pouch on his/her urostomy;-CNA S re-entered the resident's room carrying clean linens, washed his/her hands and applied gloves;-CNA S did not apply a gown;-CNA S and CNA R leaned against the resident's bed and gave the resident a partial bath;-CNA S provided frontal peri care;-The resident rolled to his/her left side;-Without changing gloves or washing his/her hands, CNA S washed the resident's back;-CNA R provided rectal peri care, changed gloves and washed his/her hands;-With the same soiled gloves, CNA S put dry shampoo in the resident's hair, touched the resident's nephrostomy tubing and tucked the soiled linens under the resident;-With the same soiled gloves, CNA S continued to tuck the soiled linens along with the clean linens under the resident;-The resident rolled to his/her right side;-With the same soiled gloves, CNA S continued to spray dry shampoo in the resident's hair, placed a clean gown on the resident and bagged the soiled linens; -CNA S dumped the bath water in the sink, removed his/her gloves and without washing his/her hands or using ABHR, touched the doorknob, opened the door and exited the room. Observation on 09/25/25 at 9:45 A.M., in the resident's room, showed the following:-The resident lay on his/her left side in bed;-The resident was incontinent of a medium amount of soft feces;-Without performing hand hygiene, CNA R and Licensed Practical Nurse (LPN) A applied gowns;-CNA R applied gloves;-LPN A placed a handful of gloves in his/her scrub pocket;-LPN A applied gloves, pulled the keys out of his/her pocket, unlocked the treatment cart and got scissors out of the cart;-LPN A removed the soiled coccyx dressing exposing the open coccyx wound;-There was a small amount of yellow/tan drainage on the dressing;-LPN A wiped stool from the resident's rectal area;-There was stool visible on LPN A's gloves;-LPN A removed his/her gloves and without washing his/her hands or using ABHR, LPN A pulled a pair of gloves out of his/her pocket and applied the gloves;-LPN A washed over the open wound with peri wash on a washcloth;-There was stool present on the washcloth;-LPN A continued to provide rectal peri care;-LPN A removed his/her gloves and without washing his/her hands or using ABHR, LPN A pulled (continued on next page) |

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| | 265360 | A. Building<br>B. Wing | 11/17/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | a pair of gloves out of his/her pocket and applied the gloves;-LPN A applied a new dressing to the wound bed, covered the wound with a dry dressing and secured the dressing with tape;-Without changing gloves or washing his/her hands, LPN A picked up the resident's nephrostomy tubing and removed the dressing from the nephrostomy site;-LPN A disposed of the dressing and applied a clean dressing;-LPN A disposed of the dressing packages, removed his/her gloves and used ABHR. During an interview on 09/25/25 at 10:20 A.M., CNA R (agency staff) said the following:-He/She has not received any training from the facility regarding infection control or EBP;-He/She is aware residents on EBP require use of a gown and gloves;-He/She should have worn a gown when providing personal care for the resident;-He/She should have washed his/her hands or used ABHR prior to applying gloves. During an interview on 09/25/25 at 12:15 P.M. LPN A (agency staff) said the following:-He/She has not received any training from the facility regarding infection control or wound care;-He/She washes his/her hands before all care/treatments and after he/she is done;-He/She should use ABHR with all glove changes, but he/she didn't;-He/She stores gloves in his/her pockets for Resident #2's treatments. Observation on 09/23/25 at 2:00 P.M., in the resident's room, showed the following:-The resident lay awake in bed;-Registered Nurse (RN) P used ABHR and applied a gown and gloves;-RN P removed the soiled dressing from the resident's coccyx wound;-There was tan drainage on the dressing;-With the same gloved hands, RN P removed the dressing from the resident's nephrostomy site;-RN P removed his/her gloves, used ABHR and applied clean gloves;-RN P measured the resident's coccyx wound with a paper measuring tool;-RN P removed his/her gloves, used ABHR and applied clean gloves;-RN P washed around the resident's nephrostomy site;-Without removing his/her gloves or performing hand hygiene, RN P picked up another wet washcloth with shampoo/body wash on it and washed the open coccyx wound;-RN P dried the open coccyx wound with a dry washcloth;-RN P cut the dressing with scissors and laid the dressing on top of the dressing package;-RN P placed the dressing into the wound bed, covered it with a dry gauze and secured the dressing with tape;-RN P removed his/her gloves, used ABHR and applied clean gloves;-RN P covered the resident's nephrostomy site with a dry dressing and secured it with tape;-RN P removed his/her gloves and used ABHR. During an interview on 09/25/25 at 4:05 P.M., RN P said the following:-He/She usually washed his/her hands when he/she applied gloves;-He/She uses ABHR with glove changes unless his/her hands are visibly soiled and he/she would wash his/her hands. 7. Review of Resident #3's Quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting hygiene;-Required substantial/maximal assistance for roll left and right;-Frequently incontinent of urine;-Occasionally incontinent of stool. Review of the resident's Care Plan, dated 09/09/25, showed the following:-The resident was mostly incontinent of bowel/bladder;-Provide peri care with incontinent episodes. Observation on 09/23/25 at 7:42 P.M. in the resident's room showed the following:-The resident sat in his/her wheelchair;-CNA R and CNA S washed their hands and applied gloves;-CNA R and CNA S transferred the resident to bed via mechanical lift;-CNA R and CNA S removed the resident's socks and pants;-The resident's incontinence brief was saturated with urine and stool;-CNA S provided frontal peri care;-The resident rolled to his/her left side;-CNA R provided rectal peri care;-CNA R removed the soiled incontinence brief, removed his/her gloves and washed his/her hands;-CNA R exited the room;-Without changing gloves or washing his/her hands, CNA S touched the resident's bed sheet and bedspread;-CNA R returned to the room, washed his/her hands and applied gloves;-Without changing gloves or washing his/her hands, CNA S assisted CNA R and placed a clean cloth incontinence pad under the resident's hips;-With the same soiled gloves, CNA S covered the resident with a sheet and blanket and straightened the resident's linens;-With the same soiled gloves, CNA S used the resident's bed controls, turned on the oxygen concentrator, placed the oxygen tubing in the resident's nose and pushed the table to the bedside;-CNA S removed his/her gloves and washed his/her hands. During an interview on 10/07/25 at 1:15 P.M., CNA S said the following:-He/She had not received any infection control training at the facility;-He/She had received training regarding EBP;-He/She should wear a gown and gloves when providing personal care for<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | residents on EBP, but he/she forgot to wear a gown;-He/She should change gloves and wash hands between dirty and clean;-He/She should wash hands or use ABHR with each glove change. 8. Review of Resident #7's Annual MDS, dated [DATE], showed the following:-Dependent on staff for personal hygiene, toileting hygiene, transfers and to roll left and right;-Always incontinent of bowel and bladder. Review of the resident's Care Plan, dated 09/23/25, showed the following:-The resident does not move his/her arms and therefore will require assistance with Activities of Daily Living (ADLs) and transfers with mechanical lift;-The resident was incontinent of bowel/bladder;-Provide peri care after incontinent episodes. Observation on 09/23/25 at 7:20 P.M., in the resident's room, showed the following:-The resident lay awake in bed;-CNA Y and Nurse Aide (NA) I washed their hands and applied gloves;-The resident was incontinent of urine;-The resident's brief was saturated with urine;-CNA Y removed the resident's incontinence brief and provided peri care;-Without changing gloves or washing his/her hands, CNA Y touched the cloth mechanical lift sling, the mechanical lift, the resident's gown and the clean cloth incontinence pad;-With the same soiled gloves, CNA Y pushed the mechanical lift to the bed;-CNA Y and NA I attached the cloth mechanical lift sling to the mechanical lift;-With the same soiled gloves, CNA Y pushed the buttons on the mechanical lift to operate it;-CNA Y and NA I transferred the resident from the bed to the chair via mechanical lift;-With the same soiled gloves, CNA Y and NA I removed the cloth mechanical lift sling from the lift;-CNA Y covered the resident with a blanket and pulled the trash from the trashcan;-CNA Y removed his/her gloves and without washing his/her hands or using ABHR, CNA Y pushed the mechanical lift out of the resident's room into the hall;-Without washing his/her hands or using ABHR, CNA Y pushed the resident in his/her wheelchair to the shower room. During an interview on 09/24/25 at 07:30 P.M., CNA Y said the following: -Hand hygiene should be done when staff entered a resident's room, before gloves were worn, when gloves were removed, or anytime the hands appeared soiled; -Gloves should be changed when performing personal care for a resident, when cleaning from the front to the back of the resident's private area, or anytime gloves appeared dirty; -Gloves should be changed after each use and before touching clean areas. 9. Review of the facility policy, Obtaining a Fingerstick Glucose Level, dated 2001, showed the following:-Wear clean gloves;-Wash the selected fingertip, especially the side of the finger, with warm water and soap. (Note: If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading);-Obtain a blood sample by using a sterile lancet;-Follow the instructions provided by the manufacturer of the glucose monitoring system to obtain a blood glucose reading;-Dispose of the lancet in the sharp's disposal container;-Remove gloves and discard into designated container;-Wash hands. 10. Review of Resident #3's undated facility face sheet, showed the resident had a diagnosis of diabetes mellitus (DM, a chronic condition characterized by high blood sugar levels). Observation on 09/23/25 at 07:40 P.M. showed the following: -LPN B put gloves on his/her hands, used a disposable alcohol pad and wiped Resident #3's finger, then pricked the finger to obtain a glucose (blood sugar) reading with a glucometer (a medical device used to measure the concentration of glucose in a person's blood); -LPN B used a disposable alcohol pad and wiped an area on Resident #3's abdomen, then administered the prescribed units of insulin into the abdomen; -LPN B removed his/her gloves and threw them away; -LPN B did not wash his/her hands or use a hand sanitizer before donning gloves or after removing them. 11. Review of Resident #38's undated facility face sheet, showed the resident had a diagnosis of diabetes. Observation on 09/23/25 at 7:45 P.M. showed the following: -LPN B put gloves on his/her hands, used a disposable alcohol pad and wiped Resident #38's finger, then pricked the finger to obtain a glucose reading with a glucometer; -LPN B removed his/her gloves and threw them away; -LPN B did not wash his/her hands or use a hand sanitizer before donning gloves or after removing them. 12. Review of Resident #47's undated facility face sheet, showed the resident had a diagnosis of diabetes. Observation on 09/23/25 at 7:50 P.M. showed the following: -LPN B put gloves on his/her hands, used a disposable alcohol pad and wiped Resident #47's finger, then pricked the finger to obtain a glucose reading with a glucometer; -LPN B removed his/her gloves and threw them away; (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -LPN B did not wash his/her hands or use a hand sanitizer before donning gloves or after removing them. 13. During an interview on 10/08/25 at 07:06 P.M., LPN B said the following: -Hand hygiene should be done before putting gloves on and obtaining a blood sugar reading, and after the procedure was completed when gloves were removed;-He/She thought he/she had used a hand sanitizer before and after using gloves when glucometer readings were obtained from residents. During an interview on 09/25/25 at 3:30 P.M., the Infection Preventionist said the following:-Staff have received education regarding EBP when it first came out and she reviewed the information with staff again this summer;-Staff were given a packet of information specific to their role regarding EBP;-Staff also receives this information during orientation;-The facility does not provide training on EBP to agency staff. She is not sure what kind of education the agency provided; -She would expect staff to perform hand hygiene prior to applying a gown; -She would expect staff to perform hand hygiene with glove changes;-Staff should change gloves and perform hand hygiene after providing peri care prior to touching clean items; -Staff should wear a gown and gloves when providing personal care for Resident #2. This information is posted outside the resident's room;-Staff should not carry gloves in their pockets and use from that supply during wound care or any personal care. During an interview on 09/25/25 at 04:55 P.M., the Director of Nurses (DON) said the following: -She would expect staff to use appropriate hand hygiene (wash hands with soap and water or use a hand sanitizer) when they entered or left a resident's room, before and after the use of gloves, or when hands were visibly soiled. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative services to assist five residents (Resident #3, #6, #7, #28 and #30) in a review of 13 sampled residents, with mobility and/or limited range of motion to attain or maintain their highest level of functioning. The facility census was 45. Review of the facility policy, Restorative Nursing Services, dated July 2017, showed the following:-Residents will receive restorative nursing care as needed to help promote optimal safety and independence;-Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g. physical, occupational or speech therapies)-Residents may be started on a restorative nursing program upon admission, during stay or when discharged from rehabilitative care;-Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care;-The resident or representative will be included in determining goals and the plan of care;-Restorative goals may include, but are not limited to supporting and assisting the resident in:-Adjusting or adapting to changing abilities;-Developing, maintaining or strengthening his/her physiological and psychological resources;-Maintaining his/her dignity, independence and self-esteem. 1. Review of Resident #6's undated medical record face sheet showed the resident's medical diagnoses included cerebral palsy (CP, a lifelong neurological disorder caused by damage or abnormal development in the brain that affects movement, muscle control, coordination, balance, and posture). Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 08/08/25, showed the following: -Cognitively intact; -No behaviors or rejection of cares; -Lower extremity ([NAME]) impairment on both sides; -Used a wheelchair; -Dependent for sit-to-lying, lying-to-sitting, and chair/bed-to-chair transfer;-No indication of therapy services. Review of the resident's care plan, last reviewed/revised on 09/24/25, showed the following: -The resident was an assist of one or two staff, depending on the task, and needed a mechanical lift for transfers due to increased spasticity (a neurological condition that causes abnormal muscle stiffness or tightness, making movement difficult) related to CP; -The resident required a mechanical lift for transfers with assist by two staff and required frequent monitoring of positioning due to spasticity caused by his/her CP diagnosis. Observation on 09/22/25 at 2:50 P.M. showed the following: -The resident sat upright in a Broda chair (a specialized wheelchair designed to provide comfort, support, and safety for individuals with complex positioning needs); -The resident was unable to move his/her legs and had limited range of motion (ROM) of arms and upper body. During an interview on 09/23/25 at 2:20 P.M., the resident said the following: -He/She had not had any therapy for a long time; he/she had not had any therapy since his/her last hospitalization, a year ago;-He/She had a lot of muscle spasticity in the low back and legs, which was painful; -He/She thought a restorative therapy program might help him/her keep his/her upper body strength; he/she had not expressed this to anyone, and no one had asked him/her about therapy. During an interview on 09/25/25 at 09:52 A.M., the Director of Therapy (DOT) said the following:-Every resident would benefit from a restorative therapy (RT) nursing program; -The facility did not have a RT program due to their staffing issues (lack of staff); -She provided an in-service about two to three months ago for all staff, and it was video-taped, on how to perform basic ROM to the upper and lower extremities of a resident when in bed, proper body mechanics and ideas for activities for residents when they attended activities; -The resident would benefit from a RT program due to his/her diagnosis of CP and his/her muscle spasticity;-She spoke with this resident in the last couple of months when a new wheelchair and occupational therapy consult had been ordered; she discussed the resident's spasticity with the resident and approached him/her about therapy, but said the resident was not interested at that time. 2. Review of Resident #28's medical record face sheet, undated, showed the resident had medical<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | diagnoses that included unspecified osteoarthritis (OA, a chronic, degenerative joint condition that causes pain, swelling and stiffness of the joints in the body and can affect a person's ability to move freely). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No behaviors or rejection of cares; -Used a walker and wheelchair; -Independent for sit-to-lying, lying-to-sitting, and chair/bed-to-chair transfers; -No indication of therapy services. Review of the resident's care plan, last reviewed/revised on 09/03/25, showed the following: -The resident was independent with most ADLs, ambulated independently in his/her room, but required a wheelchair for distance and may need (staff) assistance to go places because it was too much excursion; -The resident was at risk for falls related to confusion and unsteady gait; -Resident ambulated independently in his/her room with his/her walker; -Assist of one with a gait belt in the hallway; -Used a wheelchair for distance. Observation on 09/25/25 at 11:00 A.M. showed the resident propelled his/her wheelchair, using his/her arms and feet, from the 400 hall to the therapy room in the 500 hall, stopping several times to rest. During an interview on 09/25/25 at 11:10 A.M., the resident said the following: -He/She felt weaker now than when admitted to the facility; -He/She used to walk down the hall from his/her room (400 hall) to the therapy room (500 hall) with a walker, but now just walked in his/her room or to the nursing station by himself/herself; -He/She would like to be able to work with therapy and get stronger again; -He/She had not mentioned this to anyone because he/she knew the staff were busy and he/she didn't want to be a bother. During an interview on 09/25/25 at 09:52 A.M., the DOT said the following:-Resident #28 used to ambulate using a walker by herself/himself from his/her room on the 400 hall to the therapy room on the 500 hall, but then he/she stopped walking that far altogether; -Resident #28 needed staff to encourage him/her to walk, and to follow him/her with a wheelchair so he/she could sit down when he/she got tired; -The resident had received skilled services upon admission, as he/she had fallen at home prior to that. 3. Review of Resident #30's medical face sheet, undated, showed diagnosis of stroke. Review of the resident's admission MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No behaviors or rejection of cares; -Dependent for positioning and mobility; -No indication of therapy services. Review of the resident's care plan, last reviewed/revised on 09/17/25, showed the following: -Reposition the resident frequently;-The resident required a full body lift (mechanical lift) with assist of two staff for transfers. Observation on 09/22/25 at 2:30 P.M. and 09/23/25 at 12:50 P.M., showed the following: -The resident lay in bed on his/her back with both eyes closed; -Both hand/fingers were clenched and closed. During an interview on 09/23/2025 10:45 AM, the resident's legal representative said the following: -The resident had had a massive stroke just last Spring and was bed-bound now; -He/She was worried that the resident was not getting any type of therapy, and he/she didn't want the resident to get any weaker; -The resident's hands seemed to be getting worse; he/she had tried to open the resident's hands before and it was difficult; -The resident would benefit from ROM even if he/she could not participate in therapy. During an interview on 09/25/25 at 09:52 A.M., the DOT said the following:-If the resident had bilateral hand contractures, he/she would benefit from a restorative nursing program to perform ROM and use adaptive measure such as a washcloth inside the hand to prevent worsening of the contractures;-She had not evaluated the resident. 4. Review of Resident #3's Quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for toileting hygiene and chair/bed to chair transfer;-Required substantial/maximal assistance to roll left and right;-Lower extremity impairment on one side;-Frequently incontinent of urine;-Occasionally incontinent of stool;-Diagnosis of hip fracture. Review of the resident's Physical Therapy Treatment Encounter Note, dated 08/14/25, showed the following:-The resident was referred to skilled PT on 07/01/25 following appointment with orthopedic physician (medical specialist who diagnoses and treats conditions and injuries affecting the musculoskeletal system) with orders for PT to evaluate, no active left hip or passive abduction, weight bear as tolerated (WBAT) for assist and transfer, follow up in six weeks;-Resident with history of fall out of bed May 2025 with resulting nondisplaced intertrochanteric fracture of the left femur and (continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | neck of the femur (break in the thigh bone that occurs between the greater and lesser trochanters, extending to the femoral neck, where the bone fragments remain in good alignment and don't move significantly from their normal position);-Resident was seen for PT evaluation at that time due to no change in prior level of functioning and placed in restorative ROM program for bilateral lower extremities with no active ( movement of a leg away from the body's midline) or passive abduction (involves an assistant slowly and smoothly moving the leg outwards to the side, away from the body's midline, without the person actively engaging their muscles) per physician order;-Resident saw orthopedic physician again on 08/01/25 with new PT orders;-Again, resident has had no change in PLOF;-Resident is currently dependent on Hoyer (total body) mechanical lift as that transfer is the safest for both resident and staff;-Resident has not been ambulatory in several years;-Recommend resident continue restorative ROM program for BLE per resident tolerance. Review of the resident's Care Plan, dated 09/09/25, showed the following:-The resident will use the full body lift for transfers with staff assist of two;-No documentation regarding restorative nursing services. Review of the resident's medical record showed no documentation regarding the resident's participation in a restorative ROM program. Observation on 09/23/25 at 7:42 P.M. in the resident's room showed the following:-The resident sat in his/her wheelchair;-Staff transferred the resident to bed via mechanical lift;-Staff removed the resident's socks and pants, rolled the resident back and forth in bed and provided incontinence care. During an interview on 09/22/25 at 2:46 P.M. the resident said the following:-He/She had a fall and broke his/her leg;-He/She required a mechanical lift for transfers to and from bed;-He/She didn't qualify for skilled therapy, so he/she did his/her own exercises;-The facility does not have a restorative aide, so he/she had to do the exercises him/herself. During an interview on 09/25/25 at 09:52 A.M., the DOT said she gave staff a specific in-service for activity recommendations for Resident #3, to include ROM, encourage self-propelling from the resident's room to the dining room and back, and to continue independence as much as possible. 5. Review of Resident #7's Physical Therapy Discharge summary, dated [DATE], showed the following:Summary Since Evaluation/Start of Care:Skill: Interventions Provided:-Resident has been seen in skilled PT for BLE strengthening and transfer training per resident tolerance;-Resident and caregiver training: Resident education on how to properly perform therapeutic exercises;-Resident response: Resident has reached maximum potential with skilled services;Discharge Status and Recommendations:Restorative Nursing Program (RNP): Referral to restorative program per resident tolerance. Review of the resident's Annual MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Functional limitation in range of motion, both sides, both upper and lower extremities;-Dependent on staff for eating, personal hygiene, toileting hygiene, dressing, transfers and roll left and right;-Always incontinent of bowel and bladder;-Diagnosis of dementia. Review of the resident's Care Plan, dated 09/23/25, showed the following:-The resident has decreased mobility in his/her shoulders and arms related to cervicalgia neuropathy (pain caused by a pinched or compressed nerve root in the neck (neuropathy. This nerve dysfunction leads to symptoms like radiating pain, numbness, tingling, and muscle weakness in the arm, hand, or fingers, typically on one side) and spinal stenosis (condition where the spaces within the spinal column become narrowed, putting pressure on the spinal cord and nerve roots);-The resident does not move his/her arms and therefore will require assistance with Activities of Daily Living (ADLs), transfers with mechanical lift and eating;-The resident has pain related to arthritis, spinal stenosis and cervicalgia. Observation on 09/23/25 at 7:20 P.M., in the resident's room, showed the following:-Staff transferred the resident from his/her wheelchair to his/her bed via mechanical lift;-The resident's right hand was swollen and his/her fingers curled into his/her palm;-The resident had a sling on his/her left arm;-The resident was unable to open his/her right hand without assistance;-The resident's right thumb nail dug into his/her right index finger;-There was a deep indentation present on the resident's right index finger;-The resident told staff his/her right index finger was sore;-The resident was unable to independently hold his/her hand open;-The resident was unable to provide assistance with bed (continued on next page) |

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| | 265360 | A. Building<br>B. Wing | 11/17/2025 |

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| Lewis County Nursing Home District | 17528 State Highway 81<br>Canton, MO 63435 |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | mobility;-The resident had bilateral foot drop (difficulty lifting the front part of the foot);-Staff transferred the resident from bed to his/her wheelchair via mechanical lift;-Staff pushed the resident in his/her wheelchair to the shower room. During an interview on 09/23/25 at 8:02 P.M. the resident said the following:-He/She can't walk or stand;-He/She tried to exercise his/her right hand. During an interview on 09/25/25 at 09:52 A.M., the DOT said the following: -Resident #7 was a quadriplegic and likely had bilateral foot drop on admission, had no movement of the upper extremities but would benefit from ROM in bed. 6. During an interview on 09/22/25 at 10:00 A.M. and 09/25/25 at 04:55 P.M., the Director of Nurses (DON) said the following: -The facility did not have a restorative nurse aide;-The facility did not currently have a restorative therapy program; -The director of therapy had recently offered in-services to the nursing staff on ROM that could be provided to all residents;-She would expect nursing staff to offer ROM to residents; this could be done while they were in bed or even during their showers. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview and record review, the facility failed to ensure staff transferred one resident (Resident #4), in a review of 13 sampled residents, using appropriate technique consistent with the resident's abilities and condition to ensure the resident's safety. The facility also failed to ensure chemicals were secured in a locked storage area not accessible to residents. The facility's census was 45. Review of the facility policy, Safe Lifting and Movements of Residents, revised July 2017 showed the following:-Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents;-Manual lifting of resident's shall be eliminated when feasible;-Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. Such assessments shall include resident's preference for assistance, resident's mobility (degree of dependency), resident size, weight-bearing ability, cognitive status, whether the resident is cooperative with staff, and the resident's goals for rehabilitation, including restoring or maintaining functional ability;-Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices;-Safe lifting and movement of resident's is part of an overall facility employee health and safety program. Review of the Nurse Assistant in a Long-Term Care Facility, Student Reference Manual, 2001 revision, showed the following:-For a resident who is weak, you must have control of the resident's shoulders and hips during the transfer;-Do not attempt to transfer a resident who cannot bear any of his/her own body weight by yourself. Determine beforehand how many people are needed for the transfer. If it takes more than two persons to transfer the resident, use a mechanical lift. 1. Review of Resident #4's face sheet showed the resident's diagnoses included unspecified dementia, age related osteoporosis (bone disease characterized by a decrease in bone mineral density and structural changes that weaken the bones, making them more prone to fractures), pain and muscle weakness. Review of the resident's quarterly Minimum Data Sheet (MDS), a federally mandated assessment instrument completed by facility staff, completed 07/03/25, showed the following:-Severely impaired cognition;-Dependent on staff for chair/bed to chair transfers. Review of the resident's August 2025 physician order sheet, showed an order, dated 07/30/25, to get the resident up in a geri-chair (a specialized recliner designed to provide comfort for those with limited mobility) with a mechanical lift, or gait belt with two assist, and weight bearing as tolerated. Review of the resident's care plan, dated 08/28/25, showed the resident required two staff to assist for transfers with a gait belt. Review of the resident's September 2025 physician order sheet showed an order to get the resident up in a geri-chair with a mechanical lift, or gait belt with two assist, and weight bearing as tolerated. Observation on 09/23/25 at 11:00 A.M., showed the following:-Certified Nurse Assistant (CNA) G and CNA E assisted the resident to sit on the side of the bed;-CNA G and CNA E put a gait belt on the resident and assisted the resident to stand and pivot to a Broda chair (a specialized reclining chair);-The resident did not bear weight, and his/her legs were crossed at the ankles. During an interview on 09/23/25 at 11:00 A.M., CNA G said the transfer did not go well and the resident may need to be transferred with the mechanical lift. He/She had notified the Director of Nursing (DON) of his/her concern. Observation on 09/24/25 at 12:45 P.M., showed the following:-CNA H and CNA D dressed the resident;-CNA H put a gait belt on the resident;-CNA H, by him/herself, assisted the resident to stand; transfer assistance was not provided by two staff as the resident's care plan directed;-CNA D pulled the resident's brief and pants up;-CNA H sat the resident in the Broda chair;-The resident did not bear weight, his/her feet drug across the floor. During an interview on 10/01/25 at 9:45 A.M., CNA H said the following:-The resident was a two person assist with a gait belt; -The resident should not be transferred with only one staff;-On 9/24/25, the resident was able to bear weight when transferred and there was a second staff in the room when he/she transferred the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident by him/herself, that is why he/she transferred the resident by him/herself. Review of the resident's nursing notes, dated 09/24/25 at 6:14 P.M., showed the following:-Nursing staff notified the Director of Nursing (DON) that the resident was getting very stiff during transfers and was not bending well;-Physician notified and orders changed to a full body mechanical lift starting 09/25/25. During an interview on 09/25/25 at 5:15 P.M. and 10/07/25 at 9:20 A.M., the DON said the following:-Staff should not perform a one person transfer on a resident that was a two person transfer;-It does not make a difference if they can bear weight or not, if they were to be a two person transfer, that was what was expected, even if the resident could bear weight;-She was notified on 09/23/25 of the resident's decline in transfers with two-person assist and gait belt;-This was the first time she had heard about a change in the resident's transfer status. 2. Review of the undated facility policy, Hazardous Chemicals, showed the following:-All hazardous chemicals are to be kept locked in a secured cabinet/cart;-This included any chemical in every department. 3. Observation on 09/22/25 at 3:58 P.M., in the 500 Hall Shower Room, showed the following:-The door to the room was unlocked;-A full bottle of Buckeye Neutral Disinfectant (a multi-purpose, neutral pH, germicidal detergent, designed for use in hospital, healthcare and industrial settings) sat in an unlocked cabinet;-The front of the bottle was labeled, Keep out of reach of children and Danger; -The back of the bottle was labeled, Hazards to humans and domestic animals, Danger, corrosive. Causes irreversible eye damage and skin burns. Harmful if inhaled, swallowed or absorbed through the skin. Do not get in eyes, on ski, or on clothing. Observation on 09/23/25 at 07:50 P.M. showed an unidentified male resident ambulated down the 500 hall and went into the 500-hall shower room, unaccompanied by staff. 4. Observation on 09/22/25 at 4:00 P.M., in the 400 Hall Shower Room, showed the following:-The door to the room was unlocked;-A full bottle of Buckeye Neutral Disinfectant sat in an unlocked cabinet. Observation on 09/25/25 at 09:10 A.M., in the 400 Hall Shower Room, showed the following: -The door to the room was unlocked;-A full bottle of Buckeye Neutral Disinfectant sat in an unlocked cabinet;-Two staff assisted an unidentified resident off the toilet and out of the shower room;-CNA G saw the bottle of Buckeye Neutral Disinfectant in the unlocked cabinet and said, Oh, that cabinet's not locked up!. During an interview on 09/25/25 at 09:15 A.M., CNA G said the following: -The shower rooms on the 400 and 500 halls were always unlocked; -The Buckeye Neutral Disinfectant was used by staff to sanitize the shower, shower chairs, wall, shower nozzle, and shower sprayer/head after each shower; -The cabinet where the disinfectant was kept should be locked, but usually it was not. During an interview on 09/24/25 at 11:50 A.M., CNA Y said the following: -The shower rooms on the 400 and 500 halls were always unlocked; -Residents could enter the shower rooms unaccompanied to use the bathroom facility if they wanted to. During an interview on 09/25/25 at 5:15 P.M., the DON said disinfectants should be stored in a locked cabinet in the shower rooms. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review, the facility failed to ensure inventories of schedule II controlled substance medications (substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence), schedule IV medications (medications with a lower potential for abuse) and schedule V medications (medications with lower potential for abuse than schedule IV) were monitored and reconciled every shift, per facility policy, for five sampled residents (Resident #23, #5, #13, #7 and #2) of 12 sampled residents and ten additional resident (Resident #36, #29, #153, #16, #9, #25, #45, #152, #32 and #28). The facility census was 47. Review of the facility policy, Controlled Substances, dated November 2022, showed the following:-Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up;-Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count;-The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing (DON);-Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. 1. Observation on 01/14/26 at 4:29 P.M. in the 300/400/500 Hall Medication Room, in a double locked metal cabinet on the wall, showed the following:-Resident #45 had a pharmacy medication card of tramadol (schedule IV narcotic pain medication) 50 milligrams (mg) with a quantity of 16 tablets remaining;-Resident #36 had two pharmacy medication cards of hydrocodone-acetaminophen (schedule II narcotic pain medication) 7.5 mg-325 mg with 60 tablets per card (for a total of 120 tablets remaining);-Resident #7 had a pharmacy medication card of lorazepam (schedule IV narcotic anti-anxiety medication) 1 mg with a quantity of 90 tablets remaining;-Resident #2 had three pharmacy medication cards of oxycodone (schedule II narcotic pain medication) 5 mg with 60 tablets per card (for a total of 180 tablets remaining);-Resident #152 had one pharmacy medication card of lorazepam 0.5 mg with a quantity of 30 tablets remaining;-Resident #36 had two pharmacy medication cards of hydrocodone-acetaminophen 5 mg-325 mg with 60 tablets per card (for a total of 120 tablets remaining);-Resident #32 had a pharmacy medication card of tramadol 50 mg tablets with a quantity of 45 tablets remaining;-Resident #28 had a pharmacy medication card of tramadol 50 mg tablets with a quantity of 12 tablets remaining;-Resident #29 had two pharmacy medication cards of hydrocodone-acetaminophen 5 mg-325 mg with 60 tablets per card (for a total of 120 tablets remaining);-Resident #28 had two pharmacy medication cards of pregabalin (schedule V narcotic anti-convulsant (used to treat seizures) medication also used for nerve pain)) 75 mg with 30 caplets in one card and 45 caplets in one card (for a total of 75 caplets remaining);-Resident #153 had one pharmacy medication card of hydrocodone-acetaminophen 5 mg-325 mg with a quantity of 60 tablets remaining;-Resident #23 had one pharmacy medication card of hydrocodone-acetaminophen 7.5 mg-325 mg with a quantity of 60 tablets remaining;-Resident #16 had one pharmacy medication card of hydrocodone-acetaminophen 5 mg-325 mg with a quantity of 60 tablets remaining;-Resident #13 had one pharmacy medication card of tramadol 50 mg with a quantity of 60 tablets remaining;-Resident #9 had two pharmacy medication cards with hydrocodone-acetaminophen 7.5 mg-325 mg with 60 tablets per card (for a total of 120 tablets);-Resident #25 had three pharmacy medication cards of oxycodone 5 mg 1/2 tablets with 30 tablets per card (for a total of 90 tablets remaining);-Resident #5 had four pharmacy medication cards of hydrocodone-acetaminophen 5 mg-325 mg with a quantity of 60 tablets remaining in each card and one card of hydrocodone-acetaminophen 5 mg-325 mg with 30 tablets remaining (for a total of 270 tablets remaining);-No documentation of shift counts and/or reconciliations of the narcotic medications in the lock box. During an interview on 01/14/26 at 1:05 P.M., Licensed Practical Nurse (LPN) D said the following:-The top shelf of the<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | locked medication cabinet contained current narcotic medications, and the bottom shelf contained narcotic medications to be destroyed;-He/She had not received training regarding counting the narcotic medications in the medication room lock box;-Staff do not count the narcotic medications in the lock box in the medication room. During an interview on 01/14/26 at 4:22 P.M., Registered Nurse (RN) F said the following:-Staff do not count/reconcile the narcotics in the lock box in the medication room as they are overflow;-Sometimes the pharmacy sends multiple cards of the same narcotic medication and only one card is placed in the medication cart. The other cards are placed in the locked cabinet in the medication room. During an interview on 01/14/26 at 4:54 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Care Plan Coordinator said staff don't count the narcotic medications until they are put into the medication carts/medication pass. During an interview on 01/21/26 at 8:57 A.M., the Director of Nurses (DON) said the following:-She was aware there were narcotics in the medication room lock box;-Staff have never counted/reconciled the narcotics in the medication room lock box. During an interview on 01/20/26 at 10:48 A.M., Pharmacy Staff G said the following:-Pharmacy staff visit the facility every three months and check the medication carts;-Narcotic medications should be checked and reconciled per facility policy. During an interview on 01/14/26 at 3:51 P.M., the Administrator said the following:-The DON should monitor the medication room, medication carts and narcotic lock box;-In addition to the narcotics in the medication carts, staff should be counting narcotic medications in the lock box in the medication room at shift change. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview and record review, the facility failed to destroy two schedule II narcotic controlled substance medications (substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence) and one schedule IV narcotic controlled substance medication (medications with a lower potential for abuse) for one resident (Resident #4) in a sample of 13 residents. The facility census was 45. Review of the facility policy, Discarding and Destroying Medications, last revised November 2022, showed the following:-Medications that cannot be returned to the dispensing pharmacy (non-unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) are disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances;-All unused controlled substances are retained in a securely locked area with restricted access until disposed of;-Schedule II, III and IV (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications;-For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the Environmental Protection Agency (EPA) recommends destruction and disposal of the substance with other solid waste following these steps (take the medication out of the original containers, mix medication, either liquid or solid with an undesirable substance, (such as sand, coffee grounds, kitty litter, or other absorbent materials), place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. Completed medication disposition records are kept on file in the facility for at least two years or as mandated by state law governing the retention and storage of such records. 1. Review of Resident #4's face sheet showed the resident's diagnoses included unspecified pain, other unspecified anxiety, and pressure ulcer of sacral region (the area at the base of the spine, where the sacrum bone is located).Review of the resident's quarterly Minimum Data Sheet (MDS), a federally mandated assessment instrument completed by facility staff, completed 07/03/25, showed the following:-The resident is taking an anti-anxiety medication;-The resident is taking an opioid medication.Review of the resident's September 2025 physician's orders showed there was no current orders for hydrocodone (schedule II narcotic controlled substance for pain), morphine sulfate (schedule II narcotic controlled substance for pain) or lorazepam (schedule IV narcotic controlled substance for anxiety). Review of the resident's discontinued physician's orders showed the following:-Lorazepam was discontinued on 04/09/25;-Morphine sulfate was discontinued on 03/11/25;-Hydrocodone was discontinued on 03/10/25. Observation on 09/25/25 at 9:17 A.M., of the 300 hall medication cart lock box, showed the following:-Resident #4 had a pharmacy medication card of hydrocodone 5/325 milligrams (mg) with a quantity of 13 tablets remaining (200 days after the order had been discontinued);-Resident #4 had an unopened bottle of liquid morphine sulfate 100 mg/5 milliliter (ml) oral suspension with a quantity of 30 ml remaining (199 days after the order had been discontinued);-Resident #4 had an unopened bottle of liquid lorazepam (schedule IV narcotic controlled substance for anxiety) 2 mg/ml oral suspension with a quantity of 30 ml remaining (170 days after the order had been discontinued);(staff had not removed the resident's medications from the active medication cart and destroyed or returned the medications after the orders were discontinued per facility policy) During an interview on 09/25/25 at 2:35 P.M., Licensed Practical Nurse (LPN) A said the following:-If a medication has been discontinued, it is the responsibility of the nurse who took that order to remove the medication from the medication cart;-Discontinued medication is removed from the medication cart and put in the medication storage room;-If the discontinued medication is a controlled substance, then two nurses (usually the Director of Nursing (DON) and another nurse will use drug buster (system that dissolves unused or expired medications<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | on contact turning them into a non-toxic slurry that can then be disposed of in the regular trash) to destroy the medications and log it on a medication destruction log; -He/She was unsure why the medications had not been destroyed yet. During an interview on 09/25/25 at 5:15 P.M., the DON said the following:-Discontinued medications should be removed from the medication cart as soon as possible after receiving the discontinue order and placed in the medication room for pharmacy to pick up;-Narcotics are disposed of by two nurses and using the drug buster as soon as possible after receiving the discontinue order. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure staff prepared all food items and served the correct portion size of food items to residents with a physician's order for a pureed diet and mechanical soft diet. The facility census was 45.Review of the undated facility policy, Food Preparation and Service, showed the following:-Menus will be the basis for all food preparation;-Standardized recipes, adjusted to the proper yield for the facility, will be available and used in food preparation;-The food service director will oversee food preparation and service;-Portion control will be achieved through portions being indicated on regular and therapeutic diet menus, and availability of portion control tools including scoops, ladles, portion scales, pans appropriate for the recipes being prepared. 1. Review of the undated Resident Diet Orders showed four residents had a physician's order for a pureed diet. Review of the Diet Spreadsheet for lunch on 9/22/25 showed residents on a pureed diet were to receive the following items:-Pureed hamburger or cheeseburger on bun (#6 dip or 6-ounce serving);-Pureed breaded cauliflower (#12 scoop);-Pureed soft cooked vegetables (#12 dip or 3-ounce serving);-Applesauce (#8 dip or 4-ounce serving). Observation on 9/22/25 between 11:21 AM. to 12:32 P.M. during the lunch meal service, showed Dietary Staff V served the lunch meal. Dietary Staff V served a #16 scoop (2.25-ounces) of pureed hamburger instead of a #6 scoop (6-ounce serving). Staff did not puree the bun with the pureed hamburger as directed on the spreadsheet menu and did not prepare or serve pureed bread. Staff did not prepare or serve pureed soft cooked vegetables as directed by the spreadsheet. Staff also prepared and served pureed peaches instead of applesauce as directed by the spreadsheet. During an interview on 9/22/25 at 12:11 P.M., Dietary Staff V said the pureed hamburger was not prepared with a bun in the mixture. 2. Review of the undated Residents Diet Orders showed nine residents had a physician's order for a mechanical soft diet. Review of the Diet Spreadsheet for lunch on 9/22/25 showed residents on a pureed diet were to receive the following items:-Ground hamburger or cheeseburger on bun (#8 dip or 4-ounce serving);-Soft chopped cooked vegetables (4-ounce serving);-Chopped apple slices (1/2 cup or 4-ounce serving). Review of the recipe for Ground Hamburger or Cheeseburger showed to place #8 (4-ounce) dipper of ground beef on bottom half of bun. Add condiment of choice. Top with cheese (if serving a cheeseburger). Top with other half of prepared bun. Observation on 9/22/25 between 11:21 AM. to 12:32 P.M. during the lunch meal service, showed Dietary Staff V served residents with a physician's order for a mechanical soft diet a #12 (3-ounce serving) of ground hamburger instead of a 4-ounce serving and did not serve the ground hamburger with a bun as directed by the spreadsheet. Staff failed to prepare and serve a soft chopped cooked vegetable (should have been carrots according to the recipe) and served cold stewed tomatoes instead. Staff also failed to prepare and serve chopped apple slices and served chopped peaches instead. 3. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said the following:-Staff should follow the spreadsheet menu, meal tickets, and recipe books;-The cook was to prepare and serve the correct food items;-Staff was responsible for looking at the spreadsheet and selecting the correct serving utensil;-She overlooked that apples and applesauce were on the menu and told staff to prepare peaches. The kitchen had canned apples in stock;-She was not aware that the bun was not blended with the pureed hamburger or that staff did not serve the bun with the mechanical soft meat;-She overlooked that a second soft-cooked vegetable should have been prepared (carrots according to the recipe book) for residents on a pureed and mechanical soft diet. |

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| | 265360 | A. Building<br>B. Wing | 11/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lewis County Nursing Home District | 17528 State Highway 81<br>Canton, MO 63435 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, interview, and record review, the facility failed to prepare and serve food at a safe and appetizing temperature and failed to prepare food items according to the recipe for residents with a physician-ordered pureed diet, mechanical soft diet, and regular diet. The facility census was 45. Review of the undated facility policy, Food Preparation and Service, showed food will be served at acceptable temperatures. 1. During an interview on 09/24/25 at 1:30 P.M., Resident #45 said the following:-Most of the time the food was not good;-The food was either over cooked or under cooked or cold. During an interview on 09/24/25 at 1:30 P.M., Resident #25 said warm food was not served warm and cold food was not served cold, even when staff served the residents in the dining room. During an interview on 09/22/25 at 11:15 A.M., Resident #38 said the following:-The food was not good;-He/She usually refused what was served and ate his/her own food;-Most of the food was frozen processed food and did not taste good. During an interview on 09/22/25 at 2:46 P.M., Resident #22 said the following:-He/She ate in the main dining room;-The hot food was cold, and the cold food was hot. During an interview on 09/22/25 at 2:38 P.M., Resident #32 said the following:-The facility food didn't taste good;-He/She often ate his/her own food. During an interview on 09/23/25 at 8:18 A.M., Resident #2 said the following:-The food didn't taste good;-He/She often ate beef broth he/she purchased instead of the facility food;-The food was not seasoned well. 2. Review of the Diet Spreadsheet for lunch on 9/22/25 showed residents with a physician-ordered pureed diet were to receive the following:-Pureed hamburger or cheeseburger on bun;-Pureed breaded cauliflower. Observation on 9/22/25 at 12:39 P.M. of the sample test tray showed the following:-The temperature of the pureed hamburger was 116.4 degrees Fahrenheit (F); -The temperature of the pureed cauliflower was 111.7 degrees F. 3. Review of the Diet Spreadsheet for lunch on 9/22/25 showed residents with a physician-ordered mechanical soft diet were to receive the following:-Ground hamburger or cheeseburger on a bun;-Soft chopped parslied cauliflower. Observation on 9/22/25 at 12:39 P.M. of the sample test tray showed the following:-The temperature of the mechanical soft hamburger was 116.2 degrees F;-The temperature of the mechanical soft cauliflower was 106.3 degrees F. 4. Review of the Diet Spreadsheet for lunch on 9/22/25 showed residents with a physician-ordered regular diet were to receive the following:-Hamburger or cheeseburger on a bun;-Fried breaded cauliflower;-Fresh grapes. Observation on 9/22/25 at 12:39 P.M. of the sample test tray showed the following:-The temperature of the hamburger was 114.6 degrees F;-The temperature of the fried breaded cauliflower was 100.9 degrees F-The fresh grapes were discolored brown and mushy. 5. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said the following:-The temperature of hot food items when served to a resident should be 165 degrees F;-Staff cut up the grapes just prior to the meal. She was unsure why they turned brown. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>Based on observation, interview, and record review, the facility failed ensure residents on a pureed diet and residents on a mechanical soft diet received food in the proper form in accordance with his/her physician's orders. The facility census was 45.1. Review of the facility's undated Resident Diet Orders showed four residents had a physician-ordered pureed diet. Review of the Diet Spreadsheet for the lunch meal on 9/22/25 showed residents on a pureed diet were to receive pureed hamburger or cheeseburger on bun and pureed breaded cauliflower. Review of the recipe for Pureed Breaded Cauliflower showed to place the prepared breaded vegetables in a food processor with chicken broth. Blend until smooth. Review of the recipe for Pureed Hamburger or Cheeseburger on Bun showed to place prepared sandwiches and beef broth in a food processor. Blend until smooth. Observation and interview on 9/22/25 at 10:44 A.M. showed Dietary Staff V placed an unmeasured amount of cooked cauliflower and water (not chicken broth) in the food processor and pureed the mixture. The mixture was very thin and watery with visible chunks of cauliflower. During an interview on 9/22/25 at 10:44 A.M., Dietary Staff V said the pureed mixture should be thin and smooth. Observation on 9/22/25 between 11:21 A.M. and 12:32 P.M. during the lunch meal service showed Dietary Staff V served watery and chunky pureed cauliflower. Observation on 9/22/25 at 12:39 P.M. of the pureed diet test tray items showed the following:-The pureed hamburger was chunky and was not smooth;-The pureed cauliflower was thin and watery with chunks of cauliflower and was not smooth. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said staff should follow the spreadsheet menus and the recipe book when preparing food items. A pureed item should be smooth and baby food consistency. 2. Review of the facility's undated Resident Diet Orders showed nine residents had a physician-ordered mechanical soft diet. Review of the Diet Spreadsheet for the lunch meal on 9/22/25 showed residents on a mechanical soft diet were to receive soft chopped cauliflower. Review of the recipe for Soft Chopped Cauliflower showed to cook until fork tender and desired internal temperature is reached. Drain cauliflower and chop into bite-sized pieces. Observation on 9/22/25 between 11:21 A.M. and 12:32 P.M. during the lunch meal service showed Dietary Staff V served large chunks of cauliflower to the residents on a mechanical soft diet. The cauliflower was not soft and was not chopped into bite-sized pieces (as instructed in the recipe). Observation on 9/22/25 at 12:39 P.M. of the mechanical soft diet test tray showed the mechanical soft cauliflower was not soft and was not chopped. During an interview on 9/23/25 at 11:34 A.M., the Dietary Manager said mechanical soft items should be soft and chopped. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three Certified Nurse Aides (CNAs) in a review of three CNAs reviewed, received the required 12 hours of in-service education annually. The facility census was 45. Review of the Facility assessment dated [DATE] showed staff training/education and competencies included monthly in-services on topics of need and mandatory training as needed. 1. Review of the undated list of mandatory in-services offered to staff, dated 2025 showed the following:(9:30 A.M. and 2:00 P.M. unless otherwise posted);ALL MUST ATTEND;-01/16/25-Survey Readiness, Importance of Charting;-02/20/25-Quality of Life/Care;-03/20/25-Resident Rights/Customer Service;-04/10/25-Abuse/Neglect/Misappropriation of belongings;-05/15/25-Corporate Compliance;-06/19/25-OSHA/Slips, trips and falls; Proper Body Mechanics of Lifting;-07/18/25-Infection Control/COVID-19;-8/21/25-Disaster Preparedness/Drills;-9/18/25-Active Shooter/Elopement Drill;-10/09/25-Fire Drill and Fireman Consult;-11/20/25-Insurance Sign up;-12/12/25-2% Cafeteria Plan Sign Up. 1. Review of a list of employees hired since 11/22/2023 showed the following:-CNA H's date of hire was 01/28/24;-CNA L's date of hire was 02/13/24;-CNA S's date of hire was 01/28/24. Review of CNA H's Employee Inservice History dated 02/13/24 through 09/24/25 showed he/she attended seven in-service hours. Review of CNA L's Employee Inservice History dated 02/13/24 through 09/24/25 showed he/she attended four in-service hours. Review of CNA S' Employee Inservice History dated 01/28/24 through 09/24/25 showed he/she attended two in-service hours. During an interview on 09/25/25 at 3:25 P.M., the Director of Nursing and Administrator said the following:-The CNAs are offered at least 12 hours of in-service education annually;-The CNAs are responsible for ensuring their required in-service hours are completed as their annual raise is based on completion; (no one at the facility was tracking the in-service hours for regulatory compliance);-The facility also has recorded in-service education that was available for staff to view by appointment. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview and record review, the facility failed to ensure staff followed professional standards of practice when staff failed to follow treatment orders for one resident, (Resident #2), in a review of 13 sampled residents. The facility census was 45. Review of the facility policy, Dressings, Dry/Clean, revised September 2013, showed the following:-Verify that there is a physician's order for this procedure;-Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs;-Check the treatment record. 1. Review of Resident #2's Face Sheet showed the resident had diagnoses of spina bifida (a congenital condition in which part of the spinal cord and its meninges (three membranes layers that cover and protect your brain and spinal cord) are exposed through a gap in the backbone, often causing paralysis of the lower limbs), diabetes, reduced mobility, obesity and muscle weakness. Review of the resident's five-day Prospective Payment System (PPS) Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 06/23/25, showed the following:-Cognitively intact;-Indwelling catheter;-Applications of ointments/medications other than to feet.Review of the resident's Physician's Orders, dated September 2025, showed to change nephrostomy dressing site daily. May change more often if soiled. Cleanse with normal saline (sterile solution of 0.9 percent (%) sodium chloride used to painlessly cleanse and irrigate wounds). Apply Skin Prep (disposable, pre-moistened wipes used to prepare the skin for the application of adhesives) around tube and then drain sponge, border gauze (09/09/25).Review of the resident's Care Plan, revised 09/09/25, showed the following:-The resident has a urostomy (surgical procedure that creates an opening (stoma) in the abdomen to divert urine from the bladder to an external bag or pouch) and nephrostomy tube (a thin, flexible tube inserted into the kidney to drain urine directly into a collection bag);-If either becomes dislodged please let the nurse know immediately. Observation on 09/23/25 at 2:00 P.M., in the resident's room, showed the following:-The resident lay awake in bed;-Registered Nurse (RN) P applied a gown and gloves;-With gloved hands, RN P removed the dressing from the resident's nephrostomy site;-RN P removed his/her gloves, used alcohol based hand rub (ABHR) and applied clean gloves;-RN P covered the resident's nephrostomy site with a dry dressing and secured it with tape;-RN P did not apply Skin Prep around the resident's nephrostomy site. Observation on 09/25/25 at 9:45 A.M., in the resident's room, showed the following:-The resident lay on his/her left side in bed;-With gloved hands, Licensed Practical Nurse (LPN) A picked up the resident's nephrostomy tubing and removed the dressing from the nephrostomy site;-LPN A disposed of the dressing, did not clean the nephrostomy site and placed Vaseline gauze (sterile, non-adherent dressing made of fine-mesh gauze impregnated with white petrolatum) around the nephrostomy site and under the tubing, covered the area with a gauze sponge and secured the dressing with tape. During an interview on 09/25/25 at 12:15 P.M., Licensed Practical Nurse (LPN) A said the following:-He/She was not aware the order for the resident's nephrostomy site was to clean the area with normal saline;-He/She has been using Vaseline gauze and a dry dressing on the nephrostomy site for several weeks;-He/She was not aware of an order for Skin Prep around the nephrostomy site;-He/She did not know if the resident had an order for Vaseline gauze;-He/She has been using Vaseline gauze to keep the nephrostomy tube from sticking to the resident's stitches. During an interview on 09/25/25 at 4:05 P.M., RN P said the following:-The order for the nephrostomy site was to monitor for signs and symptoms of infection and cover daily;-He/She was not aware of the order to cleanse the nephrostomy site with normal saline and apply Skin Prep.During an interview on 09/25/25 and 11:00 A.M. and at 5:15 P.M., the Director of Nurses (DON) said the following:-Staff have access to normal saline and Skin Prep and should follow treatment orders as written including cleansing the wound and treatment.During an interview on 10/03/25 at 11:21 A.M., the resident's physician said she would expect staff to follow physician's orders. The resident's nephrostomy site should be cleansed with normal saline and covered with a dry dressing as ordered. She expected staff to notify her if they want a different treatment order. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services consistent with standards of practice, when the facility failed to ensure staff cleaned one resident's (Resident #2's) pressure ulcer (an injury to skin and underlying tissue resulting from prolonged pressure on the skin, most often on bony areas of the body) according to physician's orders, failed to complete weekly skin assessments to include measurements, appearance, and any other wound characteristics, and failed to notify the physician of a change in the wound as directed by the facility policy. Facility staff also failed to turn and reposition one resident (Resident #4), who had a pressure ulcer. The facility census was 45. Review of the facility policy, Dressings, Dry/Clean, revised September 2013, showed the following:1. Verify that there is a physician's order for this procedure;2. Review the resident's care plan, current orders and diagnoses to determine if there are special resident needs;3. Check the treatment record. Review of the facility policy, Pressure Ulcers/Skin Breakdown, revised April 2018, showed the following:Assessment and Recognition:1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss and a history of pressure ulcer(s);2. In addition, the nurse shall describe and document/report the following:a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue;b. Pain assessment;c. Resident's mobility status;d. Current treatments, including support surfaces;e. All active diagnoses;Treatment and Management:1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. Review of the facility policy, Prevention of Pressure Injuries, revised April 2020 showed the following:-Reposition all residents, with or at risk of pressure injuries, on an individualized schedule, as determined by the interdisciplinary care team;-Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines;-Teach residents, who can change positions independently, the importance of repositioning;-Provide support devices and assistance as needed;Skin Assessment:1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge;2. During the skin assessment, inspect:a. Presence of erythema (redness of the skin);b. Temperature of skin and soft tissue;c. Edema (swelling);Skin Care:6. Do not rub or otherwise cause friction on skin that is at risk for pressure injuries;Monitoring:3. Skin assessments will be completed weekly by licensed nurses. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Chapter 3, Section M, defines the different stages of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) as follows:-Stage 1: an observable, pressure related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in skin temperature, tissue consistency, sensation, and/or a defined area of persistent redness;-Stage 2: Partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue). May also present as an intact or open/ruptured blister;-Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling;-Unstageable, (known but unstageable due to coverage of the wound bed by slough (necrotic/avascular tissue in the process of separating from the viable portion of the body, usually light colored, soft, moist and stringy). 1. Review of Resident #2's Face Sheet showed the following:-The resident was admitted to the facility on [DATE];-The resident had diagnoses of spina bifida ((a congenital (present from birth) condition in which part of the spinal cord and its meninges<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (three membrane layers that cover and protect your brain and spinal cord) are exposed through a gap in the backbone, often causing paralysis (loss of muscle function, resulting in an inability to move or feel certain parts of the body) of the lower limbs)), diabetes, reduced mobility, obesity and muscle weakness. Review of the resident's Physician's Orders, dated June 2025, showed the following:-Cleanse sacral (triangular-shaped bone located at the base of the spine (tailbone)) ulcer with Normal Saline (sterile solution of 0.9 percent (%) sodium chloride used to painlessly cleanse and irrigate wounds) and pat dry. Apply Maxorb AG (silver-infused calcium alginate dressing that helps manage bacteria in wounds and provides continuous antimicrobial protection) and cover with dry dressing. Change daily until healed (05/28/25). Review of the resident's Progress Notes, dated 06/04/25 at 1:59 P.M., showed the following:-Resident does have a large wound on coccyx area. It is red with some white skin and a darker red dot in the middle;-Treatment was applied per order. Review of the resident's Physician's Orders, dated 06/17/25, showed an order to measure wounds on Tuesday. Review of the resident's Progress Notes, dated 06/17/25 at 2:03 P.M., showed the following:-Treatment done to coccyx;-No active drainage or signs or symptoms of infection;-Stage II wound measures seven centimeters (cm) long by 3.5 cm wide. Review of the resident's five-day PPS Minimum Data Set, (MDS, a federally mandated assessment instrument completed by facility staff) dated 06/23/25, showed the following:-Cognitively intact;-Lower extremity impairment in range of motion on both sides;-Dependent on staff for toileting hygiene;-Required substantial/maximal assistance to roll left and right;-Indwelling catheter (flexible tube placed in the bladder to drain urine);-Always continent of bowel;-Has a Stage I or greater pressure ulcer;-Two Stage II pressure ulcers-present on admission/re-entry;-Pressure reducing device for bed;-Turning/repositioning program;-Pressure ulcer care;-Applications of ointments/medications other than to feet. Review of the resident's Weekly Wound Assessment, dated 06/24/25, showed the following:-Description: Right coccyx;-Size: 4 cm by 1 cm 3 cm by 1 cm;-No documentation of wound characteristics;-Treatment: Cleanse sacral ulcer with Normal Saline. Apply Maxorb AG. Cover with dressing;-Results: blank. Review of the resident's Physician's Orders, dated July 2025, showed the following:-Measure wounds on Tuesday;-Cleanse sacral ulcer with Normal Saline and pat dry;-Apply Maxorb AG and cover with dry dressing;-Change daily until healed. Review of the resident's Weekly Wound Assessment, dated 07/01/25, showed no documentation staff completed a weekly wound assessment. Review of the resident's treatment administration record (TAR), dated 07/01/25, showed staff documented: forgot to measure wounds. Review of the resident's Progress Notes, showed staff documented the following:-07/02/25 at 3:02 P.M., treatment to bottom was done per order; wound looks bigger but is still shallow;-07/03/25 at 4:03 P.M., treatment to bottom was done per order; wound looks bigger but is still shallow, deep red on the inside of wound, white new skin surrounding;-07/05/25 at 2:03 P.M., treatment done to Stage II pressure ulcer on sacral area; no active drainage or signs/symptoms of infection. Review of the resident's Weekly Wound Assessment, dated 07/08/25, showed the following:-Description: Right coccyx;-Size: 6.8 cm by 2.2 cm. (worsening from the 06/24/25 assessment); No documentation of wound depth or characteristics; -Treatment: Cleanse with Normal Saline. Apply Maxorb AG. Cover;-Results: Longer but not as wide. Review of the resident's medical record, dated 07/08/25, showed no documentation the facility notified the physician of the change (worsening) in the resident's wound as the facility policy directed. Review of the resident's Weekly Wound Assessment, dated 07/15/25, showed the following:-Description: Right coccyx;-Size: 7.0 cm by 3 cm. (worsening from the 07/08/25 assessment); No documentation of wound depth or characteristics;-Treatment: Cleanse with Normal Saline. Apply Maxorb AG. Cover;-Results: Same. (Measurements indicate the wound had increased in size since last measurements.) Review of the resident's medical record, dated 07/15/25, showed no documentation the facility notified the physician of the change (worsening) in the resident's wound as the facility policy directed. Review of the resident's Progress Notes, dated 07/15/25 at 2:56 P.M., showed the following:-Treatment done to sacral area;-No active drainage or signs/symptoms of infection noted;-Wound measures 7 cm long by<br>(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) |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3 cm wide;-Pink wound bed noted. Review of the resident's TAR, dated 07/22/25, showed staff documented the resident refused weekly wound measurements. The resident's medical record showed no documentation facility staff attempted to obtain the resident's weekly wound measurements at a later time. Review of the resident's Physician's Orders, dated August 2025, showed the following:-Measure wounds on Tuesday;-Cleanse sacral ulcer with Normal Saline and pat dry;-Apply Maxorb AG and cover with dry dressing;-Change daily until healed. Review of the resident's Progress Notes, dated 08/05/25 at 10:02 A.M., showed the following:-Resident has treatment to sacral area on back; -Open wound is measuring 6.5 cm by 2.5 cm;-Wound bed is pink and healthy, no drainage noticed;-Treatment completed as ordered. Review of the resident's Weekly Wound Assessment, dated 08/06/25, showed the following:-Description: Right coccyx;-Treatment: same;-Results: blank. Review of the resident's Weekly Wound Assessment, dated 08/12/25, showed the following:-Description: Right coccyx;-Size: 6 cm by 3.5 cm. (previous measurement on 07/15/25 was 7 cm by 3 cm); No documentation of wound depth or characteristics;-Treatment: No change;-Results: smaller. Review of the resident's medical record, dated 08/12/25, showed no documentation the facility notified the physician of the change (worsening) in the resident's wound as the facility policy directed. Review of the resident's Weekly Wound Assessment, dated 08/19/25. showed the following:-Description: Right coccyx;-Size:4 cm by 2 cm by 2 cm. No documentation of wound characteristics;-Treatment: No change;-Results: smaller. Review of the resident's Braden Scale (risk assessment scale to evaluate a resident's risk of developing pressure ulcers), dated 08/20/25, showed the following:-Braden Scale Score 17 points;-Interpretation of Score: 15-18 meant AT RISK. Review of the resident's Weekly Wound Assessment, dated 08/26/25, showed the following:-Description: coccyx;-Size: 5 cm by 3 cm. (worsening from the 08/19/25 assessment); No documentation of wound depth;-Treatment: Cleanse with Normal Saline. Apply Maxorb AG. Cover;-Results: No change. Review of the resident's medical record, dated 08/26/25, showed no documentation the facility notified the physician of the change (worsening) in the resident's wound as the facility policy directed. Review of the resident's Care Plan, dated 08/27/25, showed the following:-The resident has pain related to osteoarthritis and pressure ulcers on his/her buttocks and a diagnosis of spina bifida;-The resident is at risk of and has pressure ulcers related to diagnosis of spina bifida, muscle weakness and inability to reposition him/herself in the wheelchair;-The resident is encouraged to turn side to side to stay off his/her buttock;-Complete treatments as ordered and apply barrier creams as needed and please report changes to nurse for assessment;-Charge nurse will measure weekly and report any changes to physician and family. Review of the resident's Physician's Orders, dated September 2025, showed the following:-Measure wounds on Tuesday. Special instructions: Chart size and characteristics of wound to coccyx (09/09/25);-Cleanse sacral ulcer with saline and pat dry. Apply Maxorb AG and cover with dry dressing;Change daily until healed. (09/09/25). Review of the resident's Weekly Wound Assessment, dated 09/02/25, showed the following:-Description: coccyx right;-Size: 5 cm long by 3 cm wide. No measurement of depth. No documentation of wound characteristics;-Treatment: Clean with Normal Saline. Apply Maxorb AG;-Results: No change. Review of the resident's Weekly Wound Assessment, dated 09/09/25, showed no documentation of weekly wound measurements. Review of the resident's Progress Notes showed staff documented the following:-09/16/25 at 2:15 P.M. treatment on sacral wound continues; sacral wound measures 8 cm x 3 cm x 2.8 cm deep (worsening from the 09/02/25 documented assessment); no drainage is seen at this time; treatment applied per order; No documentation facility staff notified the resident's physician regarding the worsening condition of the resident's pressure ulcer. Review of the resident's medical record, dated 09/16/25, showed no documentation the facility notified the physician of the change (worsening) in the resident's wound as the facility policy directed. Review of the resident's Weekly Wound Assessment, dated 09/23/25, showed the following:-Description: coccyx right;-Size: 5 cm long by 2 cm wide. No documentation of wound depth or characteristics;-Treatment: Clean with Normal Saline. Apply Maxorb AG;-Results: smaller.<br>(continued on next page) |

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| | 265360 | A. Building<br>B. Wing | 11/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lewis County Nursing Home District | 17528 State Highway 81<br>Canton, MO 63435 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 09/23/25 at 2:00 P.M., in the resident's room, showed the following:-The resident lay awake in bed;-Registered Nurse (RN) P used ABHR and applied a gown and gloves;-RN P removed the soiled dressing from the resident's coccyx wound;-The pressure ulcer had depth;-The wound bed was pale pink;-There was tan drainage on the dressing;-RN P removed his/her gloves, used ABHR and applied clean gloves;-RN P measured the pressure ulcer 5 cm long by 2 cm wide;-RN P said the wound had depth at approximately .25 cm;-With gloved hands, RN P picked up another wet washcloth with [NAME] Shampoo/Body Wash Summer Rain Scent on it and washed the open coccyx wound; -RN P did not cleanse the coccyx wound with Normal Saline as the order instructed;-RN P dried the open coccyx wound with a dry washcloth;-RN P cut the Maxorb AG dressing with scissors and laid the dressing on top of the dressing package;-RN P placed the Maxorb AG dressing into the wound bed, covered it with a dry gauze and secured the dressing with tape. Observation on 09/25/25 at 9:45 A.M., in the resident's room, showed the following:-The resident lay on his/her left side in bed;-The resident was incontinent of a medium amount of soft stool;-Without performing hand hygiene, Certified Nurse Aide (CNA) R and Licensed Practical Nurse (LPN) A applied gowns;-LPN A placed a handful of gloves in his/her scrub pocket;-LPN A applied gloves, pulled the keys out of his/her pocket, unlocked the treatment cart and got scissors out of the cart;-LPN A removed the soiled coccyx dressing, exposing the open coccyx wound;-There was a small amount of yellow/tan drainage on the dressing;-LPN A provided rectal pericare;-LPN A removed his/her gloves, and without washing his/her hands or using ABHR, LPN A pulled a pair of gloves out of his/her pocket and applied the gloves;-LPN A washed over the open wound with periwash (perineal wash that is ready to use and requires no water or rinsing) on a washcloth;-There was stool present on the washcloth;-The resident winced when LPN A wiped over the wound with the washcloth;-LPN A continued to provide rectal pericare;-LPN A removed his/her gloves, and without washing his/her hands or using ABHR, LPN A pulled a pair of gloves out of his/her pocket and applied the gloves;-LPN A dried the pressure ulcer with a dry towel;-The pressure ulcer had depth;-The wound bed was pale pink with scattered yellow slough;-LPN A applied the Maxorb AG dressing to the wound bed, covered the wound with a dry dressing and secured the dressing with tape;-LPN A did not cleanse the wound with Normal Saline as ordered. During an interview on 09/23/25 at 8:18 A.M., the resident said the following:-He/She has spina bifida and is paralyzed from the waist down;-He/She has a history of an infected pressure ulcer on his/her tailbone when he/she resided at home. The pressure ulcer took approximately six months to heal;-He/She did not have a pressure ulcer when he/she was admitted to the facility;-The skin on his/her tailbone was intact when he/she was admitted in January. During an interview on 09/25/25 at 12:15 P.M., LPN A said the following:-Weekly wound measurements and assessments should be completed on Tuesdays and documented in the wound book; -Sometimes he/she can't find the wound book and he/she documents the wound measurements and assessments in the progress notes;-Resident #2 has a Stage III pressure ulcer on his/her coccyx;-The resident's pressure ulcer does not have tunneling, but it does have depth;-The treatment order for the resident's pressure ulcer is to wash with Normal Saline. He/She didn't do that today, but he/she should have;-He/She washed the pressure ulcer with periwash and a washcloth today (09/25/25). During an interview on 09/25/25 at 4:05 P.M., RN P said the following:-The treatment to the resident's coccyx wound was to cleanse/wash the wound daily with soap and water or just water, dry, apply Maxorb AG to the wound bed and cover with gauze;-He/She doesn't recall seeing the order to cleanse the coccyx wound with Normal Saline;-The charge nurse on Tuesdays is responsible for completing and documenting weekly wound assessments and measurements;-The resident's coccyx wound had been improving but the last two wound measurements have been the same showing no improvement. During an interview on 09/25/25 and 11:00 A.M. and 5:15 P.M., the Director of Nurses (DON) said the following:-Staff have access to Normal Saline and should follow treatment orders as written including cleansing the wound and treatment;-The pressure ulcer won't improve if staff are not cleansing/cleaning the wound as ordered;-If staff want a different treatment order they need to contact the physician;-Staff should not<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | be cleansing a pressure ulcer with periwash or body wash;-Weekly wound measurements and assessments are the responsibility of the charge nurse as the facility does not have a wound nurse. These should be completed and documented weekly;-She doesn't know where the rest of Resident #2's weekly wound measurements are;-Resident #2's coccyx wound was completely healed/closed when the resident was admitted to the facility;-Resident #2's coccyx wound opened at the facility. During an interview on 10/03/25 at 11:21 A.M., the residents' physician said the following:-Staff should measure and assess pressure ulcers at least weekly and should document this in the resident's electronic health record (EHR);-It would not be appropriate for staff to cleanse Resident #2's pressure ulcer with body wash or periwash. The pressure ulcer should be cleansed with Normal Saline as ordered;-She would expect staff to notify her if they want a different treatment order;-She would expect staff to notify her if the pressure ulcer is not healing or worsening so she can change treatment orders. 2. Review of Resident #4's face sheet showed the resident's diagnoses included pressure ulcer of sacral (the area at the base of the spine, where the sacrum bone is located) region, unstageable, (known but unstageable due to coverage of the wound bed by slough (necrotic/avascular tissue in the process of separating from the viable portion of the body, usually light colored, soft, moist and stringy) and or eschar (thick leathery, frequently black or brown in color, necrotic tissue). Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined) type 2 diabetes mellitus, unspecified dementia, age related osteoporosis (bone disease characterized by a decrease in bone mineral density and structural changes that weaken the bones, making them more prone to fractures), pain unspecified and muscle weakness. Review of the resident's quarterly Minimum Data Sheet (MDS), a federally mandated assessment instrument completed by facility staff, completed 07/03/25, showed the following:-Severely impaired cognition;-Dependent on staff for turning, repositioning and transfers;-He/She had one stage II pressure ulcers and one stage III pressure ulcer;-At risk for developing pressure ulcers;-Turning/repositioning program. Review of the resident's care plan, dated 08/28/25, showed the following:-The resident has wounds to the coccyx (small triangular bone at the very bottom of the spine); -Monitor all areas daily, treatment to continue as ordered by physician/ nurse practitioner;-He/She required staff assist x two for transfers with gait belt and x one to be propelled in wheelchair;-No documentation to show the resident's positioning needs or an individualized schedule for repositioning per policy. Review of the resident's skin evaluation dated 09/22/25, showed the following: -He/She had a pressure ulcer on his/her coccyx measuring 10.5 centimeters (cm) in length X 5 cm wide;-He/She had pressure ulcer on his/her right gluteal fold (the horizontal crease where the upper thigh meets the buttocks) measuring 5.5 cm in length X 1.1 cm wide. Observation of wound care completed by Licensed Practical Nurse (LPN) F, on 09/23/25 at 10:20 A.M. showed the following:-The wound on the resident's right gluteal fold was covered in slough, with a small amount of serosanguinous (a fluid that contains both serum (clear watery fluid) and blood commonly found in wounds) drainage;-The wound on the coccyx had a dark area inside the wound, with red tissue and a small amount of serosanguinous drainage. Observations on 09/24/25 showed the following:-At 9:15 A.M., the resident lay in bed on his/her right side with his/her eyes closed; -No observation of staff providing care or repositioning the resident between 9:15 A.M. and 11:20 A.M.;-At 11:20 A.M., the resident continued to lay in bed on his/her right side with his/her eyes closed; -No observation of staff providing care or repositioning the resident between 11:20 A.M. and 12:10 P.M.;- At 12:10 P.M., LPN P and Certified Nursing Assistant (CNA) H in the resident's room to provide wound care; the resident was on his/her right side prior to care being provided; a small, reddened area was present on the bony area of the resident's right hip where he/she had been laying; the resident had laid in bed on his/her right side for at least two hours and fifty-five minutes before he/she was repositioned;-At 12:45 P.M., CNA H and CNA D finished peri care and transferred the resident to his/her Broda chair (a specialized chair that can tilt and provide pressure relief) and took him/her to the activity room for lunch; the resident was in the upright position;-No observation of<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | staff providing care or repositioning the resident between 12:45 P.M. and 2:10 P.M.;-At 2:10 P.M., the resident continued to set in his/her Broda chair, in the upright position, in the activity room at the table, with his/her lunch tray in front of him/her; no off-loading was present; the resident was attempting to feed him/herself;-No observation of staff providing care or repositioning the resident between 2:10 P.M. and 5:55 P.M.;-At 5:55 P.M., CNA K and CNA M moved the resident, who was in the upright position in his/her Broda chair (no offloading was present), from the commons area to his/her room and assisted the resident to bed (five hours and ten minutes from when he/she was assisted into the Broda chair). During an interview on 09/24/25 at 5:50 P.M. CNA L said the following:-He/She was responsible for the resident and his/her shift started at 2:00 P.M.;-The resident had been up since his/her shift began at 2:00 P.M. and he/she had not repositioned the resident since coming on shift;-It is usually around 7:00 P.M. when the resident lays down after supper and after he/she has had his/her medications;-The resident had a catheter and would not be incontinent of urine and does not usually have a bowel movement. During an interview on 09/24/25 at 5:55 P.M., CNA K said the following;-He/She works 4:30 P.M. - 10:00 P.M.; all CNAs on the 400 and 500 hall were responsible for this resident who resided on the 300 hall; he/she was the only dependent resident on the 300 hall;-He/She was unsure of how long it had been since the resident had been repositioned;-The resident was in his/her wheelchair in the commons room when he/she started his/her shift at 4:30 P.M.;-The resident should be repositioned every 2 hours;-He/She then had CNA M assist in laying the resident down in bed. Observations on 09/25/25 showed the following:-At 8:20 A.M., the resident lay in bed on his/her left side;-No observation of staff providing care or repositioning of the resident between 8:20 A.M. and 9:55 A.M.;-At 9:55 A.M., the resident continued to lay in bed, with the head of the bed elevated and on his/her left side; CNA O fed the resident his/her breakfast; -No observation of staff providing care or repositioning of the resident between 9:55 A.M. and 11:25 A.M.;-At 11:25 A.M., the resident continued to lay in bed on his/her left side with the head of bed elevated; the resident had laid in bed on his/her left side with the head of the bed elevated for at least three hours and five minutes. During an interview on 09/25/25 at 9:55 A.M., CNA O said the resident should be repositioned every 2 hours while in bed. During an interview on 09/25/25 at 4:25 P.M., CNA L said when the resident is up in the Broda chair, staff should alternate from sitting up to lying the Broda chair back. He/She does not put anything under the resident's hips/buttocks, only the chair cushion that is in the chair. During an interview on 10/01/25 at 9:45 A.M., CNA H said the following:-The resident should be repositioned every two hours;-The staff document repositioning on a paper log kept at the nurses station;-The resident is usually in his/her chair two to four hours, but gets checked every 2 hours;-The resident's chair will lay back for repositioning. Review of the (unnamed/untitled) paper log from the nurses station showed the following:-A list of resident names down the left side of the page to include Resident #4;-The top of the page had every hour time blocks;-A code at the bottom of the page indicated a C = changed, D = dry and a check mark = checked on;-There was no documentation of repositioning being provided on this form. During an interview on 09/25/25 and 11:00 A.M. and at 5:15 P.M., the Director of Nurses (DON) said the following:-Moving a resident from sitting up in a Broda chair to lying back in a Broda chair without offloading weight off the coccyx was not appropriate repositioning; -She would expect a resident that is up in a Broda chair to be repositioned every two hours either by laying down, removing pressure off the buttocks by propping the resident over on one side or the other every two hours. During an interview on 10/03/25 at 11:21 A.M. the residents' physician said she would expect staff to have Resident #4 on a turning and repositioning schedule for pressure relief. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>Based on interview and record review, the facility failed to ensure staff demonstrated the appropriate skills to effectively respond to one resident (Resident #17), who had a diagnosis of dementia, in a review of 13 sampled residents, when the resident became aggressive toward the staff. The facility failed to identify and implement approaches to address the resident's behaviors including agitation and striking out. When the resident was not redirectable, Nurse Assistant (NA) J restrained the resident by holding the resident's wrist to the resident's chest and wrapped his/her arms around the resident and sat him/her on the floor. The facility census was 45.1. Review of Resident #17's face sheet showed the resident had diagnoses of mild cognitive impairment and dementia. Review of the resident's Care Plan, dated 04/17/25, showed the resident had dementia and at times had delirium but was usually pleasantly confused. The resident was alert and oriented to his/her name only. He/She was usually able to make his/her needs and wants known. From time to time, he/she perceived a situation differently than it really was and needed staff to help maneuver the situation. Review of the resident's progress notes, dated 07/14/25 at 3:05 P.M., showed the Director of Nursing (DON) documented the resident was in another resident's room and staff (Nurse Assistant (NA) J) tried to get him/her to leave. The resident was agitated, kicking, hitting, calling names, had a pen in a napkin, and tried to stab staff. Staff (NA J) blocked the resident by grabbing the resident's wrist and holding it against the resident's chest. Staff pushed the panic button, and the DON entered the room and helped get the resident out of the other resident's room. The resident continued to yell, used profanity, and called the staff names. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 07/15/25, showed the following:-Severe cognitive impairment;-Short and long-term memory problem;-Decision making was moderately impaired;-Verbal behaviors directed towards others;-He/She was independent with all ambulation. Review of the resident's progress notes showed the following:-On 7/15/25 at 2:50 P.M., the DON documented the resident told the DON about bruises on the fourth and fifth knuckle on his/her right hand, stating that staff did it. The DON explained to the resident that he/she hit the staff, and staff grabbed his/her wrist and held it against his/her chest to prevent him/her from stabbing himself/herself or staff. The resident had an irregular shaped bruise on his/her right hand just below the fourth and fifth knuckle. The bruise was purple/black colored. There was no swelling or pain;-On 7/25/25 at 7:28 P.M., Licensed Practical Nurse (LPN) T documented the certified nurse assistant, and the resident fell in the hallway. Staff entered the Special Care Unit (SCU) and noted the resident on the floor sitting with his/her legs in front of him/her and his/her arms were by his/her sides. The staff said the resident was trying to get into another resident's room, and the CNA was attempting to redirect him/her out of the room and they both fell in the hallway. The resident refused to let the CNA help him/her. Another staff assisted the resident to stand. The resident continued to cuss at the staff. Review of the resident's Care plan, dated 7/30/25, showed the following:-The resident was alert to his/her name only;-He/She resided on the special care unit;-He/She may have trouble at times expressing his/her thoughts or feelings due to dementia;-He/She had dementia and at times delirium;-From time to time, he/she perceived a situation differently than what it really was and needed staff to help to maneuver through the situation; -At times, he/she was bossy with staff and residents;-He/She may need reminders of appropriate behavior; -He/She was easily irritated by these reminders and when he/she was told what to do.- The care plan provided no direction for staff how to effectively and therapeutically respond when the resident presented with behaviors The plan only described the resident. Review of the resident's progress notes, dated 08/18/25, showed staff said the resident hit him/her in the side of the face. The staff went to hold onto the resident to prevent him/her from hitting him/her again. The resident sat on the floor. During interviews on 09/22/25 at 11:10 A.M. and 4:35 P.M., the resident said the following:-NA J twisted his/her right arm a few<br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | months ago;-Another time (unable to say when), NA J shoved him/her to the floor During an interview on 09/24/25 at 11:35 A.M., NA J said the following:-A couple of months ago, the resident went in another resident's room;-He/She told the resident he/she could not be in the other resident's room;-The resident went in anyway. He/She followed the resident in the room and told him/her he/she needed to leave;-The resident started yelling at him/her and had something in his/her hand in a paper towel, swinging it;-He/She hit the panic button (a small electronic button that will send an alert sound through the overhead speakers and staff know to respond to the special care unit for assistance) crossed the resident's arms and held the resident's wrists up to his/her chest. He/She thought this was appropriate to keep them both safe. No one had trained him/her to do this. He/She did not think he/she twisted the resident's wrist; he/she just held it in place;-He/She thought the resident was going to hurt him/her or himself/herself with the ink pen hidden in the paper towel;-The second incident was more recent (8/18/25). The resident was trying to get out of the special care unit and set off the alarm;-He/She told the resident that he/she could not leave the unit;-He/She turned to shut off the door alarm;-The resident then swung at him/her, striking him/her in the back of the head and left ear;-He/She bear hugged the resident and sat him/her on the floor. He/She thought this was appropriate; no one had trained him/her to do this;-He/She called LPN B to come from the other nurses station for help;-When LPN B arrived, the resident started crying and said he/she hurt me;-He/She did not feel like he/she had been trained on how to care for residents with behaviors. During interviews on 09/23/25 at 8:45 P.M. and 10/8/25 at 7:05 P.M., LPN B said the following:-On 8/18/25, staff called him/her to the special care unit, where he/she found the resident sitting on the floor with his/her arms at his/her sides and his/her legs extended;-NA J told him/her the resident tried to get out the door. When NA J tried to redirect the resident, the resident hit NA J in the head with his/her fist. NA J went to hold onto the resident's wrists to prevent getting hit, and the resident sat on the floor;-The resident was upset and crying, but he/she did not recall the resident telling him/her that NA J hurt him/her;-He/She assessed the resident and did not identify any redness to the resident's skin and his/her range of motion was normal. The staff assisted the resident to stand and to walk to his/her room.-The resident got upset when anyone tried to redirect him/her or make him/her leave another resident's room and became aggressive;-He/She thought it was a normal response for NA J to hold the resident when trying to protect himself/herself from the resident hitting. During interviews on 09/24/25 at 5:00 P.M. and 5:15 P.M., 10/07/25 at 9:20 A.M., and 10/14/25 at 9:40 A.M., the Director of Nurses (DON) said the following:-Staff received dementia training on hire and yearly;-Staff had not received any training on how to safely take down a resident or how to handle residents with aggressive/violent behaviors. -On 7/14/25, NA J used his/her palms to press the resident's hands against his/her chest to prevent injury to himself/herself and the resident;-She felt this was an appropriate way to keep the resident and staff safe;-On 7/26/25, NA J notified her that the resident tried to get in another resident's room on 07/25/25. While NA J tried to redirect the resident, the resident kicked NA J and got his/her feet tangled up. The resident and NA J both fell to the floor;-LPN B notified her on 08/18/25 the resident tried to get out of the SCU and hit NA J in the head. While NA J tried to hold the resident to prevent getting hit, the resident sat on the floor; -She was unsure if NA J bear hugging the resident and sitting him/her down would be an appropriate response.During interviews on 09/22/25 at 4:50 P.M. and 10/07/25 at 9:15 A.M., the Administrator said the following:-NA J restrained the resident's hands on 7/14/25 when the resident tried to stab NA J; -She was on vacation and only heard about this incident so she could not say for sure if grabbing the resident's wrist was appropriate;-She did not feel like bear hugging the resident would be appropriate unless the resident was falling, and staff was trying to catch the resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265360 | A. Building<br>B. Wing | 11/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lewis County Nursing Home District | 17528 State Highway 81<br>Canton, MO 63435 |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on interview and record review, the facility failed to ensure the Quality Assurance (QA) committee meetings included the required members, including the Medical Director. The facility census was 45. During an interview on 09/25/25 at 5:40 P.M., the Administrator said the facility did not have a policy for Medical Director Responsibilities. Review of the facility Medical Director Agreement, dated 07/03/23, showed the following:-Medical Director Responsibilities included serving on facility committees, including QA and assist Administrator in implementing committee recommendations and plans of action;-Medical Director Services included QA committee;-Signed by the Medical Director on 07/17/23. Review of the undated, Policy and Procedure for the QA Committee, showed the following:-Monthly, on the third Wednesday of each month, a QA Meeting will be held at a designated location;-The Medical Director, all attending physicians, Nurse Practitioners and the Director of Nursing, Assistant Director of Nursing, Medical Records Director, Dietary Manager and Administrator will regularly attend;-The other department supervisors will attend as needed;-Minutes of the meetings will be kept by the Medical Records Director or her designee;-All of the internal working papers from each department will be reviewed and discussed;-Statements of conclusion and working plans will be recorded;-Each department supervisor will be responsible to implement the plan and report back to the committee the following month. 1.Review of the monthly QA Meeting Attendance Sheets, dated January 2025 through September 2025, showed the Medical Director attended one QA meeting on 02/11/25. (some were on the 3rd Wed of each month; a couple were scheduled on Tuesdays and one on a Thursday). During an interview on 10/03/25 at 11:21 A.M., the Medical Director said the following:-She consistently makes rounds in the facility the second and fourth Tuesdays of each month;-Facility staff are aware when she will be in the facility;-She is available for QA meetings when she makes rounds in the facility;-She had not been attending QA meetings; she was only available for QA on the 2nd and 4th Tue of each month;-Facility staff do not provide her with documentation of what was discussed at the QA meetings. During an interview on 09/25/25 at 3:25 P.M., the Administrator said the following:-The Medical Director has been employed by the facility since 2023;-The Medical Director makes rounds in the facility every other week;-The QA committee had changed the meeting date/time to accommodate the Medical Director's schedule;-The Medical Director was invited to the QA meetings;-The Medical Director had only attended one QA meeting;-The facility did not provide the Medical Director with a report of what was discussed at the QA meeting;-The facility had a Nurse Practitioner working alongside the Medical Director, but she did not attend the QA meetings. |

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on interview and record review, the facility failed to provide to the resident or the resident's representative, a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC, form CMS-10123) for two residents (Resident #38 and Resident #101), and failed to provide to the resident or the resident's representative a complete Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN, form CMS-10055) for two residents (Resident #1 and Resident #101), in a review of three discharged from service sampled residents, when the facility initiated discharge from Medicare Part A Services when benefit days were not exhausted. The facility census was 45. Review of the undated, untitled facility policy showed the following:-The facility will follow facility policy on Medicare ABN forms;-Residents using Medicare services will be given proper notice before Medicare services are discontinued;-Utilization Review Committee will review Medicare residents weekly to determine when services may be discontinued;-Case Manager or Medical Records clerk will be responsible for completing ABN forms;- Administrator will review all completed forms to ensure proper notification;- Quality Assurance (QA) Committee will review all completed ABN forms monthly. 1. Review of Resident #1's undated facility face sheet showed the following:-Medical diagnoses included repeated falls; -Had a Durable Power of Attorney for Healthcare (DPOA). Review of the undated SNF Beneficiary Protection Notification Review form (CMS-20052), completed by the facility for the resident, showed the resident's Medicare part A Skilled Services started on 07/25/25. Review of the undated SNF Notice of Medicare Non-Coverage form (CMS-10123 NOMNC), completed by the facility for the resident, showed the resident's Medicare coverage for part A skilled services would end on 08/20/25 and was signed by the resident's representative on 08/20/25. Review of the undated SNF Beneficiary Protection Notification Review form (CMS-20052), completed by the facility for the resident, showed the resident's last covered day of Part A Service was 08/21/25. Review of the facility provided, undated document, Beneficiary Notice, Residents discharged Within the Last Six Months, showed Resident #1 was discharged from Medicare Part A services on 08/21/25 and remained in the facility. Review of the resident's medical record showed the facility/provider did not issue an SNF ABN form (CMS-10055), to indicate what skilled services the resident would be discharged from, reason for services being terminated or the estimated cost to the resident should he/she choose to continue daily skilled care. 2. Review of Resident #38's undated facility face sheet showed the following: -Medical diagnoses included difficulty in walking, muscle weakness and spinal stenosis; -Resident was his/her own person. Review of an undated SNF ABN form (CMS-10055), completed by the facility for the resident, showed the following; -The resident's skilled benefits would end on 04/25/25;-The resident would have to pay out of pocket for his/her physical and occupational therapy due to the resident having plateaued in therapy; -The estimated cost of services if the resident chose to continue and pay out of pocket would be $40.00 per session;-The resident signed the form, but no date of the signature was indicated. Review of the facility provided, undated document, Beneficiary Notice, Residents discharged Within the Last Six Months, showed Resident #38 was discharged from Medicare Part A services on 04/26/25 and remained in the facility. Review of the resident's medical record showed no documentation staff provided the resident with a NOMNC form (CMS 10123). 3. Review of Resident #101's undated facility face sheet showed the following: -Medical diagnoses included a displaced intertrochanteric fracture of right femur (a fracture, or break, in the thighbone); -Had a DPOA for Healthcare. Review of the undated SNF Beneficiary Protection Notification Review form (CMS-20052), completed by the facility for the resident, showed a Medicare Part A Skilled Services Episode Start Date for the resident was 08/05/25. Review of the facility provided, undated document, Beneficiary Notice, Residents discharged Within the Last Six Months, showed the resident was discharged from Medicare Part A services on 08/30/25 and returned home. Review of the undated SNF Beneficiary Protection Notification Review form (CMS-20052), completed by the facility for the resident, showed the resident's last covered day of Part A Service was<br>(continued on next page) |

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 08/30/25. Review of the resident's medical record showed no documentation staff provided the resident with a NOMNC form (CMS-10123). Review of the resident's medical record showed no documentation staff provided the resident with a SNF ABN form (CMS-10055), to indicate what skilled services the resident would be discharged from, reason for services being terminated, and the estimated cost to the resident should he/she choose to continue daily skilled care. 4. During an interview on 09/25/25 at 03:30 P.M., the Business Office Manager (BOM) said the following: -The Social Service Director (SSD) was responsible for the completion of the SNF ABN and NOMNC forms, and was responsible to inform the resident/resident representative when residents' Medicare Part A services were ending; -She completed the form CMS 10123-NOMNC and CMS-20052 for Resident #1, and CMS-20052 for Resident #101, in the SSD's absence, but was not sure which forms were required; -She mentioned to the administrator after the state agency (SA) interview that she realized she had not completed both forms as required. During an interview on 09/25/25 at 04:00 P.M., the Administrator said the following: -The resident or resident representative should receive the written copy of both the SNF ABN and NOMNC when a resident discharges from Medicare A services;-She would expect the SNF ABN and NOMNC to be completed as directed. |