

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hunter Acres Caring Center		STREET ADDRESS, CITY, STATE, ZIP CODE 628 North West Street Sikeston, MO 63801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 87. The facility did not provide a policy on the environment. 1. Observation on 08/04/25 at 10:24 A.M., of room [ROOM NUMBER] showed: - The bathroom door with a smeared brown substance; - Dirt and debris on the floor. 2. Observation on 08/04/25 at 10:35 A.M., of room [ROOM NUMBER] showed: - A spider web in the window seal. 3. Observation on 08/05/25 at 2:55 P.M., of room [ROOM NUMBER] showed: - The bathroom flooring peeled and separated from the subfloor; - A black substance on the upper portion of all of the bathroom walls and with a musty smell. 4. Observations on 08/06/25 at 9:45 A.M., and 08/07/25 at 10:05 A.M., of room [ROOM NUMBER] showed: - A baseball-sized hole in the wooden bathroom door; - A spiderweb in the window seal. 5. Observation on 08/07/25 at 10:00 A.M., of room [ROOM NUMBER] showed: - Missing trim around the air conditioner; - Spiderwebs in the corner next to the air conditioner unit; - A strong smell of urine in the room; - Dirt and debris all over the floor; (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Paint peeled and chipped on the walls, the return vent covered in a gray/black substance, and a black substance on the top of the walls in the bathroom. 6. Observation on 08/07/25 at 10:15 A.M., of room [ROOM NUMBER] showed: - Paint and plaster peeled off the walls surrounding the toilet and the vent return covered in a gray/black substance in the bathroom. 7. Observation on 08/06/25 at 7:35 A.M of the 400 Hall Common Area showed: - Missing trim around the air conditioner; - Spiderwebs in the corner of room to the left of the T.V. During an interview on 08/07/25 at 12:45 P.M., the Maintenance Director said housekeeping staff had a daily checklist that told them what areas to clean. Staff turned the checklist into him/her at the end of the shift. Housekeeping staff did a deep clean every two weeks, which included dusting. He/She would not expect any spiderwebs to be in the facility. The floors were not able to be waxed due to the type of material of the flooring. He/She didn't know of any current issues. During an interview on 08/07/25 at 11:20 A.M., Housekeeping Staff L said there was a chart in the housekeeping closet that he/she went by to determine what to clean for the day. There was only housekeeping staff scheduled on the day shift. During an interview on 08/07/25 at 2:50 P.M., the Administrator said she would expect all residents to have a clean and homelike environment.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the insect population in the facility. The facility census was 86. Review of the facility's policy titled, Pest Control, dated May 2008, showed:- This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents;- Maintenance services assist, when appropriate and necessary, in providing pest control services. Review of the facility's Pest Control Invoices for May - August 2025 showed:- May 2025, June 2025, July 2025, and August 2025 service targeted the German roach and the house mouse;- No services targeted flies. Observations of the 200 Hall dining room showed:- On 08/04/25 at 12:20 P.M., and 08/05/25 at 12:20 P.M., an insect light trap on the wall of the dining room was plugged in but not turned on;- On 08/04/25 at 12:23 P.M., Resident #12 ate his/her food while two flies crawled on his/her dining table;- On 08/04/25 at 12:25 P.M., Resident #32 ate his/her food while three flies crawled on his/her dining table;- On 08/05/25 at 12:21 P.M., Resident #32 ate his/her food while four flies crawled on his/her dining table;- On 08/05/25 at 12:36 P.M., Certified Nurse Aide (CNA) E said the flies were bad today;- On 08/05/25 at 12:38 P.M., Resident #84 ate his/her food while flies buzzed around, and one fly crawled on his/her food on the plate;- On 08/06/25 at 8:21 A.M., Resident #32 ate his/her food while two flies crawled on his/her dining table;- On 08/07/25 at 1:37 P.M., CNA F swatted a fly with his/her hand as it flew around his/her face. During an interview on 08/07/25 at 1:45 P.M., CNA E said that flies were sometimes a problem this time of year and that staff used a fly swatter to keep them down. He/She did not know why the light trap was not turned on. During an interview on 08/07/25 at 12:00 P.M., the Director of Nursing (DON) said she expects the facility to be free of pests, including flies, and that the facility had contracted with a different pest control company this month. During an interview on 08/07/25 at 3:15 P.M., the Administrator said she would expect the facility to be free of pests, including flies.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the correct code status for one resident (Resident #2) out of 19 sampled residents and failed to address and receive an order for a code status for one resident (Resident #86) outside the sample. The facility census was 87. Review of the facility's policy titled, Advanced Directives, dated [DATE], showed:- Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or legal representative, about the existence of any written advance directives;- The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he/she chooses to do so;- Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative;- If the resident or representative indicates that he/she has not established advance directives, the facility staff will offer assistance in establishing advance directives;- Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff;- The Director of Nursing (DON) services or designee notifies the attending physician of the advance directives so that appropriate orders can be documented in the resident's medical record and plan of care;- The interdisciplinary team will review annually with the resident his/her advance directives to ensure that such directives are still the wishes of the resident during the annual assessment process and record in the medical record. - Changes or revocations of a directive must be submitted in writing to the administrator;- The administrator may require new documents if changes are extensive;- The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident's medical record and care plan.1. Review of Resident #2's medical record showed:- An admission date of [DATE];- An order for Full Code (in the event of a cardiac or respiratory arrest, a patient's healthcare team will perform all possible life-sustaining measures), dated [DATE], and discontinued on [DATE];- An order for Do Not Resuscitate (DNR - instructs healthcare professionals not to perform cardiopulmonary resuscitation (CPR) if a person's heart or breathing stops), dated [DATE].Review of the resident's Outside the Hospital Do Not Resuscitate Order (OHDNR) form, dated [DATE], showed:- Full Code hand-written with what appeared to be in highlighter ink across the form, dated and signed by the resident and his/her resident representative on [DATE].Review of the resident's Care Plan, dated [DATE], showed:- Full code status.Review of the facility's DNR binder showed:- A dark and hard-to-read copy of Resident #2's OHDNR form signed and dated by the resident, his/her responsible party, and the physician on [DATE];- Unable to read if Full Code was hand-written on the form with highlighter ink.During an observation and interview on [DATE] at 1:48 P.M., showed:- Licensed Practical Nurse (LPN) I reviewed the resident's scanned copy the resident's OHDNR signed by the resident, resident representative, and the physician on [DATE], with Full Code hand-written faintly on the form;- LPN I didn't know if the resident was a full code or a DNR.During an interview on [DATE] at 1:15 P.M., the Director of Nursing (DON) said she did not know why Resident #2's code status was changed to DNR but the resident had an OHDNR in the DNR binder.During an interview on [DATE] at 9:10 A.M., Resident #2's responsible party said the resident was a full code. The facility didn't discuss with him/her if the resident's code status should be changed.2. Review of Resident #86's medical record showed:- An admission date of [DATE];- No order for a code status;- No advance directive.Review of the resident's Care Plan, dated [DATE], showed:- Full code status.During an interview on [DATE] at 3:16 P.M., Resident #86 said he/she wanted to be a full code and wanted cardiopulmonary resuscitation (CPR) performed if he/she stopped breathing and/or heart stopped beating.During an interview on [DATE] at 1:48 P.M., LPN I (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said he/she looked in a resident's electronic medical record to determine a resident's code status by looking at the advance directive link at the top of the face sheet. The link went to the resident's actual documents scanned into the resident's chart regarding advance directives and code statuses. During an interview on [DATE] at 3:21 P.M., LPN H said he/she looked at the top of a resident's face sheet in the electronic medical chart for a code status order. During an interview on [DATE] at 2:50 P.M., the Administrator and DON said they would expect residents' code status orders to match the signed advance directive.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to attempt and ensure the physician responded to gradual dose reductions (GDRs) for medications for two residents (Residents #4 and #19) and failed to limit the use of as needed (PRN) psychotropic (medications that affect the mind, emotions, and behavior) medication orders for 14 days for one resident (Resident #19) out of five sampled residents. The facility census was 87. Review of the facility's policy titled, Medication Regimen Reviews (MRR), revised February 2025, showed: - The MRR includes a review of the medical record to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities, for example, the use of medication was inconsistent with accepted pharmaceutical services standards of practice, not supported by medical evidence, that impedes or interferes with achieving the intended outcomes of pharmaceutical services, ordered without clinical indication or in excessive dose, administered without adequate monitoring or in the presence of adverse consequences; and/or that appears to be inconsistent with the resident's stated preferences; - MRRs are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated depending on a resident's condition and/or risk for adverse consequences. - Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a medication irregularity that is deemed not life-threatening. The report contains resident's name, name of the medication, identified irregularity, and pharmacist's recommendation; - The consultant pharmacist provides the Director of Nursing (DON) services and Medical Director with a written, signed, and dated copy of all medication regimen reports; - Copies of MRR reports, including physician responses, are maintained as part of the permanent medical record; - The consultant pharmacist submits a quarterly report that includes a summary of key findings from MRRs, including status of the facility's pharmaceutical services, staff performance in complying with regulatory requirements related to medication utilization and monitoring, problem areas and irregularities noted (e.g. documentation errors, medication errors, etc.), recommended solutions for specific problem areas, follow-up reports relative to the facility's corrective action related to problem areas, and other pertinent information; - Upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them; - If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the Medical Director or (if the Medical Director is the physician of record) and the Administrator; - The facility includes a review of key issues related to medications and medication irregularities as (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	part of the Quality Assurance and Performance Improvement (QAPI) program. Review of the facility's policy titled, Tapering Medications and Gradual Dose Reductions, revised February 2025, showed: - Residents who use psychotropic medications receive GDRs, unless clinically contraindicated, in an effort to discontinue these medications; - GDR refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed at a lower dose or if a medication can be discontinued; - All medications are considered for possible tapering/GDR; - The staff and practitioner consider GDRs under certain circumstances, including when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms, or a resident's condition has not responded to treatment or has declined despite treatment; - Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated; - After the first year, the facility will attempt a GDR at least annually, unless clinically contraindicated; - The time frames and duration of tapering/GDR attempts are based on relevant factors including other medications the resident is taking, underlying causes of symptoms, individual risk factors, and pharmacologic characteristics of the medications; - Some medications (e.g., antidepressants, sedative/hypnotics, opioids) may need more gradual tapering to minimize withdrawal symptoms or other adverse consequences; - For any individual who is receiving a psychotropic medication, the GDR may be considered contraindicated for reasons that include, but are not limited to the continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; - GDR attempts are documented in the medical record. The documentation includes the date of the GDR attempt, outcome of the dose reduction attempt, any return or worsening of symptoms, and plan regarding any future GDR attempts. Physician documentation contains the rationale for why GDR attempts are clinically contraindicated for the resident. 1. Review of Resident #4's August 2025 Physician Order Sheet (POS): (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An admission date of 09/21/21; - Diagnoses of cerebrovascular disease (a group of disorders that affect blood vessels and blood supply to the brain), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, leading to problems with memory, thinking, and behavior), generalized anxiety disorder (excessive, uncontrollable worry about everyday things that persists for at least six months), and major depressive disorder (long-term loss of pleasure or interest in life); - An order for Abilify (an antipsychotic (a medication used to treat symptoms of psychosis) medication) 5 milligrams (mg) by mouth one time a day for mood disorder, dated 06/05/24, and discontinued 01/15/25; - An order for Abilify 5 mg by mouth one time a day related to major depressive disorder, dated 01/15/25. Review of the resident's MRR dated 10/02/24, showed: - Pharmacist requested a GDR for the Abilify 5 mg daily dose; - The physician failed to respond. During an interview on 08/07/25 at 10:50 A.M., the resident's Physician Assistant (PA) said he/she received the GDR requests directly from the pharmacist. He/She did not receive any GDR request to reduce Resident #4's Abilify on 10/02/24. 2. Review of Resident #19's August 2025 POS showed: - An admission date of 03/24/21; - Diagnoses of anxiety, major depressive disorder, opioid dependence, chronic pain, nausea, bipolar (a mental disorder that causes unusual shifts in mood), insomnia (difficulty sleeping), and restless leg syndrome; - An order for Ambien (a hypnotic medication to help sleep) 5 mg give 1.5 tablet by mouth every 24 hours PRN for insomnia, dated 06/05/24, and no end date; - An order for buspirone (an antianxiety medication) 10 mg by mouth three times a day related to anxiety disorder, dated 05/04/24; - An order for hydroxyzine (an antianxiety medication) 50 mg by mouth every eight hours PRN for anxiety, dated 10/09/24, and no end date; - An order for Rexulti (an antipsychotic medication) 1 mg by mouth once a day for depression, dated 06/06/24. Review of the resident's MMR showed: - On 11/04/24, 12/02/24, and 08/05/25, the pharmacist requested the physician review the hydroxyzine 50 mg every eight hours PRN for anxiety order extended past the 14 days without (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to follow their policy and procedure to complete Criminal Background Checks (CBC) and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused, neglected, and/or misappropriated funds or property from a resident) prior to the hire date for three employees (Employees A, B, and C) out of ten sampled employees . The facility census was 86. Review of the facility's policy titled, Background Screening Investigations, dated March 2019, showed:- Background checks, reference checks, and criminal conviction checks on all potential direct access employees and contractors should be conducted. Background and criminal checks are initiated within two days of an offer of employment and completed prior to employment. Review of the facility's policy titled, Abuse Prevention Program, not dated, showed:- As part of the resident abuse prevention, the administration will conduct employee background checks. 1. Review of Employee A's personnel file showed: - A hire date of 08/30/24;- No documentation of a CBC completed prior to the hire date;- No documentation of a EDL completed prior to the hire date;- The facility failed to perform the CBC and EDL prior to the hire date. 2. Review of Employee B's personnel file showed:- A hire date of 11/04/24;- No documentation of a CBC completed prior to the hire date;- No documentation of a EDL completed prior to the hire date;- The facility failed to perform the CBC and EDL prior to the hire date. 3. Review of Employee C's personnel file showed:- A hire date of 12/20/24;- No documentation of a CBC completed prior to the hire date;- No documentation of a EDL completed prior to the hire date;- The facility failed to perform the CBC and EDL prior to the hire date. During an interview on 08/07/25 at 3:10 PM, the Administrator said that the CBC and EDL should be done prior to employment.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a standardized assessment tool used in nursing homes to collect comprehensive information about residents' functional capabilities and health status) for two residents (Residents #38 and #46) out of 19 sampled residents. The facility census was 87. Review of facility's policy titled, Resident Assessments, dated October 2023, showed:- Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews;- The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments;- Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. 1. Review of Resident #38's Medical Record showed:- An admission date of 11/13/19;- Diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), intellectual disabilities (significant limitations in both intellectual functioning and adaptive behavior), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Review of the resident's PASRR Level II screening, dated 12/09/22, showed:- Resident with a serious mental illness and intellectual developmental disability or related condition. Review of the resident's annual MDS, dated [DATE], showed:- Not evaluated by a Level II PASRR. 2. Review of Resident #46's Medical Record showed:- An admission date of 10/28/21;- Diagnoses of schizophrenia, paranoid personality disorder (a mental health condition characterized by a pervasive distrust and suspicion of others, even when there is no valid reason to be suspicious), delusional disorders (a mental illness characterized by one or more persistent, false beliefs that last for at least one month), bipolar disorder, anxiety disorder, violent behavior, hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), and homicidal ideations (thoughts or fantasies about killing another person). Review of the resident's PASRR Level II screening, dated 11/22/21, showed:- Resident with a serious mental illness. Review of the resident's annual MDS, dated [DATE], showed:- Not evaluated by a Level II PASRR. During an interview on 08/07/25 at 2:15 P.M., the MDS Coordinator said the PASRR Level II determination should be documented on the MDS. During an interview on 08/07/25 at 2:50 P.M., the Administrator and the Director of Nursing (DON) said they would expect the MDS to accurately reflect the resident's status.		

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NAME OF PROVIDER OR SUPPLIER Hunter Acres Caring Center		STREET ADDRESS, CITY, STATE, ZIP CODE 628 North West Street Sikeston, MO 63801	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to establish a care plan for two residents (Resident #38 and #69) out of 19 sampled residents. The facility census was 87. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, showed: - The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1. Review of Resident #38's medical record showed: - An admission date of 11/13/19; - Diagnoses of chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems), sleep related hypoventilation (a breathing disorder where breathing becomes too shallow or slow during sleep, leading to insufficient oxygen and/or excessive carbon dioxide in the blood), shortness of breath, and nicotine dependence; - An order for bilevel positive airway pressure machine (BiPAP - a type of non-invasive ventilation used to assist with breathing) at bedtime for sleep apnea (repeated pauses in breathing during sleep), dated 06/05/24; - An order for oxygen at two liters per minute per nasal canula (a flexible tube inserted into the nostrils to provide supplemental oxygen) as needed for COPD, dated 06/05/24. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 06/19/25, showed: - Used a non-invasive mechanical ventilator. Review of the resident's Care Plan, revised 06/22/25, showed: - Did not address the BiPAP and oxygen use. During an observation and interview on 08/05/25 at 2:52 P.M., showed: - The resident's BiPAP machine sat on the bedside table and the oxygen concentrator sat at the head of the bed; - The resident said his/her BiPAP was used at night and oxygen when he/she was short of breath. 2. Review of Resident #69's medical record showed: (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An admission date of 12/19/23; - Diagnoses of asthma and wheezing (breathing condition causing narrowing of airways making it more difficult to breath), pleural effusion (fluid in lung space), and insomnia (difficulty sleeping); - An order to apply continuous positive airway pressure (CPAP &ndash; delivers a continuous flow of air to open the airways) at a pressure of 14 at night and with naps for sleep apnea, dated 03/05/25. Review of the resident's annual MDS, dated [DATE], showed: - Used a non-invasive mechanical ventilator. Review of the resident's Care Plan, revised 06/06/25, showed: - Did not address the resident's CPAP use. Observation on 08/05/25 at 9:05 A.M., showed the resident's CPAP machine sat at the bedside. During an interview on 08/05/25 at 12:06 P.M., the resident said he/she wore his/her CPAP at night. He/She put it on sometimes by himself/herself and sometimes with staff assistance. During an interview on 08/07/25 at 11:00 A.M., the Care Plan Coordinator said he/she talked to staff, checked the residents' orders, and went to daily meetings to get information on the residents' current conditions. Oxygen needs, including BiPAP and CPAP use should be on the care plan. The care plans were updated when a resident went out to the hospital or for a physician's visit and came back with new orders, a change in condition, or quarterly. During an interview on 08/07/25 at 2:50 P.M., the Administrator and the Director of Nursing (DON) said they would expect the care plan to accurately reflect the resident's current condition, needs, and care areas. The care plan should be revised with a resident's change in condition.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to follow physician's written orders for one resident (Resident #2) out of 19 sampled residents. The facility census was 87. Review of the facility policy titled, Telephone Orders, dated February 2014, showed:- Verbal telephone order may only be received by licensed personnel;- Order must be reduced to writing by the person receiving the order and recorded in the resident's medical record;- The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information.1. Review of Resident #2's medical record showed:- An admission date of 12/08/21; - Diagnoses of congestive heart failure (CHF - a condition where the heart can't pump enough blood to meet the body's needs), type II diabetes mellitus (a chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), generalized anxiety disorder (excessive, uncontrollable worry about everyday things that persists for at least six months), mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age), and morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems).Review of the resident's August 2025 Physician Order Sheet (POS) showed: - An order for Seroquel (an antipsychotic (medications that treat psychosis, a condition where a person's perception of reality is impaired) medication) 25 milligram (mg) give 12.5 mg by mouth at bedtime, dated 05/15/25, and discontinued on 05/20/25;- An order discontinue the Seroquel 12.5 mg by mouth at bedtime, dated 05/20/25;- An order for Seroquel 25 mg 1/2 tablet by mouth at bedtime, dated 05/20/25, and discontinued on 06/19/25; - An order to discontinue Seroquel 12.5 mg by mouth at bedtime, dated 06/17/25.Review of the resident's Behavioral Health Note, dated 06/17/25, showed:- Resident continued to receive Seroquel 12.5 mg even though the medication was discontinued during last visit on 05/20/25.Review of the resident's Medication Administration Record (MAR), dated May 2025 - June 2025, showed:- The resident received Seroquel 25 mg 1/2 tablet at bedtime from 05/20/25 to 06/01/25, and 06/03/25 - 06/18/25;- Received 29 doses of the Seroquel 25 mg 1/2 tablet after discontinued.During an interview on 08/07/25 at 10:50 A.M., the behavioral Physician Assistant (PA) said he/she discovered during a visit on 06/17/25, the resident was still administered Seroquel. On the previous visit on 05/20/25, he/she had written an order to discontinue the Seroquel. He/She wrote another order to discontinue the Seroquel on 06/17/25.During an interview on 08/07/25 at 2:10 P.M., Licensed Practical Nurse (LPN) H said the nurse on duty received the orders for the residents on his/her hall. The orders were entered into the electronic medical record by the nurse on duty.During an interview on 08/07/25 at 2:50 P.M., the Administrator and the Director of Nursing (DON) said they would expect physician orders to be entered into the system accurately.During an interview on 08/14/25 at 3:28 P.M., the Administrator said their policies regarding written orders reflected the same practice as telephone and verbal orders. The written order was scanned into the electronic medical record after the order was entered by the nurse.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to put dietitian recommendations into place for one resident (Resident #4) out of four sampled residents that had excessive weight loss. The facility census was 87. Review of the facility policy titled, Weight Assessment and Intervention, dated March 2022, showed:- Residents are weighed upon admission and at intervals established by the interdisciplinary team;- Any confirmed weight change of five percent (%) or more since the last weight assessment will be reported to the dietitian in writing by nursing. Review of the facility policy titled, Nutritional Assessment, dated October 2017, showed:- The dietitian will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition;- The dietitian will determine an estimate of calorie, protein, nutrient, and fluid needs;- The dietitian will determine whether the resident's current intake is adequate to meet his/her nutritional needs;- The dietitian will determine special food formulations;- Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications;- Individualized care plans shall address the identified causes of impaired nutrition;- Individualized care plans shall address the resident's personal preferences;- Individualized care plans shall address goals and benchmarks for improvement;- Individualized care plans shall address time frames and parameters for monitoring and reassessment. 1. Review of Resident #4's medical record showed:- An admission date of 09/21/21;- Diagnoses of cerebrovascular disease (a group of disorders that affect blood vessels and blood supply to the brain), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, leading to problems with memory, thinking, and behavior), generalized anxiety disorder (excessive, uncontrollable worry about everyday things that persists for at least six months), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the resident's Weight Summary, dated 03/01/25 - 08/31/25, showed:- On 03/04/25, weight of 136.6 pounds (lbs);- On 04/02/25, weight of 135.6 lbs;- On 05/01/25, weight of 136.4 lbs;- On 06/06/25, weight of 124.2 lbs, an 8.94% weight loss in 30 days;- On 07/01/25, weight of 128.4 lbs;- On 08/01/25, weight of 129.0 lbs, a 5.56% weight loss in less than 180 days. Review of the resident's Dietician Assessment, dated 06/24/25, showed:- Weight of 124.2 pounds;- Nutritional plan to continue a mechanical soft diet with extra portions as needed with a divided plate, add a house supplement twice a day, and provide encouragement as needed at meals. Review of the resident's Physician Order Summary (POS), dated 08/07/25, showed:- An order for a regular diet with mechanical soft texture, regular/thin consistency, a divided plate, dated 07/09/24;- No order for a house supplement twice daily as recommended by the dietitian. During an observation on 08/04/25 at 12:10 P.M., and 08/05/25 at 12:32 P.M., showed:- The resident fed him/herself using a divided plate;- The resident was not provided with extra portions of food and a house supplement;- The resident ate 75% of the meal and did not request additional servings;- Staff did not encourage the resident to eat;- Staff did not document the resident's food intake. During an interview on 08/07/25 at 2:10 P.M., Licensed Practical Nurse (LPN) H said the dietitian gave the order recommendations to the nurse on duty and they entered the orders into the electronic medical record. During an interview on 08/07/25 at 2:50 P.M., the Director of Nursing (DON) and the Administrator said they would expect dietitian recommendations to be implemented. During a phone interview on 08/15/25 at 8:30 A.M., the Dietitian said the facility contacted him/her via phone or email. The nutrition recommendations were provided to the DON and the Dietary Manager. The DON or nurse designee would be responsible for changing the diet orders in the resident's electronic medical record.		