STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265393	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Hills Living Center	996 State Highway 248 Branson, MO 65616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Based on observations, record review, and interviews, the facility failed to ensure staff assessed one resident (Resident #30), of two sampled residents reviewed for self-administration of medications, to determine if they were clinically appropriate and safe to self-administer medications before allowing them to administer their own medication. Review the facility policy titled, Medications, Self-Administration, Self Storage, Leave At Bedside, undated, showed the following: -The resident has a right to self-administer medication unless the interdisciplinary team has determined that this practice is unsafe for an individual resident; -If a resident expresses a desire to self-administer medication, the interdisciplinary team must assess the resident's cognitive, physical, and visual ability to carry out this responsibility. The mental status and any psychiatric diagnoses must be taken into account. The 'Evaluation Assessment to Self-Administer Medications will be used for this purpose; -When the resident self-administers medications, the resident will be re-assessed on an ongoing basis for continued safety of this practice. The evaluation assessment will be completed annually or with significant change by nursing and reviewed by the interdisciplinary team to determine if the resident is still capable of self-administer medications; -The physician's order sheet will reflect the current status of the resident's self-administering medications. 1. Review of Resident #30's Resident Face Sheet showed the following: -admitted [DATE], with the most recent readmitted [DATE]; -Diagnoses included acute respiratory failure with hypoxia (decreased oxygen level) and hypercapnia (increased carbon dioxide level in the bloodstream typically caused by inadequate respiration) and acute bronchitis. Review of a resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 03/07/24, showed the resident had moderate cognitive impairment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current Care Plan showed the following: -Start date of 08/19/19, indicated the resident had an alteration in respiratory status due to anemia and asthma; -The care plan directed staff to administer the resident's medications as ordered. (The staff did not care plan regarding the resident's ability to self-administration of any medications.) Review of the resident's Observation History, dated 02/19/23 through 03/20/24, showed staff did not document completion of a self-administration of medication evaluation for the resident. Review of the resident's Physician's Order Report, dated 02/20/24 through 03/20/24, showed the following: -An order, dated 09/22/19, for an albuterol sulfate aerosol inhaler (used to treat difficulty breathing), two puffs by inhalation every six hours for asthma. The order included, Special Instructions: May keep at bedside; however, the resident's Physician Order Report did not reflect orders for self-administration of their albuterol inhaler. Observations and interview on 03/20/24, at 9:01 A.M., showed a Ventolin inhaler (the name brand for albuterol) at the resident's bedside. The resident said the inhaler stayed in their room all the time. The resident said the nurses were aware the inhaler was in their room since the nurses were the ones that brought the inhaler to the room for the resident's use. During an interview on 03/20/24, at 10:30 A.M., Certified Medication Technician (CMT) #6 said he/she was aware the resident had an order to keep their inhaler at bedside. He/she thought the resident had been assessed for self-administration and acknowledged the resident administered their inhaler independently. During an interview on 03/20/24, at 11:17 A.M., the Director of Nursing (DON) said prior to a resident being allowed to self-administer medication a self-administration assessment had to be completed and an order for self-administration obtained from the physician. The DON said assessments for self-administration of medications was completed quarterly and with any change in a resident's condition and could be found in the electronic medical record (EMR) under the observation history. The DON stated there were no residents in the facility that had been approved to self-administer medications.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46863 Based on interviews, and record review, the facility failed to resolve a grievance and document full resolution of the grievance for one resident (Resident #8) of two residents reviewed for grievances. Review of an undated facility policy titled Resident Grievances showed the following: -The coordinator (or designee) shall conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint; -The coordinator will maintain files and records of the facility, relating to such grievances; -The coordinator will issue a written decision on the grievance no later than 30 days after its filing. 1. Review of Resident #8's Resident Face Sheet showed the following: -admitted [DATE]; -Diagnoses included chronic diastolic (congestive) heart failure (a long-term condition in which the heart can't pump blood well enough to meet the body's needs), acute kidney failure, anemia (a condition in which the body does not have enough healthy red blood cells), type 2 diabetes mellitus with hyperglycemia (high blood sugar levels), and chronic pain syndrome. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an Assessment Reference Date (ARD) of 03/05/24, showed the resident was cognitively intact. Review of the resident's current Care Plan showed the following: -As of 12/22/21, the resident had a problem telling staff what they want or understanding staff instructions due to being hard of hearing, and the resident wore bilateral hearing aids; -Intervention directed staff to answer the resident's questions and repeat them as necessary, observe the resident to see if they understand, and allow the resident time to respond and give the resident cues/reminders if needed. Review of a facility document titled Concern/Grievance Report, dated 02/05/24, showed the following: -The resident initiated a grievance due to $200.00 being misplaced; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 02/09/24, the facility resolved the grievance and noted, $100 was found in residents personal wallet continue search of other misplaced funds. During an interview on 03/18/24, at 11:00 A.M., the resident said they had $200.00 go missing at the facility. The Director of Nursing (DON) located $100 in their room during a search. The resident said a $100.00 was still missing, and the facility did nothing else. During an interview on 03/21/24, at 10:35 A.M., the DON said she had filed a report with the state agency as a result of the resident's grievance filed on 02/05/24. The DON indicated that they were finished with the investigation after locating some of the missing money. During an interview on 03/21/24, at 2:15 P.M., the Social Worker (SW) said she worked as the facility grievance coordinator. When she received a report of a concern or a grievance form, she interviewed the person who filled out the grievance form. She took the investigation data that was gathered to the head of the department and let them come up with a solution. She then shared the resolution with the Administrator and then with the family members verbally over the phone. The resident reported they were missing $200 cash in February (2024). The DON informed her of the grievance for the missing money. The SW oversaw this grievance and worked with the DON. The SW looked in the resident's wallet the day that the $200.00 cash was reported missing, and there was no money in the resident's wallet. Some of the money was located, but she was unaware of who had located it. After locating some of the money, they stopped the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46659 Based on observation, interview, and record review, the facility failed to ensure two (Resident #12 and Resident #72) of 2 residents reviewed for activity of daily living (ADL) care received services to maintain grooming/personal hygiene. Specifically, the facility failed to ensure staff provided nail care and shaved facial hair for Resident #2 and #72. In addition, the facility failed to assist Resident #72 with a bath/shower twice weekly in March 2024 per the facility's shower schedule. Review of a facility policy titled Activities of Daily Living (ADL), undated, showed the purpose of the policy was to assist resident in achieving maximum function. (The policy did not addressed assisting residents with shaving or nail care. Review of the facility's Certified Nursing Assistant (CNA) Job Description, dated May 2006, showed the following: -CNA provides personal hygiene needs, including bath (complete, partial, tub/shower, Sitz and skin care); -CNA provides other duties as assigned; -CNA must have the ability to provide personal care for the frail elderly and for acute, chronic, and terminally ill patients. 1. Review of Resident #12's Resident Face Sheet showed the following: -admitted [DATE]; -Diagnoses included weakness, personal history of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke), chronic pain, rash, and aphasia (a brain disorder where a person has trouble speaking or understanding other people speaking). Review of Resident #12's Admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an Assessment Reference Date (ARD) of 02/09/24, showed the following: -Resident dependent on staff for a shower/bathing and required partial/moderate assistance with personal hygiene (including shaving and washing/drying the face and hands); -Resident had upper and lower extremity impairment on one side; -Resident exhibited no behavior symptoms of rejection of care. Review of the resident's current Care Plan, dated 02/03/24, showed the following: -Resident at risk for pressure ulcers related to immobility, incontinence, and the need for extensive assistance with transfers; (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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to keep the resident clean and as dry as possible. (Staff did not care plan regarding the resident's personal hygiene needs or preferences.). Review of the facility's shower schedule showed the resident was scheduled to receive a shower every Tuesday and Friday. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review, dated February 2024 and March 2024, showed the following: -Staff were required to document whether the resident's toenails needed to be trimmed; -There was no specific area that prompted staff to document whether the resident was shaved or their fingernails were trimmed; -Staff wrote on the 03/07/24 shower form that the resident was shaved and their nails were cleaned and trimmed; -The resident's last documented shower was on 03/14/24. Staff did not document regarding the resident's nails or shaving of the resident on that day. During an interview on 03/18/24, at 11:16 A.M., the resident nodded their head to indicate yes when asked if they would like to be shaved and if they would like their nails to be shorter. Observations on 03/19/24, at 8:03 A.M. and 10:53 A.M., showed the resident had facial hair and long that needed to be trimmed. During an interviews on 03/19/24, at 11:15 A.M., CNA #13 said the resident liked to be shaved, noting the last time he/she provided the resident a shower was on 03/04/24 (15 days prior). At that time the CNA had shaved the resident and trimmed their nails. The resident did not refuse ADL (activities of daily living - dressing, grooming, bathing, eating, and toileting) care. During an interview on 03/20/24, at 11:40 A.M., Licensed Practical Nurse (LPN) #16 said he/she did not think the resident refused showers/bathing, noting staff should make sure the resident's nails were trimmed and facial hair was shaved. 2. Review of Resident #72's Resident Face Sheet showed the following: -admitted [DATE]; -Diagnoses included pain, other reduced mobility, personal history of TIA, osteoarthritis (a type of arthritis that happens when the cartilage that lines the joints is worn down and bones rub against each other) of hip, scoliosis (a sideways curve of the spine), other intervertebral disc degeneration and radiculopathy (a range of symptoms produced by the pinching of a nerve root in the spinal column) of the lumbar region, and age-related osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of bone changes). Review of the resident's admission MDS, with an ARD of 01/03/24, showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident had intact cognition; -Resident needed setup or clean-up assistance from staff with showers/bathing and personal hygiene (including shaving and washing/drying the face and hands); -Resident had upper and lower extremity impairment on one side and exhibited no behavior symptoms of rejection of care. Review of the resident's current Care Plan showed the following: -An area, dated 01/11/24, for the resident's ability to complete ADLs, including, in part, maintaining personal hygiene, had deteriorated related to a recent health decline. (Staff did not care plan interventions to ensure the resident's personal hygiene needs were met.) Observation and interview on 03/18/24, at 10:57 A.M., showed the resident had long fingernails and facial hair. The resident said their nails were too long and they did not like having a beard. The resident said they received a shower once a week. During an interview on 03/19/24, at 2:03 P.M., the resident said they did not get a shower the previous day as scheduled, noting it had been quite a few days since they had a bath or shower. Observation and interview on 03/20/24, at 11:12 A.M., showed the resident continued to have long facial hair and long fingernails. The resident said they would like to have their face shaved and nails trimmed when they got a shower/bath, but staff did not offer. Review of the facility's shower schedule showed the resident was scheduled to receive a shower on Mondays and Thursdays. The instructions showed for staff to mark who received a shower or refused, complete shower sheet, and put in shower book in alphabetical order by last name. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review, dated March 2024, showed the following: -Staff documented they assisted the resident with a bed bath on Monday, 03/04/24; Monday, 03/11/24; and Tuesday, 03/19/24; -Staff did document assisting the resident with a shower on Thursday, 03/07/24; or Thursday, 03/14/24; -Staff did not document regarding shaving the resident or trimming his/her fingernails. During an interview on 03/20/24, at 11:14 A.M., Registered Nurse (RN) #12 said the resident did not always like to take a shower, but staff could provide an adequate bed bath, trim their fingernails, and shave their facial hair. During an interview on 03/20/24, at 11:24 A.M., CNA #13 said he/she had never assisted never assisted the resident with a shower, but typically made sure to offer to shave the resident and trim their nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/24 at 11:34 A.M., CNA #15 said he/she gave the resident a bed bath on 03/17/24, but failed to complete a shower sheet. He/She stated he/she did not offer to trim the resident's nails and did not offer to shave the resident, but he/she should have offered the services to the resident. During an interview on 03/20/24, at 11:40 A.M., Licensed Practical Nurse (LPN) #16 said the resident refused showers at times, but most of the time, the resident would allow staff to provide a bed bath. Staff should also ensure the resident's facial hair was shaved and nails were trimmed per the resident's preferences. 3. During an interview on 03/20/24, at 11:14 A.M., RN #12 said staff should complete a shower sheet after a bath or shower. The shower or bath process should include shaving and nail care. Staff were also supposed to shave all residents and trim their nails when needed. 4. During an interview on 03/20/24, at 11:24 A.M., CNA #13 said that showers were provided twice per week, noting residents should be shaved and have their fingernails trimmed when needed. 5. During an interview on 03/20/24, at 11:34 A.M., CNA #15 said showers and bathing should include shaving a resident and trimming the resident's nails, noting staff should complete a shower sheet. If a resident refused a bath or shower, he/she would document the refusal on the shower sheet. 6. During an interview on 03/20/24, at 11:27 A.M., CNA #14 said shaving and trimming nails were part of a bath or shower. Shower sheets were completed and placed in a binder at the nurses' station. Staff should offer to trim the residents' nails and shave them when providing baths/showers. 7. During an interview on 03/20/24, at 2:45 P.M., CNA #17 said when providing a shower or bath, staff should offer to shave facial hair and trim the residents' fingernails. 8. During an interview on 03/20/24, at 11:40 A.M., Licensed Practical Nurse (LPN) #16 said shower sheets should be completed for baths and showers. Staff were to offer to trim residents' nails and shave the residents when providing showering assistance. 9. During interviews on 03/20/24, at 8:22 A.M. and 2:52 P.M., the Director of Nursing (DON) said she expected staff to provide two showers weekly and, on alternating days, staff should provide a bed bath. She expected residents' nails to be trimmed and clean and for staff to offer to shave residents' faces every day. 10. During an interview on 03/20/24, at 3:03 P.M., the Administrator said he had high standards and expected residents to be well groomed and bathed. He said he expected staff to offer to shave residents and trim their nails as needed, particularly when long or dirty.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524 Based on observations, interviews, and record review, the facility failed to ensure nursing staff supervised residents during medication administration to ensure medications were taken as prescribed and medications were not left unattended in residents' rooms for four residents (Residents #51, #33, #46, and #7) of nine sampled residents reviewed for accidents and hazards. The facility also failed to identify and investigate a fall for one resident (Resident #48) of three sampled residents reviewed for falls. 1. Review of the facility policy titled, Medications, Storage Of, undated, showed the following: -All medications for residents must be stored at or near the nurses' station in a locked cabinet, a locked medicine room, or one or more locked mobile medication carts. Review of the facility policy titled Medication Administration, undated, showed the following: -Remain in room while the resident takes the medication. 2. Review of Resident #51's Resident Face Sheet showed an admitted [DATE] with the most recent readmitted [DATE]. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an Assessment Reference Date (ARD) of 02/01/24, showed the resident was cognitively intact. Observation on 03/18/24, at 9:48 A.M., showed a cup that contained three white pills in the resident's room. Upon return to the room, after getting a nurse, the pill cup was empty. The resident said they had just taken the medications. During an interview on 03/18/24, at 10:12 A.M.,, the resident said nursing staff normally remained with them while they took their medications and did not normally leave them at their bedside. The resident indicated they were sleepy that morning and fell asleep before taking all of their medications. 22445 3. Review of Resident #33's Resident Face Sheet showed the following: -admitted [DATE]; -Diagnoses that included essential hypertension (high blood pressure), cognitive communication deficit, and unspecified macular degeneration (a disease that affects a person's central vision). Review of the resident's quarterly MDS, with an ARD of 01/15/24, showed the resident had moderate cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/18/24, at 9:38 A.M., showed a medication cup that contained a small blue-gray tablet and four white tablets in the resident's room. The resident said the nurse brought the pills into their room that morning about 9:00 A.M. and left the medications in the room for them to take as they wanted. During an interview on 03/18/24, at 9:54 A.M., Licensed Practical Nurse (LPN) #4 said she did not leave the medications in the resident's room and indicated Certified Medication Technician (CMT) #5 had given the medications to the resident. LPN #4 said the medications should not have been left in the resident's room. During an interview on 03/18/24, at 9:56 A.M., CMT #5 said he/she had been taught that medications should not be left in residents' rooms; however, he/she left the resident's medications in their room, because he/she trusted the resident would take them. CMT #5 identified the tablets observed in the resident's room as Tylenol 325 milligrams (mg), two tablets of vitamin C 500 mg tablets, one tablet of amiodarone (a medication to treat an irregular heartbeat), and Sinemet (a medication for Parkinson's disease). CMT #5 said the danger of leaving the medication in the resident's room could be another resident or visitor taking the medications, or if the resident waited too long to take the medications, there was a risk of double-dosing some of the medications. 46863 4. Review of Resident #46's Resident Face Sheet showed the following: -admitted [DATE]; -Diagnoses included allergic rhinitis (inflammation and swelling of the mucous membrane of the nose), chronic obstructive pulmonary disease (COPD - a group of diseases that cause airflow blockage and breathing-related problems), acute and chronic respiratory failure with hypercapnia (increased carbon dioxide levels in the bloodstream), altered mental status, respiratory failure, and vascular dementia with behavioral disturbance. Review of the resident's quarterly MDS, with an ARD of 02/11/24, showed the resident had moderate cognitive impairment. Observation on 03/18/24, at 9:25 A.M., showed medications were at the resident's bedside on the resident's rolling tray table. The medications included a three-ounce (oz) bottle of antifungal powder, fluticasone propionate nasal spray 60 milligrams (mg), and an Advair Diskus inhaler. During an interview at the time of the observation, the resident said they did not know why the antifungal powder was in their room. The resident said staff helped them administer the nasal spray and that staff did not put it away that day. During an observation and interview on 03/18/24, at 9:51 A.M., LPN #7 observed the medications at the resident's bedside and said the medications were not supposed to be left at a resident's bedside. LPN #7 said another resident could wander into the resident's room and get into the medications. 5. Review of Resident #7's Resident Face Sheet showed the following: -admitted [DATE]; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included pain in the left hip, unspecified skin changes, altered mental status, pain in the leg, and chronic pain syndrome. Review of the resident's quarterly MDS, with an ARD of 03/04/24, showed the resident was cognitively intact. Observation on 03/18/24. at 10:19 A.M., showed medications were at the resident's bedside. A 1.25-ounce (oz) tube of muscle rub cream and two 3 oz tubes of a lidocaine topical pain reliever were observed on the resident's rolling tray table, and an opened, unsealed individual 5 gram, single-use pack of skin ointment and a tube of antifungal ointment were observed on the resident's nightstand. During an observation and interview on 03/18/24, at 10:30 A.M., LPN #7 observed the medications at the resident's bedside. The LPN said the muscle rub and topical pain relievers should be in the treatment cart instead of the resident's room. 6. During an interview on 03/19/2024, at 1:23 P.M., LPN #1 said he/she had seen medications in cups left unattended in residents' rooms before. Staff became overwhelmed at times with their workload and when staff left medications with a resident to take, they normally went back to ensure the resident took them. There was no way to ensure residents safely took medications that were left with them or if they threw them away, flushed them, or if another resident took the medications. During an interview on 03/19/24, at 1:55 P.M., CMT #3 said if a resident was cognitively intact, he/she sometimes left medications with them to take on their own. He/she had found cups of medications on tables in the dining room. If medications were left unattended, a different resident could potentially take them. During an interview on 03/20/24, at 11:15 A.M., the Director of Nursing (DON) said the danger of leaving medications at a resident's bedside was that staff would not know if the resident took their medications, and the resident could have an adverse event. Someone else could take the medications. The DON expected staff administering medications to stay with the resident until they took all medications unless there was an emergency. Cups of medications should not be left in residents' rooms and indicated all unattended medications should be locked in a medication cart, a medication room, or if a resident could keep medication at their bedside. She expected them to be kept locked so that no other resident could have access. During an interview on 03/21/24, at 9:23 A.M., the Administrator said he expected CMTs and nurses to follow the facility's policies and procedures for medication administration and said if something was not appropriate to have at a resident's bedside, staff should not leave it unattended. 7. Review of the facility policy titled, Event Investigation, undated, showed the following: -Purpose to investigate the cause of all marks, discolorations, skin breaks and injuries which have not been witnessed. To identify any injuries after a resident sustains an event; -Interview the resident to determine cause of any conditions identified; -Interview any witnesses to determine cause of any condition identified; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Hills Living Center	996 State Highway 248 Branson, MO 65616

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Implement preventive measures as appropriate; -Complete a Report of Event Form as soon as possible whenever there is an unusual, unexpected and/or unintended event that is not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a resident or visitor. Examples of when a form should be completed include fall or person found on the floor; -Any staff member who discovers, witnesses, or is involved in an event should immediately report the event to the nurse in charge. The charge nurse is responsible for completion of the Report of Event Form and forwarding to the DON as soon as possible. Review of Resident #48's Resident Face Sheet showed the following: -admitted [DATE] with most recent readmission on 12/25/23; -Diagnoses included COPD with acute exacerbation (worsening or increase in symptoms), anxiety disorder, type two diabetes mellitus with hyperglycemia (increased blood glucose levels), peripheral vascular disease, iron deficiency anemia, and chronic congestive heart failure. Review of the resident's quarterly MDS, with an ARD of 02/18/24, showed the resident had moderate cognitive impairment. The resident required supervision or touching assistance for chair/bed-to-chair transfers. Review of the resident's Care Plan showed revealed a Problem area, with a start date of 02/14/23, that indicated the resident was at risk for falls due to COPD exacerbation. During an interview on 03/21/24, at 9:03 A.M., LPN #7 said on 03/06/24 the resident reported they got tangled up in their oxygen tubing and went down on one knee, but was able to get themselves up and into the bed from the floor. The resident indicated the incident occurred overnight the night before the resident reported it to LPN #7. Despite the resident's description of what happened, he/she did not consider the incident a fall because the resident only went down on one knee. LPN #7 said to be considered a fall, both knees would have needed to go down on the floor. LPN #7 said when a resident had a fall, the facility's process was to check the resident's vital signs, conduct neurological assessments, check the resident's range of motion, notify the resident's medical doctor and resident representative, and document information about the fall in the resident's progress notes. Review of the resident's Resident Progress Notes showed staff did not document regarding a fall on 03/06/24. During an interview on 03/21/24, at 10:35 A.M., the DON said following a fall, he/she expected staff to assess the resident, ensure their safety, notify the physician , resident representative, and the DON, document in the resident's electronic medical record (EMR), and create a fall event in the EMR. An event report should be completed for each fall. The DON said she ran event reports off on a weekly basis and reviewed them daily, along with interventions. The DON was not aware of a fall involving the resident on 03/06/24. If a resident's knee went to the ground, it was considered a fall, and staff should initiate a fall assessment and follow the facility's fall process. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/24 at 3:12 P.M., the Administrator said if a resident reported their knee went down to the ground, he expected staff to investigate the incident as a fall. He said a fall investigation involved interviewing the resident and gathering additional statements to determine what happened. MO00232950

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524 Based on record review, and interviews, the facility failed to monitor and document the bruit (a whooshing sound that can be heard with a stethoscope) and thrill (gentle vibration caused by blood flow) of a resident's arteriovenous (AV) shunt for one resident (Resident #61) of one sampled resident reviewed for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services. Review of a facility's policy titled, Dialysis, Care of a Resident Receiving, undated, showed the following: -Purpose to utilize the following guideline to provide care for a resident that is receiving dialysis; -Care of the AV shunt/fistula/graft specified, feel for the thrill sensation daily; -Checking the thrill sensation specified nurses will check the thrill daily and document daily. This will be documented on the resident's treatment record; -At the AV site feel for a pulse. The pulse is the blood flow through the access; -If no thrill sensation is felt notify the physician. 1. Review of Resident #61's Resident Face Sheet showed the following: -admitted [DATE] with a readmitted [DATE]; -Diagnoses included end stage renal disease (ESRD), anxiety, and type two diabetes mellitus with diabetic nephropathy (the chronic loss of kidney function occurring in those with diabetes mellitus). Review of a quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 01/02/24, showed the following: -Resident was cognitively intact; -Received dialysis services while a resident of the facility. Review of the resident's current Care Plan showed the following: -A focus area, with a start date of 09/28/22, showing the resident had an alteration in kidney function related to ESRD; -Resident received hemodialysis each Monday, Wednesday, and Friday; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Encourage the resident to go to dialysis as ordered per the facility van, administer medications as ordered, check the resident's dialysis access site daily for signs or symptoms of infection, and to notify the physician of significant changes. (Staff did not care plan related to checking the bruit or thrill of the resident's AV shunt.) Review of the resident's Active Orders and Order History showed the following: -An order, dated 09/28/22, for staff to monitor the resident's AV site for signs and symptoms of infection every shift; -An order, dated 06/10/23, for dialysis three times per week on Mondays, Wednesdays, and Fridays. (There was no order to check the resident's AV shunt for bruit and thrill until 03/19/24, during the survey.) Review of the resident's Medication Administration Record, dated 03/01/24 to 03/19/24, showed staff did not document monitoring the bruit and thrill of the resident's AV shunt prior to 03/19/24. During an interview on 03/19/24, at 1:23 P.M., Licensed Practical Nurse (LPN) #1 said the resident currently had an AV shunt for dialysis access. Staff observed the resident's AV shunt daily for any redness or other changes, but did not check the bruit and thrill. If staff were supposed to check the bruit and thrill, there would be orders prompting them to do so. LPN #1 confirmed he/she had not been checking the bruit and thrill for the resident's AV shunt. During an interview on 03/19/24, at 2:39 P.M., the resident said their AV shunt was in their left arm. Per the resident, nursing staff felt around the shunt site periodically, but did not routinely assess their AV shunt site using a stethoscope. During an interview on 03/19/24, at 3:39 P.M., LPN #2 said when a resident was received dialysis, nursing staff checked the resident's AV shunt site for any swelling or bleeding and also checked the bruit and thrill to ensure blood was flowing and the AV shunt was functioning properly. It was important to check the bruit and thrill of an AV shunt, because it could alert nursing staff if something was wrong with the shunt. After reviewing the resident's orders, LPN #2 confirmed there was no order directing staff to check the bruit and thrill, but indicated he/she did so anyway out of habit. During an interview on 03/21/24, at 9:21 A.M., the Director of Nursing (DON) said when a resident was on dialysis and had an AV shunt, she expected nursing staff to check the bruit and thrill every shift to ensure proper blood flow. The DON was unaware there was no order directing staff to check the resident's bruit and thrill prior to 03/19/24. During an interview on 03/21/24, at 9:23 A.M., the Administrator said he expected an order to be in place for nursing staff to monitor and document the bruit and thrill of a dialysis resident's AV shunt.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50494 Based on observation, interview, and record review, the facility failed to ensure the physician reviewed and acted upon medication irregularities reported by a Consultant Pharmacist in a timely manner for one resident (Resident #16) of five residents reviewed for unnecessary medications. Review of facility guideline titled, Drug Review, undated, showed the following: -All medications given to each resident will be reviewed on a monthly basis in order to review drug interactions, ensure adherence to stop orders. ensure accuracy in administration, and evaluate medications appropriate to diagnosis; -The pharmacist reviews all federal indicators, and a monthly report form is filled out to show any problem areas. The report lists any problems noted, the date, and signature of reporter; -Medications should not show unnecessary or excessive use and should have a diagnosis to support them; -Problems identified shall be addressed according to need in consultation with physician; -Follow up on problems needs either the Director of Nursing's (DON) or pharmacist's signature to show that the problem has been addressed; -Any order changes are handled in the proper manner and changes conveyed to pharmacy. 1. Review of Resident #16's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an Assessment Reference Date (ARD) of 01/22/24, showed the following: -admitted [DATE]; -Diagnoses included non-Alzheimer's dementia and unspecified disorientation; -Resident was unable to complete the interview to determine cognition; -Resident rejected care and had verbal behavioral symptoms directed toward others; -In the prior seven days or since admission, the resident had taken antipsychotic, hypnotic, and opioid medications; -There was a documented indication for use of the medications. Review of the resident's Care Plan, dated 01/16/24, showed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident received psychotropic medications and had a potential for drug-related complications associated with the use of Seroquel (quetiapine - an antipsychotic medication) and lorazepam (a sedative, antianxiety medication); -Interventions directed staff to monitor for side effects and indicated the doctor and the pharmacist would review the resident's medications monthly for possible problems and to determine if the resident could take a lower dose. Review of the resident's Physician Order Report, dated 01/01/24 through 01/31/24, showed the following: -An order, dated 01/16/24, for oral lorazepam intensol 2 milligrams (mg)/milliliter (mL), providing 0.5 mL (1 mg) by mouth every four hours as needed (PRN) for unspecified dementia at an unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; -An order, dated 01/16/24, for delayed-release divalproex (Depakote - anticonvulsant, migraine headache preventer, and bipolar therapy agent) 125 milligrams (mg) daily, oral, at bedtime for a diagnosis of other specified health status; -An order, dated 01/19/24, for lorazepam intensol 2 mg/mL, provide 1 mL (2 mg) for agitation PRN every four hours with a diagnosis identified as unspecified dementia at an unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. (Staff did not document discontinuation of the 01/16/24 order.); -A current order for Robitussin Cough+Chest Congestion DM (dextromethorphan-guaifenesin) liquid, 5-100 mg/5 mL, providing 10 mL by mouth for acute cough PRN. (The order did not indicate how often staff could administer the medication.) Review of the resident's Pharmacist's Recommendation to Prescriber forms, with a recommendation date of 01/31/24, showed the following: -The resident had two PRN orders for lorazepam intensol, one directing staff to provide one mg every four hours as needed (ordered 01/16/24) and one directing staff to provide two mg every four hours as needed (ordered on 01/19/24). The pharmacist indicated the orders must specify when to give the 1 mg dose and when to give the 2 mg dose; -The pharmacist indicated the PRN lorazepam intensol orders lacked a stop date and that the Centers for Medicare and Medicaid Services (CMS) required for PRN orders for psychotropic drugs be limited to 14 days unless the prescriber documented the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order in the medical record; -The consultant pharmacist asked the prescriber to consider particular clarifications pertaining to the lorazepam intensol orders/diagnosis; -There was no documentation the prescribing physician reviewed/acted upon the pharmacy recommendations from 01/31/24 until 03/18/24, after the survey was initiated. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Pharmacist's Recommendation to Prescriber forms, with a recommendation date of 01/31/24, revealed the following: -The resident had an order for PRN Robitussin Cough+Chest Congestion DM that lacked a PRN dosing interval. The pharmacist documented that the order was incomplete without the PRN dosing interval. The pharmacist recommended the prescriber consider clarification of the dosing interval to every four hours PRN for cough or chest congestion; -There was no documentation the prescribing physician reviewed/acted upon the pharmacy recommendation from 01/31/24 until 03/18/24, after the survey was initiated. Review of the resident's Pharmacist's Recommendation to Prescriber forms, with a recommendation date of 01/31/24, showed the following: -The resident was receiving divalproex acid (Depakote) for dementia with behavioral disturbance. The pharmacist recommended the prescriber consider one of the following: obtaining laboratory (lab) tests that included a complete blood count (CBC), comprehensive metabolic panel (CMP), and a valproic acid (Depakote) level on the next routine lab day; obtaining a valproic acid level only on the next routine lab day; or denoting that lab tests were not necessary at the time due to hospice/clinical goals; -There was no documentation the prescribing physician reviewed/acted upon the pharmacy recommendations from 01/31/24 until 03/18/24, after the survey was initiated. Observation on 03/18/24, at 9:45 A.M., showed the resident had their eyes closed while in bed. Observation 03/18/24, at 10:30 A.M. showed the resident was sleeping. Observation on 03/19/24, at 9:00 A.M., showed the resident had their eyes closed in a wheelchair in front of a television by a day room. During an interview on 03/18/24, at 2:00 P.M., the resident's representative said during every visit they had with the resident, the resident was sleeping, and it was difficult to awaken the resident. During an interview on 03/20/24, at 9:00 AM, the Pharmacy Consultant said all residents' medications regimens were reviewed monthly. If there was an urgent recommendation, she contacted the facility immediately and, if the recommendation was not urgent, she emailed the recommendations to the DON and prescribing physician. The resident's 01/31/24 recommendations were emailed to facility staff on 02/19/24. She stated when she completed another resident review on 02/29/24, the physician had not addressed some of the recommendations; however, she did not address that with the facility. During an interview on 03/19/24, at 3:26 P.M., the Medical Director said he had not seen the pharmacy recommendations for the resident from 01/31/2024. The Pharmacy Consultant normally emailed the recommendations, and he typically addressed those recommendations within seven to ten days. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/24, at 10:46 A.M., the DON said the Pharmacy Consultant emailed medication regimen recommendations to the DON and Medical Director. Pharmacy recommendations should be sent to the facility within a few days of the consultant pharmacist's review. The DON was not aware that the Medical Director had not addressed the Pharmacy Consultant's recommendations for the resident. During an interview on 03/20/24, at 9:29 A.M., the Administrator said he had not received any concerns from the Pharmacy Consultant or other staff that the Medical Director was not addressing pharmacy reviews/recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46863 Based on observation, record review, and interviews, the facility failed to ensure an expired medication was not stored in a resident's room for one resident (Resident #8) of 21 sampled residents. Review of the facility policy titled, Medications, Storage of, undated, showed the following: -All medications for residents must be stored at or near the nurses' station in a locked cabinet, a locked medication room, or one or more locked mobile medication carts; -No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. 1. Review of Resident #8's Resident Face Sheet showed an admitted [DATE]. Observations on [DATE], at 11:18 A.M., showed a tube of hydrocortisone cream in the resident's room. The cream had an expiration date of [DATE]. During an interview on [DATE], at 11:22 A.M., Licensed Practical Nurse (LPN) #1 said the hydrocortisone cream in the resident's room had an expiration date of [DATE]. He/she had not previously seen the cream in the resident's room. During an interview on [DATE], at 11:15 A.M., the Director of Nursing (DON) said she was not aware that the resident had expired hydrocortisone cream in their room. Certified nurse assistants (CNAs) periodically looked for medications in residents' rooms and said she expected them to remove and report any items they found.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 50494 Based on observations and interviews, the facility failed to ensure a privacy curtain was in place between two residents (Resident #16 and Resident #17) who resided in one of 48 semi-private rooms in the facility. 1. Observations on 03/18/24, at 11:59 A.M., showed Resident #16 and Resident #17 shared a semi-private room. The privacy curtain between their beds was missing. Observations on 03/19/24, at 12:04 P.M., and on 03/20/24, at 10:35 A.M., showed the privacy curtain between the two residents was missing. During an interview on 03/20/24, at 12:09 P.M., Certified Nurse Assistant (CNA) #9 said he/she had been employed at the facility for approximately one year and did not recall if there had ever been a privacy curtain between the residents' beds. He/she did not think the privacy curtain was a concern due to the poor cognition of both residents. During an interview on 03/20/24, at 12:19 P.M., Licensed Practical Nurse (LPN) #8 said he/she was not aware of the missing privacy curtain in residents' room. If it had been brought to his/her attention, he/she would have contacted housekeeping or maintenance staff to address the concern. During an interview on 03/20/24, at 12:40 P.M., the Environmental Supervisor said a floor technician took the privacy curtain down from the residents' room on 03/17/24 to wash it. A replacement curtain should have been hung when it was taken down to wash; however, the Environmental Supervisor said the facility had a limited supply of replacement curtains available and was unsure if a replacement was available on 03/17/24. During an interview on 03/21/24, at 9:30 A.M., the Director of Nursing (DON) said semi-private rooms should have privacy curtains to provide privacy for the residents. The cognitive status of the residents was irrelevant and indicated all residents should have privacy curtains. During an interview on 03/21/24, at 10:30 A.M., the Administrator said semi-private rooms should have privacy curtains to provide privacy for the residents. The Administrator was not aware of a limited supply of privacy curtains and indicated if a curtain was taken down, a replacement curtain should be hung immediately.