STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265395	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cori Manor Healthcare & Rehabilitation Center	560 Corisande Hills Road Fenton, MO 63026

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 39360 Based on interview and record review, the facility failed to notify residents of the availability and location of the most recent survey results in an accessible location to residents. This deficient practice had the potential to affect all residents and visitors. The facility's census was 92. The facility did not provide a policy. During a resident council meeting on 05/02/24 at 2:58 P.M., Resident #6, #26, #47, #57, #79 and #87 collectively said they were not aware of a binder that had survey results or the placement of it. During an interview on 05/01/24 at 3:30 P.M., the Administrator said they had been unable to find the survey results, among other things, since the administration change. During an interview on 05/07/24 at 5:09 P.M., the Administrator said there had been a new survey binder created and it was placed on the front table.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 39360 Based on interview and record review, the facility failed to consistently document a code status for one resident (Resident #56) out of 19 sampled residents and one resident (Resident #6) outside the sample. The facility's census was 92. Review of the facility's Advanced Directives policy, revised [DATE], showed: - Prior to or upon admission of a resident, the social services director (SSD) or designee will inquire about the existence of written advance directive; - The resident or representative will be provided written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if chosen to do so; - The resident or representative is given the option to accept or decline assistance; - Nursing staff will document, in the medical record, the offer to assist and the resident's decision to accept or decline assistance; - Information about whether or not the resident executed an advance directive will be displayed prominently in the medical record that is retrievable by any staff; - If the resident or resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff; - The director of nursing services or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care; - The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings; - The plan of care is consistent with his or her documented treatment preferences and/or advance directive; - The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident record and care plan. 1. Review of Resident #6's medical record showed: - An admitted [DATE]; (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A face sheet, dated [DATE], reflecting a full code (all resuscitation measures, including cardiopulmonary resuscitation (CPR- lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped) status; - An order for Do Not Resuscitate (DNR-individual does not wish to have CPR attempted), dated [DATE]; - An Outside of Hospital Do-Not-Resuscitate (OHDNR), signed and dated [DATE]; - A second OHDNR, signed and dated [DATE]; - Care plan, revised [DATE], with full code status on the heading, and full code status, dated [DATE], listed with interventions and goals, as well as a DNR status, dated [DATE], listed with interventions and goals in the body of the care plan. During an interview on [DATE] at 2:35 P.M., Resident #6 said he/she had graduated from hospice to become a full code. 2. Review of Resident #56's medical record showed: - An admitted [DATE]; - An order for a full code status, dated [DATE]; - Consent for DNR, dated [DATE]; - An OHDNR, signed and dated [DATE]; - Care Plan, last revised [DATE], with DNR. During an interview on [DATE] at 10:05 A.M., Certified Nurse Assistant (CNA) N said there is a list at the 100 hall nurses's station that has every resident's code status. Another way to look is on the resident's door. If it has a star beside the name, it means one thing and if there is no star then it means something else. He/She does not know if the star beside the name means full code or not. During an interview on [DATE] at 11:24 A.M., CNA O said there is a sheet at the 100 hall nurse's station with everyone's code status. A star beside resident name on resident's room, means they are a DNR and no star beside resident name on resident's door, means full code. During an interview on [DATE] at 2:30 P.M., the Director Of Nursing (DON) said the code status is found on the run sheet at the nurses station, but most accurate is to pull it up on the computer charting system. The code status is on the facesheet. During an interview on [DATE] at 5:09 P.M., the Administrator and Director of Operations said the code status should be reflected consistently throughout the resident's chart.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46555 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 92. Review of the facility's general cleaning procedure check off list, undated, showed: report all dirty curtains or cubical blinds, burnt out light bulbs, or items that are missing from the room to the housekeeping supervisor so that any maintenance issues can be given to the maintenance director for repairs in the rooms. Observations of room [ROOM NUMBER] showed: - On 04/30/24 at 12:57 P.M., the resident's oxygen concentrator had debris on the filter and on left side of the concentrator. Twenty drywall patches on the walls of the room and on the corner by the closet and by the window that were not painted over; - On 05/03/24 at 2:00 P.M., the resident's oxygen concentrator had debris on the filter and on left side of the concentrator. Twenty dry wall patches on the walls of the room and on the corner by the closet and by the window that were not painted over. Observation on 04/30/24 at 2:23 P.M. of room [ROOM NUMBER] showed the privacy curtains stained with a brown substance. Observation on 05/02/24 at 9:27 A.M. of room [ROOM NUMBER] showed the bottom drawers missing from the closet and the trim bent in. During an interview on 05/07/24 at 5:05 P.M., the Administrator and Director of Operations said they would expect curtains to be clean and free from dirt, debris, and stains. They would expect oxygen concentrators to be cleaned weekly. They would expect closets and drawers to be in working condition. They would expect the walls of resident rooms to be free from drywall patches after maintenance has had a reasonable amount of time to paint over the patches.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to provide discharge documentation that included appropriate communicated information to receiving facility such as basis for transfer, specific needs that couldn't be met, facility attempts to meet needs and special instructions or precautions for on-going care, including a copy of the resident's discharge summary, to ensure a safe and effective transition of care for one resident (Resident #92) out of three sampled residents. The facility's census was 92. Review of the facility's policy, Discharge Summary and Plan, revised October 2022, showed: - When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge; - The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident; - As part of the discharge summary, the nurse reconciles all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation is documented; - A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs, the post-discharge plan, and the discharge summary. Review of the facility's policy, Resident Discharge, dated July 2005, showed: - If the resident is being transferred to another facility, the facility will prepare an informational transfer summary. 1. Review of Resident #92's medical record showed: - An admitted [DATE] and discharged to another facility on 01/18/24; - No discharge summary or recapitulation of stay. During an interview on 05/03/24 at 2:15 P.M., the Social Services Director (SSD) said when a resident is transferred to another facility, the discharge summary would not be filled out. However, the nurses would be the ones to fill it out if so. During an interview on 05/03/24 02:25 P.M., the Administrator said the SSD would do this, but he said when a resident is transferred to another facility, they normally don't do a discharge summary/recapitulation. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/24 at 5:10 P.M., the Director of Operations said the facility will do a discharge summary/recapitulation if a resident is going home. If a resident is going to another nursing home, they just send orders and documentation. They don't do a discharge summary/recapitulation of stay when going from nursing home to nursing home.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for transfer, and failed to notify a representative of the Office of the State Long-Term Care Ombudsman for 10 residents (Resident #2, #4, #11, #14 #52, #56, #64, #67, #85, and #444) out of 19 sampled residents. The facility's census was 92. Review of the facility's policy, Discharge Summary Form and Transfer to a Hospital with Bed Hold Form Documentation, undated, showed: - Upon obtaining a discharge order to transfer a resident to the hospital, the Transfer to Another Facility form is to be filled out explaining the reason why the resident is being transferred and explaining the bed hold policy; - After explaining to the resident why he/she is being transferred, the bed hold policy is explained and the resident is to sign the document; - If the transfer is a 911 transfer, the guardian/responsible party/next of kin is to be notified and the reason for the transfer and the bed hold policy is explained; - A copy of the signed Transfer to Another Facility is to be placed in the chart to ensure proof that the document was completed; - Upon discharge, the discharge summary is to be filled out with all information known upon discharge; - Completing the discharge summary and/or placing all legal documentation in the chart upon transfer of a resident is a Standard of Nursing Practice. 1. Review of Resident #2's medical record showed: - Transferred to the hospital on 02/18/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 08/01/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 2. Review of Resident #4's medical record showed: - Transferred to the hospital on 03/04/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Transferred to the hospital on 12/04/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of the transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 3. Review of Resident #11's medical record showed: - Transferred to the hospital on 04/09/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 4. Review of Resident #14's medical record showed: - Transferred to the hospital on 12/28/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 01/04/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 01/17/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 02/07/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 02/19/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 5. Review of Resident #52's medical record showed: - Transferred to the hospital on 01/22/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 12/23/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 11/14/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 6. Review of Resident #56's medical record showed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Transferred to hospital on 11/02/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 7. Review of Resident #64's medical record showed: - Transferred to the hospital on 01/26/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 8. Review of Resident #67's medical record showed: - Transferred to the hospital on 8/29/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 4/10/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 9. Review of Resident #85's medical record showed: - Transferred to the hospital on 12/30/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 02/06/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 03/04/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. 10. Review of Resident #444's medical record showed: - Transferred to the hospital on 03/25/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer; - No documentation of transfer/discharge notice given to the Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/02/24 at 9:35 A.M., the Social Services Director (SSD) said he/she does not issue a transfer/discharge notice in writing to resident/representative for residents that are transferred to the hospital. During an interview on 05/07/24 at 5:10 P.M., the Administrator and Director of Operations said when a resident is hospitalized , they would expect staff to notify the resident or resident's representative in writing of the reason for transfer and send a copy to the Ombudsman. 46460 46555 47447 49150 49152 47678

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to inform the resident and/or legal representative in writing of their bed hold policy at the time of transfer to the hospital for ten residents (Residents #2, #4, #11, #14, #52, #56, #64, #67, #85, and #444) out of 19 sampled residents. The facility's census was 92. Review of the facility's policy, Discharge Summary Form and Transfer to a Hospital with Bed Hold Form Documentation, undated, showed: - Upon obtaining a discharge order to transfer a resident to the hospital, the Transfer to Another Facility form is to be filled out explaining the reason why the resident is being transferred and explaining the bed hold policy; - After explaining to the resident why he/she is being transferred, the bed hold policy is explained and the resident is to sign the document; - If the transfer is a 911 transfer, the guardian/responsible party/next of kin is to be notified and the reason for the transfer and the bed hold policy is explained; - Completing the discharge summary and/or placing all legal documentation in the chart upon transfer of a resident is a Standard of Nursing Practice. 1. Review of Resident #2's medical record showed: - Transferred to the hospital on 02/18/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 08/01/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 2. Review of Resident #4's medical record showed: - Transferred to the hospital on 12/04/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 03/04/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 3. Review of Resident #11's medical record showed: - Transferred to the hospital on 04/09/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 4. Review of Resident #14's medical record showed: - Transferred to the hospital on 12/28/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 01/04/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 02/07/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 02/19/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 5. Review of Resident #52's medical record showed: - Transferred to the hospital on 01/22/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 12/23/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 11/14/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 6. Review of Resident #56's medical record showed: - Transferred to the hospital on 11/02/23, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 7. Review of Resident #64's medical record showed: - Transferred to the hospital on 01/26/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 8. Review of Resident #67's medical record showed: - Transferred to the hospital on 8/29/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 4/10/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 9. Review of Resident #85's medical record showed: - Transferred to the hospital on 12/30/23, and readmitted to the facility on [DATE]; - Transferred to the hospital on 02/06/24, and readmitted to the facility on [DATE]; - Transferred to the hospital on 03/04/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. 10. Review of Resident #444's medical record showed: - Transferred to the hospital on 03/25/24, and readmitted to the facility on [DATE]; - No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer. During an interview on 05/02/24 at 09:35 A.M., the Social Services Director (SSD) said they do not issue a written copy of the bed hold policy to residents or their representatives for signature when residents are sent out to the hospital because it was included in the initial admission package. During an interview on 05/07/24 at 5:05 P.M., the Administrator and Director of Operations said they expect staff to inform the resident or resident representative in writing of the bed hold policy upon hospitalization . 46460 46555 47447 47678 49152

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	265395	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cori Manor Healthcare & Rehabilitation Center	560 Corisande Hills Road Fenton, MO 63026

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555 Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility) assessment for one resident (Resident #67) out of 19 sampled residents and one resident (Resident #6) outside the sample. The facility's census was 92. Review of the facility's policy titled, MDS Completion and Submission Timeframes, revised October 2023, showed timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual. Review of the RAI Manual, revised October 2023, showed: - The Assessment Reference Date (ARD) must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill; - The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days); - The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an significant change in status assessment (SCSA) were met. 1. Review of Resident #6's medical record showed: - A quarterly MDS assessment, dated 01/28/23, showed the resident received hospice (health care focused on the quality of life of a terminally ill person) services; - A discharge date of [DATE] from hospice services; - A quarterly MDS assessment, dated 07/29/23, showed the resident received hospice services; - The facility failed to complete a significant change MDS within 14 days after the discharge of the resident's hospice services. 2. Review of Resident #67's medical record showed: - A significant change MDS, dated [DATE], showed the resident no longer received hospice services; - A discharge date of [DATE] from hospice services; - The facility failed to complete a significant change MDS within 14 days after the discharge of the resident's hospice services. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/24 at 5:05 P.M., the Administrator and Director of Operations said they would expect the MDS to be updated and completed within the required time frames and accurately reflect the resident's current status. During an interview on 05/17/24 at 3:56 P.M., the MDS Coordinator said she would expect a significant change MDS to be completed with each hospice admission and discharge. The MDS assessments should reflect the current condition of the resident and be completed per the RAI Manual. 49152

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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 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** 46460 Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for four residents (Resident #2, #9, #64, and #69) out of 19 sampled residents and one resident (Resident #6) outside the sample. The facility census was 92. Review of the facility's policy titled, MDS Completion and Submission Timeframes, revised October 2023, showed timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual. 1. Review of Resident #2's medical record showed: - An admitted [DATE]; - Diagnoses of cerebral palsy (a disorder of movement, muscle tone, or posture), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and diabetes mellitus (a group of diseases that result in too much sugar in the blood); - An order for pioglitazone (a non-insulin diabetes medication), 15 milligrams (mg) daily, dated 08/04/23; - No order for insulin; - A quarterly MDS assessment, dated 02/21/24, with Section N checked for receiving insulin seven days out of the seven day look back period. 2. Review of Resident #6's medical record showed: - An admitted [DATE]; - Diagnoses of anemia (low blood levels of iron) , macular degeneration (an eye disease that causes vision loss) , acute angle glaucoma (an eye disease that causes vision loss) , hypertension (high blood pressure), bipolar (a mental disorder that causes unusual shifts in mood), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), other recurrent depressive disorders, gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and vascular dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning); - No diagnosis of Parkinson's disease; - An annual MDS assessment, dated 04/18/24 with GERD, macular degeneration, and glaucoma not marked under section I. Parkinson's disease marked under section I. - Discharge from hospice services on 06/06/23; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A quarterly MDS assessment, dated 07/29/23, with J1400 (Does the resident have a condition or chronic disease that may result in a life expectancy of less than six months?) checked yes. 3. Review of Resident #9's medical record showed: - An admitted [DATE]; - Diagnoses of major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety, COPD and rheumatoid arthritis (a chronic inflammation disorder usually affecting small joints in hands and feet); - No diagnosis of post traumatic stress disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); - A quarterly MDS assessment, dated 02/26/24 with section I checked for diagnoses of anxiety, depression and PTSD. During an interview on 05/03/24 at 12:20 P.M., the Social Services Director (SSD) said Resident #9 did not have a PTSD diagnosis. 4. Review of Resident #64's medical record showed: - An admitted [DATE]; - Diagnoses of dementia, aphasia (loss of ability to understand or express speech caused by brain damage), cerebral infarction (stroke, damage to the brain from interrupted blood supply), anxiety, major depressive disorder, cardiac arrhythmia's (abnormal heart beat), cardiac murmur (heart not pumping efficiently), acute respiratory disease, hypertension, dysphagia (difficulty swallowing), GERD, diabetes mellitus, hyperlipidemia (high blood level of cholesterol), and epileptic seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness); - A quarterly MDS assessment, dated 02/27/24, with cardiac dysrhythmias, GERD, dementia, and anxiety not marked under section I. 5. Review of Resident #69's medical record showed: - An admitted [DATE]; - Diagnoses of pneumonia, unspecified mood disorder, moderate protein-calorie malnutrition, major depressive disorder, Vitamin B-12 deficiency anemia, anxiety, unspecified convulsions, diastolic (congestive) heart failure, and pain; - An annual MDS assessment, dated 03/04/24, with heart failure, pneumonia, and Vitamin B-12 deficiency anemia not marked under section I. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/24 at 5:10 P.M., the Administrator and Director of Operations said they would expect the MDS assessments to accurately reflect the resident's condition. During an interview on 05/17/24 at 3:56 P.M., the MDS Coordinator said she would expect all active diagnoses to be reflected in Section I, and a non-insulin diabetes medication should not be coded as insulin. The MDS assessments should reflect the current condition of the resident and be completed per the RAI Manual. 49152

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555 Based on interview and record review, the facility failed to update and revise care plans with specific interventions to meet individual needs for two residents (Resident #67 and #444) out of 19 sampled residents. The facility census was 92. Review of the facility's policy, Care Plans, Comprehensive Person-Centered revised March 2022, showed: - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; - The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission; - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; any specialized services to be provided as a result of PASARR recommendations; and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. 1. Review of Resident #67's medical record showed: - An admitted [DATE]; - Diagnoses of chronic kidney disease, stage 4 (long standing disease of the kidneys leading to renal failure), cellulitis (a bacterial infection of the skin) of the buttock, gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), insomnia (difficulty sleeping), and heart failure (condition where the heart does not pump blood like it should); - Orders for meropenem (an antibiotic) reconstituted solution, 500 milligrams (mg), give 1000 mg; intravenous every 12 hours (9:00 A.M. and 9:00 P.M.), dated 04/18/24; - Normal saline flush (sodium chloride 0.9 % flush) syringe, give 10 milliliter (mL) injection every day and night shift, dated 04/18/24; - PICC (peripherally inserted central catheter - a long, thin tube inserted through a vein and used to give medications) dressing change weekly on Sunday, dated 04/18/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 05/02/24, showed it did not address the PICC line. 2. Review of Resident #444's medical record showed: - An admitted [DATE]; - Diagnoses of bacteremia (a bacterial infection in the blood stream), Type 2 diabetes mellitus (trouble controlling blood sugar), congestive heart failure (condition where heart does not pump blood like it should), acute osteomyelitis (bone infection) of left ankle and foot, non pressure chronic ulcer (ulcer caused by poor circulation); - Orders for daptomycin (an antibiotic) reconstituted solution 350 mg, inject 615 mg intravenously (IV) every 24 hours for 42 days, dated 04/02/24; - PICC dressing change weekly on Wednesday, dated 04/10/24. Review of the resident's care plan, revised 04/22/24, showed it did not address the PICC line. During an interview on 05/07/24 at 5:10 P.M., the Administrator and Director of Operations said they would expect the care plans to reflect the current condition of the resident and when the Registered Nurse who takes care of the care plans isn't available, the facility staff should update them.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on interview and record review, the facility failed to follow physician's orders for two residents (Resident #11 and #56) out of 19 sampled residents and failed to obtain a treatment order for one resident (Resident #11) out of 19 sampled residents. The facility's census was 92. Review of the facility's Medication and Treatment Order policy, revised July 2016, showed: - Medications and treatments will be consistent with principles of safe and effective order writing; - Did not address following physician orders for medication administration. Review of the website www.drugs.com showed: - Take levothyroxine tablets and capsules on an empty stomach, at least 30 to 60 minutes before breakfast with a full glass of water; - Take the medicine at the same time each day. 1. Review of Resident #11's medical record showed: - An admitted [DATE]; - Diagnoses of hypothyroidism (underactive thyroid that produces too few hormones, causing the metabolism to slow down), nutritional anemia (deficiency in vitamins and/or minerals) and shortness of breath; - An order for levothyroxine (a hormone medication that treats hypothyroidism), 100 micrograms (mcg), one tablet by mouth, every morning on an empty stomach, dated 08/06/23; - No order for prevalon boots (a cushioned boot that provides proper position of the heel for off-loading pressure.) Observations of the resident showed: - On 05/01/24 at 9:44 A.M., the resident lay in bed wearing prevalon boots; - On 05/02/24 at 11:00 A.M., the resident lay in bed wearing prevalon boots; - On 05/03/24 at 9:17 A.M., the resident lay in bed wearing prevalon boots. During an interview on 05/07/24 at 2:42 P.M., the Assistant Director of Nursing (ADON) said she would expect residents to have orders for all medications and treatments, including prevalon boots, and this resident does not have an order for prevalon boots. She will have to look into that. Staff does take them off sometimes because they get hot and itchy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's Medication Administration Record (MAR), dated 03/02/24 through 05/03/24, showed: - Medication administration times ranged from 7:46 A.M. until 12:45 P.M.; - Medication administered late on 20 out of 64 days. 2. Review of Resident #56's medical record showed: - An admitted [DATE]; - Diagnoses of hypothyroidism, shortness of breath, vitamin deficiency and abnormal results of thyroid function studies; - An order for levothyroxine, 125 mcg, one tablet by mouth, every morning, dated 11/04/23. Review of Resident #56's MAR, dated 03/02/24 through 05/03/24, showed: - Medication administration times ranged from 7:01 A.M. until 12:34 P.M.; - Medication administered late on 30 out of 64 days. Review of the resident's thyroid stimulating hormone (TSH) 3-UL labs (measures the amount of TSH in the blood to determine how the thyroid is working), dated 01/02/24, showed a value of 9.093 micro-international units per milliliter (ulU/ml). Normal values range from 0.340-5.500 ulU/ml. During an interview on 05/03/24 at 10:51 A.M., the Director of Nursing (DON) said levothyroxine should be given on an empty stomach or at bedtime. During an interview on 05/03/24 at 10:51 A.M., Licensed Practical Nurse (LPN) M said levothyroxine should be given on empty stomach or two hours after eating. Resident #56's TSH labs support not receiving it correctly. During an interview on 05/03/24 at 12:15 P.M., Certified Medication Technician (CMT) K said thyroid medications should be given before the resident eats, usually before 6:00 A.M. 46460

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555 Based on interview and record review, the facility failed to ensure staff provided the necessary care and services in accordance with professional standards of practice for two residents (Resident #67 and #444) out of 19 sampled residents. Staff failed to follow policies, procedures, and physician orders regarding peripherally inserted central catheter (PICC) line care and administration of intravenous (IV) Antibiotics. The facility census was 92. Review of the facility's policy, Peripheral and Midline IV Catheter Flushing and Locking, dated March 2022, showed: - For short and long peripheral venous catheters (PIVCs - a thin, soft tube placed into a peripheral vein for venous access to administer intravenous therapy such as medication and fluids) and midline catheters (a thin, soft tube that is placed into a vein, usually in the arm) used for intermittent infusions, flush the catheter and aspirate for blood return prior to each infusion and at least every 24 hours to assess catheter function. Lock following each use; - Use a syringe barrel size of I0 milliliters (mL) or greater when flushing to avoid excessive pressure inside the catheter, prevent potential rupture of the catheter, and prevent dislodgement of clots; - Apply the push-pause technique to flush catheter; - When flushing after an IV push medication, flush at the same rate of injection as the medication; - If there is resistance or difficulty during flushing procedure, evaluate need for site rotation; - Monitor for infiltration of the vein (when some of the fluid leaks out into the tissues under the skin where the tube has been put into your vein) during flushing procedure; - Follow manufacturer's instructions for flushing if different from above; - Document procedure in treatment administration record; - Note location of catheter, condition of insertion site, and dressing in nurse's notes; - Record any complications and/or communications with the physician in nurse's notes; - Report any complications to supervisor, oncoming shift, and physician (if necessary); - Report any other information per facility protocol. 1. Review of Resident #67's medical record showed: - An admitted [DATE]; (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of chronic kidney disease, stage 4 (long standing disease of the kidneys leading to renal failure), cellulitis (a bacterial infection of the skin) of the buttock, gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), insomnia (difficulty sleeping), and heart failure (condition where the heart does not pump blood like it should); - Orders for meropenem (an antibiotic) reconstituted solution, 500 milligrams (mg), give 1000 mg; intravenous every 12 hours (9:00 A.M. and 9:00 P.M.), dated 04/18/24; - Normal saline flush (sodium chloride 0.9 % flush) syringe, give 10 milliliters (mL) injection every day and night shift, dated 04/18/24; - PICC dressing change weekly on Sunday, dated 04/18/24. During an interview on 04/30/24 at 12:57 P.M., the resident said he/she recently returned from the hospital and is now on IV antibiotics. He/she said they changed the bandage on his/her PICC line shortly after he/she arrived back to the facility, but have not changed it again since. Observations of the resident's PICC line showed: - On 04/30/24 at 12:57 P.M., a dressing dated 04/20/24; - On 05/03/24 at 11:55 P.M., a dressing dated 04/20/24, with a merepenem (an antibiotic) infusion connected and running; - On 05/03/24 at 12:40 P.M., a dressing dated 04/20/24, with infusion complete; - On 05/03/24 at 2:20 P.M., the infusion complete but still connected to the PICC line. During an interview on 05/03/24 at 2:20 P.M., the resident said the infusion had been done for a long time, but the staff had not disconnected it or flushed the line yet. Sometimes it takes them a little while to get back to him/her to get it done. During an interview on 05/03/24 at 12:30 P.M., the Director of Nursing (DON) and Licensed Practical Nurse (LPN) M denied Resident #67 had a PICC line. 2. Review of Resident #444's medical record showed: - An admitted [DATE]; - Diagnoses of bacteremia (a bacterial infection in the blood stream), type 2 diabetes mellitus (trouble controlling blood sugar), congestive heart failure (condition where heart does not pump blood like it should), acute osteomyelitis (bone infection) of left ankle and foot, and non-pressure chronic ulcer (ulcer caused by poor circulation); - Orders for daptomycin (an antibiotic) reconstituted solution 350 mg, inject 615 mg intravenously (IV) every 24 hours for 42 days, dated 04/02/24; - PICC dressing change weekly on Wednesday, dated 04/10/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PICC line information card showed PICC line is in the right basilic vein, 40 centimeters (cm) long with arm circumference to 41 cm. Observation of the resident's PICC line showed: - On 04/30/24 at 11:28 A.M., PICC line to right upper arm; - On 05/01/24 at 3:24 P.M., the PICC line dressing dated 04/24/24 with some blood around the catheter site; - On 05/02/24 at 2:17 P.M., LPN M attempting to flush resident #444's line with major difficulty. The PICC line was pulled out approximately three centimeters, appeared kinked, and was unclamped; - On 05/02/24 at 3:02 P.M., the PICC line had a dried blood ring around the catheter approximately three centimeters from the insertion site. During interviews, Resident #444 said: - On 05/01/24 at 3:24 P.M., the antibiotics infuse without difficulty and the PICC line flushes fine; - On 05/02/24 at 3:02 P.M., LPN M flushed it this morning since the PICC looked like it may not flush right, and that it flushed sluggish and in a difficult manner. The catheter looks farther out than yesterday and he/she was hoping it would still work; - On 05/03/24 at 8:35 A.M., they came and put a new PICC line in last night. During an interview on 05/02/24 at 2:17 P.M., in the presence of the Director of Nursing (DON), LPN M said the night nurse did the dressing change yesterday and accidentally pulled the line part of the way out. They may have to contact the PICC line company to come look at it. They flushed the line earlier, and the line appeared to be farther out of placement than yesterday. During an interview on 05/03/24 at 8:30 A.M., LPN M said the PICC line company came last night around 9:00 P.M. and changed the PICC line. During an interview on 05/07/24 at 5:05 P.M., the Administrator and Director of Operations said they would expect a registered nurse to complete PICC line dressing changes. They said it should be flushed and cared for according to the physician orders. They said after the infusions are completed they should be disconnected from the line. They said their staff should not attempt to reinsert the PICC catheter if it were to become displaced.

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Cori Manor Healthcare & Rehabilitation Center	560 Corisande Hills Road Fenton, MO 63026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47447 Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day, seven days a week. This deficiency had the potential to affect all residents. The facility census was 92. The facility did not provide a RN coverage policy. Review of the nursing schedules for February 1, 2024 through April 30, 2024, showed: - No RN scheduled for 02/17/24; - No RN scheduled for 03/02/24; 03/03/24; 03/16/24; 03/17/24; 03/30/24; 03/31/24; - No RN scheduled for 04/13/24; 04/14/24; 04/27/24; 04/28/24; - No RN scheduled for 11 days out of 90 days. During an interview on 05/07/24 at 5:16 p.m., the Administrator said she would expect the facility to have RN coverage for at least eight hours a day for seven days a week.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47447 Based on observation and interview, the facility staff failed to post the required daily nurse staffing information which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, in a prominent location readily accessible to residents and visitors. The facility census was 92. Observations from 04/29/24 through 05/03/24 showed the required daily nurse staffing information not found near any of the nurse's stations or the main lobby where it would be easily visible to residents and visitors. During an interview on 05/03/24 at 9:20 A.M., Certified Nurse Aide (CNA) L said the daily nurse staffing information was posted in the nurse's office behind the nurse's station, and that it is not accessible to residents or visitors. During an interview on 05/07/24 at 5:20 P.M., the Administrator said she would expect facility staffing to be posted in a prominent location that is readily accessible to residents and visitors.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555 Based on observation and interview, the facility failed to repair the convection oven, stove top burners, flat top grill, and oven. This had the potential to affect all residents. The facility failed to ensure outside food stored in residents' personal refrigerators was stored at least 40 degrees or below, failed to ensure expired foods were thrown away and refrigerators were cleaned regularly. This deficient practice affected three residents (Resident #64, #69, and #444) out of 19 sampled residents and one resident (Resident #43) outside the sample and had the potential to affect all residents with personal refrigerators. The facility census was 92. Review of the facility's policy titled, Foods Brought by Family/Visitors undated, showed food brought by family/visitors that is left with the resident to consume later will be labeled and dated with a use by date and stored in a manner that is clearly distinguishable from facility-prepared food. Perishable foods must be stored in a re-sealable container with a tight-fitting lid in a refrigerator below 40 degrees. Containers will be labeled with the resident's name, the item and with the use by date (three days after being prepared). The nursing staff/or food service staff will discard food on or before the package expiration date. The nursing or food service staff will discard any foods prepared for the resident that show obvious signs of potential food-borne danger {for example mold growth, foul odor, and past expiration dates). 1. The facility did not provide a kitchen equipment repair policy. Observations on [DATE] at 10:52 A.M. of the facility flat top grill and oven showed: - A wooden block holding up the left front side of the stove; - Rust covering the inside of the oven; - Rust colored debris on the sides of the outside of the stove; - A knob missing off the front of the stove; - Debris built up on the front and around the knobs of the stove. Observations on [DATE] at 10:54 A.M. of the facility convection oven showed: - Debris on the top of the oven; - Rust around the hinges and sides of the doors; - Black carbon and debris build up throughout the inside of the oven. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 4:05 P.M., the Dietary Manager (DM) said the flat top stove's oven doesn't work and only half of the flat top works. Only two out of six of the burners on the regular top stove work and the side panels on the convection oven do not work, causing the convection oven to cook unevenly. He/She was told the convection oven is old and the parts to fix it are obsolete. He/She has let administration know the appliances are not in working order; however, they have failed to fix or replace them. It slows the process of getting the meals cooked and makes it challenging on the dietary staff to complete their job. During an interview on [DATE] at 10:47 A.M., Cook B said he/she feels equipment slows the cooking process down and inhibits their ability to be efficient with preparing the meals. The convection oven cooks unevenly. There was some part that broke, but he/she was told it's old and the parts needed to fix it are unavailable, so the only way to fix it is to buy a new one. Only half of the cook top works and only two stove burners work. The other ovens don't work, and it makes it challenging to prepare the meals in an efficient manner. During an interview on [DATE] at 11:57 A.M., Cook C said the flat top oven doesn't work and only the left half of the flat top cooking surface works. Only the front left burner and back right burner works out of the six stop top burners. The oven doesn't really work either due to it cooking too hot from the bottom and always burning everything. Because of that, they are unable to use it. The convection oven has broken parts where it won't circulate the heat correctly, so it cooks unevenly. It is a major issue trying to cook the meals at correct temperatures and makes it difficult to get the meals completed in a timely manner. During an interview on [DATE] at 5:05 P.M., the Administrator and the Director of Operations said they would expect all equipment to be maintained in working order and free from carbon build up and debris. 2. Observation on [DATE] at 3:10 P.M. of Resident #64's personal refrigerator showed: - Two strawberry peach applesauce six count packs, dated [DATE]; - A 24 count package of string cheese, expired [DATE]; - Leftover food from a fast food restaurant, undated and unlabeled. During interviews, Resident #64 said: - On [DATE] at 03:10 P.M., the food from the fast food restaurant was a little over a week old; - On [DATE] at 02:15 P.M., no one checks his/her fridge for expired food, checks the temperature, or cleans it. Observation of Resident #69's personal refrigerator showed: - On [DATE] at 12:16 P.M., an open, uncovered vanilla pudding container with whipped topping and cookie on top; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On [DATE] at 3:26 P.M., an open, uncovered vanilla pudding container with whipped topping and cookie on top; - On [DATE] at 3:09 P.M., an open, uncovered vanilla pudding container with whipped topping and cookie on top; - On [DATE] at 2:30 P.M., an open, uncovered vanilla pudding container with whipped topping and cookie on top. Observation of Resident #444's personal refrigerator showed: - On [DATE] at 11:28 A.M., a sandwich, hard to the touch, wrapped and dated ,d+[DATE]; - On [DATE] at 3:24 P.M., a sandwich, hard to the touch, wrapped and dated ,d+[DATE]; - On [DATE] at 3:08 P.M., a sandwich, hard to the touch, wrapped and dated ,d+[DATE] and a second sandwich dated ,d+[DATE]; - On [DATE] at 2:29 P.M., a sandwich, hard to the touch, wrapped and dated ,d+[DATE] and a second sandwich dated ,d+[DATE]. During an interview on [DATE] at 11:28 A.M., Resident #444 said no one checks his/her fridge for expired food, checks the temperature, or cleans it. During an interview on [DATE] at 10:59 A.M., the Dietary Manager (DM) said dietary staff does not check resident refrigerators. The DM said he/she believed it was either housekeeping or the maintenance man's responsibility. During an interview on [DATE] at 11:06 A.M., Housekeeper A said they do not have thermometers in the resident refrigerators, but from time to time they will open them to make sure they appear cold and working. There is not a specific process in place or schedule for checking the temperatures, cleaning them, and throwing out expired food. If a resident tells them they want their refrigerator cleaned, then they will clean them. During an interview on [DATE] at 2:19 P.M., Resident #43 said no one checks his/her fridge for expired food, checks the temperature, or cleans it. During an interview on [DATE] at 2:22 P.M., the Director of Nursing (DON) said housekeeping is responsible for checking temperatures, checking for expired foods, and cleaning resident refrigerators. During an interview on [DATE] at 5:05 P.M., the Administrator and Director of Operations said housekeeping is responsible for checking temperatures, checking for expired foods, and cleaning resident refrigerators. They should be checking them daily.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46460 Based on interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement Plan (QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved.) The facility census was 92. Review of the facility's policy, Quality Assurance and Performance Improvement Program, revised February 2020, showed: - The QAPI committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee; - The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include tracking and measuring performance, establishing goals and thresholds for performance measurement, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities, and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed; - The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan; - The QAPI plan is presented to the state agency annually during the recertification survey, and as requested during any other survey or by Centers for Medicare & Medicaid Services (CMS); - The QAPI coordinator manages QAPI committee activities and changes to the QAPI plan; - The QAPI coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessment methodologies and documentation, and in making adjustments to the plan. The facility provided QAPI policies, but did not have a QAPI plan in place. During an interview on 05/01/24 at 1:36 P.M., the Administrator said they are starting fresh with QAPI; they couldn't find any past documentation. They have no PIPs in place, but they plan on having weekly QAPI meetings.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46460 Based on interview and record review, the facility failed to ensure the Quality Assurance Performance Improvement (QAPI) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The facility census was 92. Review of the facility's policy, Quality Assurance and Performance Improvement Program, revised February 2020, showed: - This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents; - The administrator is responsible for assuring that this facility's QAPI program complies with federal, state, and local regulatory agency requirements; - The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include tracking and measuring performance, establishing goals and thresholds for performance measurement, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities, and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed; - The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan; - The QAPI plan is presented to the state agency annually during the recertification survey, and as requested during any other survey or by Centers for Medicare & Medicaid Services (CMS). Review of the facility's Quality Assurance and Performance Improvement Program - Governance and Leadership policy, revised March 2020, showed: - The quality assurance and performance improvement program is overseen and implemented by the QAPI committee, which reports its finding, actions, and results to the administrator and governing body; - The administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program; - The governing body is responsible for ensuring that the QAPI program is implemented and maintained to address identified priorities; is sustained through transitions of leadership and staffing; is based on data, resident and staff input, and other information that measures performance; and focuses on problems and opportunities that reflect processes, functions, and services provided to the residents; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The following individuals serve on the committee: Administrator, or a designee who is in a leadership role; Director of Nursing Services; Medical Director; Infection Preventionist; and representatives of the following departments, as requested by the Administrator: Pharmacy, Social Services, Activity Services, Environmental Services, Human Resources, and Medical Records; - The committee meets at least quarterly (or more often as necessary); - The responsibilities of the QAPI committee are to collect and analyze performance indicator data and other information. Review of the facility's QAPI committee notes showed: - An Inservice Log with the topic QAPI/5 Star provided by the Administrator, dated 04/26/24, showed no evidence of the Medical Director, Director of Nursing, or Infection Preventionist attending the meeting; - No Performance Improvement Projects (PIPs) in place. During an interview on 05/01/24 at 1:36 P.M., the Administrator said they are starting fresh with QAPI; they couldn't find any past documentation of QAPI. They recently had a meeting. They have no PIPs in place, but they plan on having weekly QAPI meetings.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46460 Based on interview and record review, the facility failed to maintain quarterly Quality Assurance and Improvement Program (QAPI) committee meetings with the required members. The facility census was 92. Review of the facility's Quality Assurance and Performance Improvement Program - Governance and Leadership policy, revised March 2020, showed: - The quality assurance and performance improvement program is overseen and implemented by the QAPI committee, which reports its finding, actions, and results to the administrator and governing body; - The administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program; - The governing body is responsible for ensuring that the QAPI program is implemented and maintained to address identified priorities; is sustained through transitions of leadership and staffing; is based on data, resident and staff input, and other information that measures performance; and focuses on problems and opportunities that reflect processes, functions, and services provided to the residents; - The following individuals serve on the committee: Administrator, or a designee who is in a leadership role; Director of Nursing Services; Medical Director; Infection Preventionist; and representatives of the following departments, as requested by the Administrator: Pharmacy, Social Services, Activity Services, Environmental Services, Human Resources, and Medical Records; - The committee meets at least quarterly (or more often as necessary). Review of an Inservice Log with the topic QAPI/5 Star provided by the Administrator, dated 04/26/24, showed no evidence of the Medical Director, Director of Nursing, or Infection Preventionist attending the meeting. During an interview on 05/01/24 at 1:36 P.M., the Administrator said they are starting fresh with QAPI. They couldn't find documentation of past QAPI meetings, but they recently had a meeting. They have no Performance Improvement Projects (PIPs) in place, but they plan on having weekly QAPI meetings. During an interview on 05/07/24 at 5:10 P.M., the Administrator and Director of Operations said they would expect the facility to have QAPI meetings at least quarterly with the required members present.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, interview, and record review, the facility failed to screen four residents (Resident #4, #11, #69, and #444) out of five sampled residents for Tuberculosis (TB - a communicable disease that affects the lungs characterized by fever, cough and difficulty breathing.) The facility's census was 92. 1. Review of the facility's policy, Screening Residents for Tuberculosis, revised August 2019, showed: - This facility shall screen all residents for tuberculosis infection and disease; - The admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB; - If a potential resident has been exposed to active TB or is at increased risk of TB infection, he or she will be screened for latent tuberculosis infection (LTBI) using tuberculin skin tests (TS) or interferon gamma release assay (IGRA); - Screening of new admissions or readmissions for tuberculosis infection and disease is in compliance with state regulations; - The facility will conduct an annual risk assessment to determine risk of exposure; - Residents who have risk factors for exposure to active TB are retested for LTBI and symptoms of active TB; - Residents who have health conditions or take medications that predispose them to developing active TB disease once infected are tested regularly according to their exposure risk assessment. These conditions include human immunodeficiency virus (HIV - a virus that attacks the body's immune system), substance abuse, silicosis (a lung disease caused by breathing in tiny bits of silica), diabetes (group of diseases that result in too much sugar in the blood), kidney disease, low body weight, organ transplants, head and neck cancer, treatment with corticosteroids (a type of anti-inflammatory drug) and/or certain treatments for rheumatoid arthritis (chronic autoimmune inflammatory disorder where the body attacks its own healthy cells, usually affecting small joints in the hands and feet) or Crohn's disease (a chronic inflammatory bowel disease that affects the lining of the digestive tract). Review of Resident #4's medical record showed: - admitted [DATE]; - Annual TB test given on left forearm on 02/20/24, with no read date; - No documentation of TB testing or screening. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's medical record showed: - admitted [DATE]; - Last annual screening completed on 01/19/23; - No documentation of annual TB testing or screening since. Review of Resident #69's medical record showed: - admitted [DATE]; - Last annual screening completed on 01/19/23; - No documentation of annual TB testing or screening since. Review of Resident #444's medical record showed: - admitted [DATE]; - Last annual screening completed on 01/19/23; - No documentation of annual TB testing or screening since. 49152

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 47678 Based on observation and interview, the facility failed to provide a dining room large enough to accommodate the residents. This affected one resident (Resident #14) out of 19 sampled residents and three residents (Resident #26, #28, and #84) outside the sample and had the potential to affect all residents. The facility census was 92. The facility did not provide a dining room policy. 1. Observation on 04/30/24 at 12:29 P.M. of the main dining room showed: - 11 round tables with room for four chairs at each table; - Total of 44 seating places to dine; - One table with five residents. 2. Observation on 05/01/24 at 12:56 P.M. showed an unknown staff member squeezing between tables bumping two residents' chairs while they were eating. 3. Observation of the assisted dining room on 05/02/24 at 12:11 P.M. showed: - 21 seating places for residents and staff to assist with dining in the assisted dining room; - A total of 65 seating places in the two dining rooms. During an interview on 04/30/24 at 12:31 P.M., Resident #14 said he/she gets food and takes it back to his/her room because the dining room is packed like a can of sardines. During an interview on 04/30/24 at 2:58 P.M., Resident #84 said the dining room is too full. Some residents have to leave and come back when there is a seat available. During an interview on 05/02/24 at 10:10 A.M., Resident #28 said residents cannot choose where to sit. The Administrator said residents in wheelchairs have to go to one side of the dining room. During an interview on 05/02/24 at 10:30 A.M., Resident #26 said the dining room is overcrowded and it is frustrating that the other residents do not have a place to sit. The facility used to have another dining room before, where the therapy room is now. During an interview on 05/07/24 at 5:30 P.M., the Director of Operations said residents can eat in either dining room, residents in wheelchairs can be transferred to a regular chair, and she would expect staff to be able to pass trays without bumping into residents while they are eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265395	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cori Manor Healthcare & Rehabilitation Center	560 Corisande Hills Road Fenton, MO 63026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39360 Based on observation and interview, the facility failed to provide a safe and functional environment for the residents by allowing items to be stored on top of overbed light fixtures for residents in three rooms. Storing items on the overbed light creates a hazard of the items falling on the resident below, and does not utilize the light fixtures as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 92. The facility did not provide a policy for overbed lighting safety. Review of the Receipt of Facility Rules and Regulations, included in the facility's admission packet, showed residents are not allowed to store personal items, including clothing, on the heater/air conditioner unit or the overhead light fixture. This is considered a safety hazard. 1. Observation of room [ROOM NUMBER], bed two, showed: - On 04/30/24 at 3:10 P.M., three stuffed animals on the light over the bed; - On 05/01/24 at 9:40 A.M., three stuffed animals on the light over the bed. 2. Observation of room [ROOM NUMBER], bed two, showed: - On 04/30/24 at 11:12 A.M., two heart-shaped crafts hanging on the light over the bed; - On 05/01/24 at 9:42 A.M., two heart-shaped crafts hanging on the light over the bed. 3. Observation of room [ROOM NUMBER], bed two, showed: - On 04/30/24 at 12:23 P.M., a stuffed animal on the light over the bed; - On 05/01/24 at 9:42 A.M., a stuffed animal on the light over the bed. 4. Observation on 04/30/24 at 11:22 A.M. of room [ROOM NUMBER], bed two, showed a white stuffed animal and hat on the light over the bed. 5. Observation on 04/30/24 at 2:24 P.M. of room [ROOM NUMBER], bed one, showed a stuffed frog on the light over the bed. During an interview on 05/07/24 at 5:10 P.M., the Administrator and Director of Operations said items should not be placed on the light fixtures due to a possible fire hazard.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47447 Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year. This affected two out of two sampled Certified Nurse Assistants (CNA) D and E. The facility's census was 92. 1. Record review of CNA D's in-service record showed: - A hire date of 04/10/19; - A total of one hour of annual in-service training for April 2023 through April 2024; - Less than twelve hours of in-service education for April 2023 through April 2024. 2. Record review of CNA E's in-service record showed: - A hire date of 03/11/19; - A total of four hours of annual in-service training for April 2023 through April 2024; - Less than twelve hours of in-service education for April 2023 through April 2024. During an interview on 05/07/24 at 5:16 p.m., the Administrator said she would expect CNAs to have at least 12 hours of in-service education per year. The facility did not provide an in-service training policy.