STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265406	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Oaks Caring Center	1310 Hovis Street Mountain Grove, MO 65711

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on interview and record review, the facility failed to issue accurate and fully completed Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) to one resident (Resident #49) of three sampled residents reviewed for beneficiary notice. The facility census was 67. Review of Resident #49's electronic medical record (EMR) Census tab showed an admitted [DATE] for Medicare A services. Review of a document titled, Beneficiary Notice - Residents discharged Within the Last Six Months, completed by the facility and listing the residents who had been discharged from skilled services, showed the following: -The resident received an SNFABN on 08/13/24. -The resident chose Option One, I want the care listed above. I want Medicare to be billed for an official decision on payment which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on MSN. -The form did not document the reason why Medicare might not pay and the estimated cost. During an interview on 01/10/25, at 11:46 A.M., Certified Medical Technician (CMT) 1 said the following: -When the Social Services Director (SSD) did insurance verification, if she did not put the amount in there, the CMT had to go and figure out the amount, and usually didn't get it on the SNFABN. The CMT said he/she explains that if they meet the criteria, they won't have to pay, and he/she verbally gives them the cost per day if they want to continue. During an interview on 01/10/25, at 10:44 A.M., with the Administrator, Director of Nursing, and Regional Nurse Consultant, the Administrator said her expectations were for staff to have the form filled out with all information, so residents would know the cost for services.

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview and record review, the facility failed to refer one resident (Resident #4) of two sampled residents for a Pre-Admission Screening and Resident Review (PASARR) Level Two evaluation after the resident was diagnosed with a serious mental illness (SMI). The facility census was 67. Review of the facility's policy titled, Admission Criteria, revised March 2019, showed all new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid PASARR process. The policy did not address the process when a new serious mental illness diagnosis is given to a resident. Review of Resident #4's Admission Record, undated, located in the resident's electronic medical record (EMR) under the Profile tab, showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included bipolar disorder (mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function) in partial remission. Review of the resident's Physician Order, dated 07/17/24, and located in the resident's EMR under the Orders tab, showed an order for Seroquel (an antipsychotic medication) 200 milligram (mg) by mouth two times a day for bipolar disorder, anxiety disorder, and depression. Review of the resident's Level One Nursing Facility PASARR, dated 12/31/21, and located in the resident's EMR under the Documents tab, showed the following: -For question two Does the individual have a current, suspected, or history of a Major Mental Illness [MMI] as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition, staff did not mark any mental illnesses. The level one screening was negative for a level two evaluation. During an interview on 01/09/25, at 10:55 A.M., the Minimum Data Set Coordinator (MDSC) said she was responsible for all PASARRs. The MDSC reviewed the resident's PASARR Level One, dated 12/31/21, and verified no mental illnesses were identified. When reviewing the resident's physician orders and diagnoses, the MDSC verified the resident received an antipsychotic medication for the SMI of bipolar disorder. She did not submit a level two PASARR and should have once the diagnosis was added. During an interview on 01/10/25, at 3:14 P.M., the Administrator said it was her expectation a significant change for a PASARR Level Two evaluation would have been submitted when the resident received the diagnosis of bipolar disorder.

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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** 30622 Based on observation, interview, and record review, the facility failed to ensure residents and their representatives were invited to the care plan meeting and failed to ensure the full Interdisciplinary Team (IDT) participated in the care conferences for one resident (Resident #11) of three sampled residents reviewed for care planning. The facility census was 67. Review of the facility's policy titled, Care plans, Comprehensive Person-Centered, dated March 2022, showed the following: -The 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; -If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process; -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident; -The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being; -Care plan interventions are chosen only after data gathering, proper sequencing of events, care consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' conditions change; -The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition and when the resident has been readmitted to the facility from a hospital stay. Review of Resident #11's Admission Record, located in the electronic medical record (EMR) located under the Profile tab, showed the following: -admitted [DATE]; -Diagnoses included vascular dementia, moderate with anxiety, high blood pressure, anxiety disorder, and hemiplegia (paralysis that affects only one side of the body). (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 Conference Summary, provided by the facility and dated 04/11/24, showed the Social Services Director (SSD), Activity Director (AD) and Minimum Data Set Coordinator (MDSC) were the only IDT members in attendance. The resident and/or her representative were not in attendance. Review of the resident's Care Plan Conference Summary, provided by the facility and dated 10/02/24, showed the IDT members in attendance were the MDSC and the Dietary Manager (DM). Staff did not document if the resident or his/her representative were invited. During an interview on 01/07/25, at 2:39 P.M., Family Member (FM) 1 said he/she attended two or three care plan meetings in the four years the resident had lived in the facility. He/she and his/her sibling had not received any notifications inviting them to the quarterly care plan meetings. During an interview on 01/09/25, at 6:09 P.M., the MDSC said Human Resource (HR) 2 was responsible for notifying the families when a care plan meeting was scheduled. The notification was supposed to be sent out with the monthly statements. The SSD, MDSC, DM, and AD attended the meetings. The physician would occasionally participate in the meetings. The meeting attendees signed the care plan conference summary and it was scanned into the EMR. She provided HR 2 with a list of care plan meetings that were due each month. He/she confirmed the resident and/or representative were not in attendance at the care plan meetings. During an interview on 01/09/25, at 6:15 P.M., the SSD said she mailed a letter to the family member or public administrator (PA) based on the schedule the MDSC provided. She did not send them by certified mail or keep a tracking log to document when the letters were mailed. During an interview on 01/10/25, at 10:27 A.M., FM 2 said he/she was only aware of two care plan meetings happening since the resident was admitted to the facility. He/she had not received notices in the mail with the monthly statements about when the care conferences were going to be scheduled During an interview on 01/10/25, at 10:24 A.M., the SSD stated the following staff members composed the facility IDT team: SSD, MDS, AD, and DM. During an interview on 01/10/25 at 2:30 PM, the Administrator stated the following members were invited to the care plan meetings: SSD, AD, DM, MDS, the residents and/or their representatives. She stated the physician was invited along with the Director of Nursing, floor nurse, and an aide. Most of the time the nurse and aides did not attend. Family members and PAs who did not attend were updated via phone. 36898

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on observation, interview, and record review, the facility failed to ensure resident pressure ulcer care and preventions was provided per standards of practice, when the facility failed to consistently assess and document full assessments of a pressure ulcer, failed to care plan and implement preventative measures related to pressure ulcer development, and failed to ensure the wound care provider was notified and provided care for the a known pressure ulcer, for one resident (Resident #4). The facility also failed to accurately document regarding a pressure ulcer and provide ordered pressure reducing interventions for one resident (Resident #31). The facility census was 67. Review of the facility's policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised March 2014, showed the following: -The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss and a history of pressure ulcer(s); -In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; and current treatments, including support surfaces; -The physician will authorize pertinent orders related to wound treatments, including wound cleansing an debridement approaches, dressing, and application of topical agents if indicated for type of skin alteration; -The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. 1. Review of Resident #4's Admission Record, undated, located in the resident's EMR under the Profile tab, showed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Review of the resident's Admission Nursing Evaluation, dated 12/05/23 and provided by the facility, showed the following: -Bruise to left abdomen skin fold, excoriated; -Scab to right great toe; -Abrasion to second and third toe on left foot; -Reddened area to left buttock. (Staff did not document any pressure ulcers upon admission to the facility.) (continued on next page)

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	265406	A. Building B. Wing	01/10/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) with an Assessment Reference Date (ARD) of 12/06/24, located in the resident's EMR under the MDS tab, showed the following: -Resident was moderately cognitively impaired; -Resident at risk for developing pressure ulcers, had unhealed pressure ulcers, and had a stage three pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible). Review of the resident's current care plan showed no care planned interventions of pressure reducing devices or other interventions to prevent pressure ulcer development. Review of the resident's physician Wound Care Visit Report, progress notes provided by the facility, showed the following: -On 07/03/24, wound #7 of right, posterior thigh was a stage 3 pressure injury pressure ulcer and has received a status of not healed. The initial wound encounter measurements were 2.5 centimeters (cm) x 1.6 cm x 0.1 cm. -On 08/01/24, wound #7 of right, posterior this was a stage 3 pressure injury and had received an outcome of resolved. Review of the resident's Skin Assessments, provided by the facility, dated 08/08/24, showed pressure ulcer to right posterior thigh, stage 3, full thickness, measured 0.5 x.0.5 x 0.1. Review of the resident's physician Wound Care Visit Report, progress notes provided by the facility, dated 09/05/24, showed wound #7 of right, posterior thigh was a stage 3 pressure injury pressure ulcer and had received a status of not healed. Measurements were 0.5 cm x 0.5 cm. x 0.1. Review of the resident's Skin Assessments, provided by the facility, showed the following: -On 09/05/24, an open lesion (other than ulcers, rashes, and cuts),to upper right thigh; -On 12/19/24, diabetic foot ulcer toes, left great and second right, other skin issue, open area, right posterior thigh measured 0.6 x 0.8; -On 01/02/25, pressure ulcer/Injury, right thigh, measured 0.8 cm x 1.5 cm. Review of the facility records showed no documentation of Wound Care Visit Reports between 09/05/24 through 01/09/25. Review of the resident's physician Wound Care Visit Report, progress notes provided by the facility, dated 01/09/25, showed the resident had a stage three pressure injury to his/her right posterior thigh. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/08/25, at 12:06 P.M., the resident said he/she developed a pressure ulcer over the past year. When asked if the facility had attempted to get him/her to use any pressure-reducing devices to help offload, the resident said the facility had not offered any type of devices to assist him/her; however, they did sometimes ask him/her to turn over on his/her side for a while. The resident said it was hard for him/her to stay in that position long. During an interview on 01/08/25, at 3:55 P.M., the Director of Nursing (DON) said the last time the resident was seen by the wound care provider was back in September 2024 for his/her toe. When asked if there was any documented evidence the wound care provider had been made aware of the open area on the resident's right thigh, the DON said the provider had not been made aware. The DON said facility nurses did not stage wounds and it was her expectation as soon as the nursing staff became aware the pressure had reopened, the resident would have been added to the list to see the Wound Nurse Practitioner (WNP). During an interview on 01/09/25, at 11:00 A.M., the Wound Nurse Practitioner (WNP) said he/she observed the resident today for the first time since September 2024 after being notified the resident had an open area on the right posterior thigh. The wound was a stage three and was a recurring problem for this resident. The WNP said he/she gave new wound care orders to the facility today. During an interview on 01/09/25, at 1:05 P.M., Registered Nurse (RN) 2 said he/she was currently the facility's wound care nurse. The resident did currently have an open area to his/her right thigh area. To his/her knowledge the resident never had a stage three pressure ulcer. For residents with stage three or above pressure ulcers the facility usually ordered a low air loss mattress. Observation on 01/09/25, at 2:08 P.M., with Licensed Practical Nurse (LPN) 1 and the DON showed the resident's right posterior thigh had a stage three wound with a pink wound bed and no drainage. During an interview on 01/09/25, at 2:14 P.M., Nursing Assistant Student (NA) 1 said to his/her knowledge there were no interventions of pressure relieving and/or pressure reducing devices in place for the resident. During an interview on 01/09/25, at 3:34 P.M., the DON said the resident's care plan did not include, and had not included, interventions of any pressure reducing and/or pressure relieving devices. The DON also said after reviewing the resident's medical records, including the nursing skin assessments, he/she could not identify when the resident's stage three pressure ulcer reopened. During an interview on 01/10/25, at 2:32 P.M., the WNP said 01/09/25 was the first time he/she had written an order for the resident's pressure ulcer since being resolved in September 2024. Anytime there was an active wound, there was usually a standing order for offloading weight, pressure reducing and pressure relieving devices would have been beneficial to promote healing if the resident was compliant with the interventions. During an interview on 01/10/25, at 3:14 P.M., the Administrator said it was her expectation nursing staff would have correctly documented what they assessed. When the nurse discovered the resident's stage three pressure had reopened, it was her expectation the resident would have been put on the list to be seen by the wound care provider on their next visit to the facility and if needed notify the wound care provider to obtain orders. (continued on next page)

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	265406	A. Building B. Wing	01/10/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #31's Admission Record, located under the Resident tab in the EMR, showed the following: -admitted [DATE]; -Diagnoses included Parkinson's disease without dyskinesia (a term for a group of movement disorders that cause involuntary muscle movements). Review of the resident's hospice Physician Orders, dated 11/12/24, located in the paper hospice chart, showed the resident should have bolsters for roll control and mattress low air loss. Review of the resident's significant change MDS, located under the Resident tab of the EMR with an ARD of 11/20/24, showed the following: -The resident was moderately cognitively impaired; -Staff did not indicate the resident had a pressure ulcer. Review of the hospice contract, signed 11/27/24 and provided by the facility, showed hospice was responsible for providing the facility with a low air loss mattress and bolster rolls. Review of the resident's Physician Orders, dated 12/12/24, located under the Orders tab of the EMR, showed an order for air mattress with bolster cover to bed with alternating air for decline and to help with skin condition and comfort. (One month after hospice notes showed the air mattress should be in place.) Review of the resident's care plan, dated 11/01/24, and located under the Resident tab of the EMR, showed the following: -Resident at for impaired skin integrity and pressure ulcers; -On 12/12/24, air mattress in place; -On 12/23/24, resident had wound to left inner elbow. Staff to position resident to reduce causes of friction or shear. Review of the resident's progress notes showed staff did not document regarding the new wound to the resident's left inner elbow. Review of the resident's skin assessment sheet, dated 12/25/24 and located under the Assessments tab of the EMR, showed the had a skin tear on the left elbow. Review of the resident's Physician Progress Note, dated 01/02/25, provided by the facility, showed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound#1 to left elbow was an unstageable pressure injury (obscured full thickness skin and tissue loss pressure ulcer) and had received a status of not healed. The initial wound encounter measurements were 1. 8 cm length, x 2.3 cm width, with an area of 4.14 square cm. There was a moderate amount of serosanguineous (contains or relates to both blood and the liquid part of blood (serum)) drainage noted. The wound bed was 76-100%, granulation tissue (pink-red moist tissue that fills an open wound, when it starts to heal) and 1-25% slough (non-viable tissue). The periwound texture was normal. The periwound skin color was normal. During a observation on 01/09/24, at 2:25 P.M., the resident had an unstageable wound on his/her left inner elbow. The wound bed was covered with eschar (dead or devitalized tissue that is hard or soft in texture). The resident was not on a low air loss mattress that was ordered on 12/12/24. During an interview and record review on 01/09/24, at 2:35 PM, Licensed Practical Nurse (LPN) 1 verified and confirmed the resident had an order for a low air loss mattress and he/she was not currently on one. He/she said the resident was on one in the past and was not sure why he/she was no longer on a low air loss mattress. The resident was currently only on a scoop mattress with bolsters. During an interview on 01/09/25, at 1:37 P.M., LPN 1 verified and confirmed the skin assessment documentation, dated 12/25/24, was incorrect. He/she said the resident did not have a skin tear. He/she had an unstageable wound on his/her left inner elbow. The resident had Parkinson's and shook a lot. His/her arm was rubbing against the arm of the wheelchair and hospice was going to provide sheepskin to pad the arm of the wheelchair. During interviews on 01/10/25, at 9:25 A.M. and 9:38 A.M., the Hospice Nurse said the following; -The resident had orders for a low air loss mattress and bolsters; -A low air loss mattress was delivered on 11/13/24 and was picked up on 11/18/24 at the facility's request. During an interview on 01/09/24, at 2:36 P.M., the DON said the resident should still be on a low air loss mattress, and she was not sure why he/she wasn't. During an interview on 01/09/24, at 2:37 P.M., the Assistant Director of Nursing (ADON) said she was not aware of the resident was no longer on a low air loss mattress. The hospice provider originally provided a low air loss mattress for the resident. During an interview and record review on 01/09/25, at 5:45 P.M., the Administrator verified and confirmed the hospice company was responsible for providing the low air loss mattress and bolsters for the resident. 30622

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview and record review, the facility failed to ensure the residents environment was free from accident hazards as possible and failed to ensure all residents that required supervision during food consumption were supervised for one resident (Resident #36), of five sampled residents, when staff left the resident, who had an ordered pureed diet and was care planned for supervision while eating, access to an non-resident use area with food, resulting in the resident attempting to consume non-pureed food, choking, and being intubated. The facility census was 67. The facility Administrator, Director of Nursing (DON), and Regional Nurse Consultant were informed on 01/07/25, at 7:05 P.M., the an Immediate Jeopardy (IJ) which began on 01/03/25. The IJ was removed on 01/08/25 as confirmed by surveyor onsite verification. Review of the facility's policy titled, Hazardous Areas, Devices, and Equipment, revised July 2017, showed the following: -All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible; -A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include but are not limited to the following open areas or items that should be locked when not in use; -Any element of the resident environment that has the potential to cause injury and that is a accessible to a vulnerable resident is considered hazardous; -Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, and cognitive abilities. Review of Resident #36's Admission Record, undated, located in the resident's electronic medical record (EMR) under the Profile tab showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included anoxic brain damage (occurs when brain lacks oxygen) and dysphagia (difficulty swallowing). Review of the resident's comprehensive care plan, located in the resident's EMR under the Care Plan tab, showed the following: -On 07/11/24, resident at risk for weight loss and dehydration, initiated 07/11/24; -On 07/11/24, provide supervision during meals; (continued on next page)

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	265406	A. Building B. Wing	01/10/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 07/22/24, resident intake of nutrients will meet metabolic needs. Review of the resident's Hospital Inpatient Discharge Summary, dated 11/20/24, and located in the resident's EMR under the Documents tab, showed the following: -The resident was admitted to the hospital on 11/18/24 with admitting diagnoses which included pneumonia; -Discharge diagnoses included altered mental status (AMS) from pneumonia, resolved; aspiration (accidental inhalation of food, liquid, or other material into the lungs) pneumonia, improved; elevated liver function test (LFTs), improving, likely from pneumonia; -The resident was experiencing increasing weakness and poor appetite for a few days. The resident reported not eating and drinking well and had complained of a headache. Scans revealed bi-basilar pneumonia (a type of pneumonia that affects the base of both lungs). -The resident needed to be on aspiration precautions and head of bed at 45 degrees during and after meals as well as a soft mechanical diet with nectar thickened liquids. Review of the resident's Physician Order, dated 12/16/24, showed regular diet of pureed texture with nectar/mildly thick consistency liquids. Review of the resident's quarterly Dietary Profile, dated 12/16/24, showed the following; -Current diet order was pureed; -Current texture of food was pureed; -Utensils included plate guard and nosey cup (a drinking cup with a cut-out for the nose that allows the user to drink without tilting their head back); -Resident at with partial assistance. Review of the resident's Nursing Progress Note, dated 01/03/25, and located in the resident's EMR under the Progress Notes tab, showed the resident was found standing in another resident's room unable to breathe. Staff performed the Heimlich maneuver and suction was completed. Resident's blood oxygen level was down to 67% (normal is 90% or above). Emergency medical service (EMS) arrived. Review of the resident's hospital Clinical Report, dated 01/03/25, and provided by the facility, showed the following: -Chief complaint airway obstruction. This started just prior to arrival. Resident brought into the emergency department at approximately 3:15 P.M. History from EMS said resident at nursing home and had a choking episode. The resident swallowed a whole piece of food when he/she should be on a liquid diet. EMS was called and performed the Heimlich on scene for multiple minutes noting food particulate in the patient's oropharynx (the middle part of the throat, behind the mouth); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265406	A. Building B. Wing	01/10/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident present with severe respiratory distress. The resident was completely obtunded (having a reduced level of consciousness or alertness) with agonal breathing (gasping), profoundly cyanotic (marked by or causing a bluish or purplish discoloration (as of the skin and mucous membranes) due to deficient oxygenation of the blood) with highly abnormal vital signs on monitor and diminishing oxygen level. -Resident was in peri-arrest (the period either just before or just after a full cardiac arrest). Resident had no visible oropharyngeal particulate. Auscultated (listened to) lungs with no air movement, but resident still attempting to breath. Resident was intubated (a medical procedure that involves inserting a flexible tube into the trachea, or windpipe, to keep the airway open). Food particulate noted in the glottis (middle region inside the larynx (voice box). Scooped food particulate as much as possible into the posterior oropharynx. -After ensuring airway safety, staff removed all food particles remaining in the oropharynx. Review of the resident's hospital Inpatient History and Physical, dated 01/03/25, and provided by the facility, showed the following: -Resident had history of aspiration pneumonia and was brought to the emergency department due to an episode of choking; -While waiting in the emergency department the resident went into respiratory arrest and there was an impacted food bolus found in the glottis; -Resident ended up needing to be intubated and ultimately food bolus was removed. During an interview on 01/07/24, at 2:02 P.M., Family Member (FM) 36 said he/she was the resident's legal guardian. The family member said he//she had never given permission for the facility to allow the resident to refuse his/her modified diet consistency. The resident was supposed to be supervised when he/she was eating food. One of the aide's ordered a pizza for him/herself and the resident ate a whole garlic knot where he/she sustained a choking incident and had to be transported to the hospital and undergo a procedure to remove food stuck in his/her throat. The resident could not swallow and would have to have a feeding tube put in. During an interview on 01/07/25, at 2:45 P.M., Certified Nursing Assistant (CNA) 1 said he/she was assigned to the resident on 01/03/25. He/she had ordered pizza and garlic knots and had it in the break room on the secured unit. He/she had to redirect the resident out of the break room a couple times because he/she came in and asked for pizza. CNA 1 said he/she left the break room to take residents to smoke outside and when she left the room, the resident and CNA 2 were still in the break room. While he/she was standing at the door watching the residents smoke, he/she was also looking back at the hall when he/she saw the resident walk out of the break room, clinched over with his/her mouth open like he/she was trying to cough something up. CNA 1 said he/she immediately went to the resident and attempted the Heimlich maneuver on him/her and called for a nurse's help over the walkie talkie. He/she was not successful with the Heimlich. He/she was aware the resident was on a puree diet and that the break room door was to be closed when no staff were in there. (continued on next page)

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	265406	A. Building B. Wing	01/10/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/07/25, at 3:03 P.M., CNA 2 said he/she was working on the resident's unit on 01/03/25. He/she had redirected the resident out of the break room many times because he/she was trying to get the pizza, after he/she and CNA 1 telling the resident he/she could not have it. CNA 2 said after CNA 1 left to take the smokers out, about a minute or two afterwards a call light was activated, and he/she went to answer the call light. CNA 2 said when he/she got up to leave the room, the resident said he/she was right behind him/her. However, the resident never left the break room and stayed in there with no staff. The CNA said he/she did not look back to ensure the resident left the room where the pizza and food items were left. He/she was aware the resident was on a pureed diet and he/she was also aware the room was to be locked anytime staff were not in there. During an interview on 01/07/25, at 4:37 P.M., the Director of Nursing (DON) said she was working on 01/03/25 when she heard a page come over the walkie talkie for a nurse to come to The Unit STAT (immediately). The DON finished the phone call with a family member and went to the unit where she observed the charge nurse performing the Heimlich maneuver on the resident. It was not successful, so she took over. The resident was sitting in a chair slumped over and his/her lips were blue. She picked the resident up out of the chair, stood him/her up and started performing the Heimlich maneuver. At that time 911 was called. She was able to get two very small pieces of food to come up and the resident started breathing. The DON said the resident's breathing was unlabored and his/her lips returned to normal color. The resident was drooling so a nurse suctioned his/her cheek and at that time the resident slumped back over, and his/her lips started turning purple again. The DON got him/her back up, did two blows to the upper back, and then started the Heimlich again where a piece of food the size of a quarter came out. The food was the consistency of wet bread. The DON said the resident accessed the unit kitchen (staff identified as staff break room). The door should never be unlocked nor should a resident ever be left in the room alone. It was her expectation staff would not eat food in front of the residents and that they would use the designated staff break room to eat their meals. Due to accessing when left attended the resident had to be intubated and will have to have a feeding tube and not be able to have food by mouth. During an interview on 01/10/25, at 2:59 P.M., the Medical Director said it was his/her expectation the resident would have been kept safe from choking. During an interview on 01/10/25, at 3:14 P.M., the Administrator said it was her expectation the CNAs would have followed the facility's policy and use the equipment provided such as self-closing and self-locking doors to keep residents safe. It was also her expectation staff would not have allowed the resident to access non-resident areas and to ensure items unsafe to the resident would have been kept out of the resident's reach. NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO00247487, MO00247670

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917 Based on interview, observation, and record review, the facility failed to provide care and services to maintain acceptable parameters of nutritional status, when staff failed to follow-up on and implement multiple weight loss interventions for one resident (Resident #2), of nine sampled residents reviewed for weight loss, who had a significant weight loss. The facility census was 67. 1. Review of Resident #2's Admission Record, located under the Profile tab of the electronic medical record (EMR), showed the resident admitted on [DATE]. Review of the resident's EMR Diagnosis tab showed the resident's diagnoses included schizoaffective disorder (chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression.), depression with anxiety, hypothyroidism (condition that happens when the thyroid gland doesn't make or release enough hormone into the bloodstream), and gastroesophageal reflux disease (GERD). 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 12/30/24, and located in the EMR under the MDS tab, showed the resident had moderately impaired cognition. Review of the resident's EMR Vitals tab showed on 09/26/24, the resident weighed 128.8 pounds (lbs). Review of the resident's Registered Dietician's (RD) progress note located under the Progress Notes tab of the EMR, dated 09/29/24, showed the following: -An initial nutrition/dietary note for the resident with estimated calorie needs = 1700 kcal (calories)/day and 59 gm (grams)/day of protein, health shakes with meals, a regular diet, regular texture, and thin consistency liquid. Review of the resident's physician's order, located under the Orders tab of the EMR, dated 10/03/24, showed an order for a regular diet and supplement liquid shake with every meal to prevent weight loss. Review of the resident's care plan, located under the Care Plan tab of the EMR, dated 10/08/24, showed the following; -The resident was at risk for weight loss and dehydration; -Interventions included adding chocolate health shakes, obtaining labs and diagnostics, offering meal or liquid food supplements, offer meal alternatives, provide snacks, and when the resident refuses or has difficulty with solid food, provide nutritious foods that can be taken from a cup or a mug where appropriate. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress note located under the Progress Notes tab of the EMR, dated 10/17/24, showed Certified Nursing Assistant (CNA) 1 documented the resident reported to him he/she was choking on his/her food and explained to him/her he/she was working on not choking and that he/she was afraid of choking on his/her medication. Review of the resident's medical record showed no document follow-up by the charge nurse or Director of Nursing (DON) regarding the resident's choking concerns. Review of the resident's progress note located under the Progress Notes tab of the EMR, dated 10/29/24, showed the resident requested a puree diet for one day and then requested return to a regular diet. Review of the resident's progress note located under the Progress Notes tab of the EMR, dated 11/14/24, showed the Clinical Nurse Practitioner (CNP) 1 documented the following: -The resident reported having difficulty eating his/her food throughout the day due to a choking problem. -The resident struggled to consume his/her meals and tried a pureed diet for one day. He/she preferred softer foods. -The resident's difficulty eating due to a choking problem was a significant concern and his/her attempt at a pureed diet and preference for softer foods would be considered in developing a nutrition plan. -The resident's difficulty swallowing and choking on food, leading to reduced food intake and recommended a consultation with a speech therapist to evaluate swallowing function or dietitian for recommended appropriate dietary modification. Review of the resident's medical record showed staff did not document regarding follow-up on the CNP's recommendations related to the resident's choking and difficulty eating. Review of the resident's progress note located under the Progress Notes tab of the EMR, dated 11/21/24, showed Registered Nurse (RN) 3 documented the resident had obvious or likely cavity or broken natural teeth. Review of the resident's medical record showed staff did not document regarding follow-up due to the dental issues noted on 11/21/24. Review of the resident's progress note, located under the Progress Notes tab of the EMR, dated 12/24/24, showed the Medical Director (MD) documented a recommendation for the psych doctor to consider changing the medication order for Topamax (an anticonvulsant) that could contribute to weight loss. Review of the resident's medical record showed staff did not document regarding follow-up on the MD's recommendations regarding the resident's Topamax. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes, located under the Progress Notes tab of the EMR, dated 12/29/24, showed the RD documented the resident's weight decreased 10.6% in 90 days and recommended staff request an appetite enhancing medication from the physician. Review of the resident's medical record showed staff did not document regarding follow-up on the RD's recommendation regarding an appetite enhancing medication. Review of the resident's EMR Vitals tab showed on 01/06/25, the resident weighed 106.6. lbs (a loss of 22.2 lbs or 17 percent.) Observation on 01/08/25, at 12:28 P.M., showed the resident was in his/her room with his/her lunch tray on the bedside table. It appeared the resident did not eat any of the meal. Observation on 01/09/25, at 12:43 P.M., showed the resident was in his/her room with his/her lunch tray on bedside table. It appeared the resident did not eat any of the meal. During an observation on 01/10/25, at 12:16 P.M., the resident was in his/her room and had not received his/her lunch tray. When asked if he/she wanted to eat lunch, the resident said yes and stood unassisted and walked to the dining room. The Assistant Director of Nursing (ADON) seated the resident and the resident told the ADON he/she wanted some cottage cheese. Approximately five minutes later, the ADON brought the resident a full plate of regular diet of chopped meat patty, mashed potatoes and gravy, and green peas. The ADON was reminded the resident wanted a dish of cottage cheese. Approximately three minutes later, the ADON served the resident a small bowl of cottage cheese. The resident quickly ate the cottage cheese and returned to his/her room. Staff did not provide beverages to the resident. During an interview on 01/09/25, at 12:10 PM, the CNP1 said he documented in the EMR a recommendation for the resident to receive a consultation or evaluation for swallowing because the resident expressed to him/her that he/she was choking on his/her food. He/she provided the resident with basic mental health services along with management of his/her medications, but no staff member had communicated to him/her that the physician recommended a change to the Topamax medication that could contribute to the resident's weight loss. During an interview on 01/09/25, at 6:50 PM, the Medical Director said he was not aware that CNP1 had recommended a consultation for choking and issues with swallowing. He referred medication for the resident to be monitored and/or changed by CNP1 due to the resident's psych diagnosis. The Medical Director said he assumed his documented recommendation for Topamax being changed was communicated to CNP1. His expectations were physician progress notes reviewed by the appropriate nursing staff and should have been followed up with communicating recommended medication changes and speech consultation for the resident. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/10/25, at 10:50 A.M., the Director of Nursing (DON) said that food intake was always monitored and measured and documented by the CNA staff for the resident, but she could not provide evidence of that documentation. She had not read the progress notes of previous staff and physicians that documented intervention recommendations for a swallow consultation with the speech therapist, changing the Topamax medication, ordering a medication that would enhance the resident's appetite, or progress notes that documented the resident was choking on his/her food at meals. Her expectations were for nursing staff to read the resident's progress notes and follow up with recommended interventions to prevent severe weight loss of a resident. During an interview on 01/10/25, at 3:14 P.M., the Administrator said her expectations for any resident with unplanned weight loss was for them to be discussed in the weekly weight loss meeting that included the dietary manager, the DON, the Social Services Director, and the MDS RN, along with staff from the therapy department and the medical records department as needed. Significant weight loss was discussed to identify the reason, cause, and possible new interventions. She could not provide evidence of weekly weight loss meetings. Her expectation of her nursing staff was to communicate physicians' orders and that the nursing staff always read the physician's progress notes and recommendations unless written as an order. She was not aware of the recommendations previously documented in the resident's progress notes for a swallow test, a change in the resident's Topamax medication, or a recommendation for new prescription medication that would enhance the resident's appetite.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview and record review, the facility failed to ensure behavioral health services were provided for one resident (Resident #64) of two sampled residents reviewed for PASARR Level II. The facility census was 67. Review of the facility's policy titled, Behavioral Health Services, revised February 2019, showed the following: -The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care; -Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care; -Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care; -Behavioral health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care. Review of Resident #64'sAdmission Record, undated, located in the resident's EMR under the Profile tab showed the following: -admitted [DATE]; -Diagnoses included bipolar disorder (mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function), major depressive disorder, delusional disorder, insomnia, and generalized anxiety disorder (GAD). Review of the resident's Pre-Admission Screening/Resident Review (PASARR), dated 10/23/24 and provided by the facility, showed the following: -No recommendations for specialized services were approved. -The PASARR Level II Evaluation indicated the resident's could be met at this time in a Nursing Facility; -The PASARR Level II Evaluation indicated the following supports and services are to be provided by the facility: behavior support plan, structured environment, and crisis intervention services; -Assess and plan for crisis intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis including who to contact for assistance, how to work together with client during crisis, and how to determine when the crisis is over. (continued on next page)

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	265406	A. Building B. Wing	01/10/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The plan should also identify a physician and emergency medical services that should be contacted. -Suicide precautions marked. Review of the resident's electronic and paper medical records showed staff did not have documented evidence of a behavior support plan or any type of crisis intervention services in place. During an interview on 01/09/25, at 10:55 A.M., the Minimum Data Set Coordinator (MDSC) reviewed the resident's PASARR Level II. When asked about Level II indicating the documented services that were to be provided by the facility, the MDSC said she had never noticed and was not aware those services needed to be provided by the facility. The MDSC verified the resident was not and had not received services for a behavior support plan to be developed nor had crisis intervention services been obtained. During an interview on 01/10/25, at 2:59 P.M., the Medical Director said if the resident's PASARR Level II indicated the facility was to ensure the resident received services such as a behavior support plan and crisis intervention services, it was his expectation the resident would been provided the services. During an interview on 01/09/25, at 11:00 AM, the Administrator said she was not aware that PASARR Level II evaluations indicated specific services the facility had to ensure the resident received.

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	265406	A. Building B. Wing	01/10/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622 Based on interview and record review, the facility failed to implement a 14 day stop date for the as needed (PRN) use of an anti-anxiety medication and/or provide a rationale for the continued use of the medication for two residents (Resident #39 and #64) of two residents reviewed for anti-anxiety medications. The facility census was 67. Review of the facility's policy titled, Medication Utilization and Prescribing - Clinical Protocol, dated July 2016, showed the following: -When a medication is prescribed in response to an identified problem, condition, or risk, the physician and staff will identify the indications (condition or problem for which it is being given, or what the medication is supposed to do or prevent), considering the resident's age, conditions, risks, health status, and existing medication regimen. -The physician and staff will review the rationale for existing medications that lack clear indication or are being used intermittently on a PRN basis. 1. Review of Resident #39's Admission Record located under the Resident tab in the electronic medical record (EMR) showed the following: -admitted [DATE]; -Diagnoses included Alzheimer's disease, depression, anxiety disorder, and unspecified dementia. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) located under the Resident tab of the EMR, showed the resident was severely cognitively impairment. Review of the resident's care plan, dated 08/26/24 and revised on 10/08/24, located in the EMR under the Care Plan tab, showed the following: -The resident used psychotropic medications (medications that affect the brain and nervous system's chemical makeup); -The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/ behavioral impairment through review date. -On 09/09/24, alprazolam (an antianxiety medication) scheduled added for anxiety; -On 10/08/24, alprazolam changed to twice daily with one PRN. (continued on next page)

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	265406	A. Building B. Wing	01/10/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's January 2025 Physician Orders, located under the Orders tab of the EMR, showed an order, dated 10/08/24, for alprazolam oral tablet 0.5 milligrams (mg), give one tablet by mouth two times a day related to anxiety disorder and give one tablet by mouth every 24 hours as needed for increased episodes of anxiety. Review of the resident's EMR record showed staff did not document in the progress notes regarding the alprazolam order, dated 10/08/24, or a rational for the continued use of the medication. During an interview on 01/09/25, at 10:00 A.M., Licensed Practical Nurse (LPN) 1 verified the resident's PRN alprazolam order did not include a 14-day stop date. He/she said it should have a 14-day stop date. During an interview on 01/09/25, at 10:28 A.M., the Pharmacist confirmed his/her report titled, PRN Sedation, dated 10/27/24 and provided to the facility, indicated the resident's alprazolam order should have a 14-day stop date. He/she provided the facility with a report with all recommendations. The resident was flagged in November 2024 and December 2024 as needing a PRN stop date for the alprazolam 0.5 mg PRN anxiety order. He/she was not sure why the facility did not contact the physician to obtain a 14-day stop date or discontinue the medication. During an interview on 01/09/25, at 11:03 A.M., the Medical Director said he was aware of PRN orders needing a 14-day stop date. He received pharmacy recommendations monthly and these were reviewed and sent back to the facility. He verified his notes from November 2024 did not include a rationale for the continued use of alprazolam. He felt like the resident did need the order for alprazolam PRN and the resident had a history of increased anxiety/aggression. During an interview on 01/09/25, at 9:41 AM, the Director of Nursing (DON) verified the PRN alprazolam order did not include a 14-day stop date. She said it should have a 14-day stop date. 2. Review of Resident #64's Admission Record, undated, located in the resident's EMR under the Profile tab showed the following: -admitted [DATE]; -Diagnoses included generalized anxiety disorder (GAD). Review of the resident's Physician Orders, dated 12/05/24 and located in the resident's EMR under the Orders tab, showed the resident was ordered lorazepam (a fast-acting antianxiety medication) 0.5 mg every 12 hours PRN for anxiety. The PRN order did not have a stop date. During an interview on 01/10/25, at 11:11 A.M., the consultant Pharmacist said he/she sent a recommendation to the physician on 12/28/24 for a stop date to be added to the lorazepam. 3. During an interview on 01/10/25, at 2:59 P.M., the Medical Director said he was aware PRN antianxiety medications were supposed to have a stop date. The Medical Director said he normally only ordered PRN antianxiety medications for 14 days at a time; however, since the facility had switched to an EMR system, they had not figured out how to set the system up to catch if a PRN did not have a stop date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265406	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Oaks Caring Center	1310 Hovis Street Mountain Grove, MO 65711

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/25, at 10:53 A.M., the Administrator said it was her expectation physicians followed the federal regulations when determining what medications were necessary to be ordered for the residents. 36898

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265406	A. Building B. Wing	01/10/2025

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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 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. 36898 Based on observation, interview, and record review, the facility failed to store medications per standards of practice when staff failed to remove expired medications from the a medication cart that contained current medications to be administered to residents The facility census was 67. Review of the facility's policy titled, Medication Labeling and Storage, dated February 2023, showed the following: -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; -If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. During an interview and observation on 01/07/25, at 5:17 P.M., one medication card of furosemide (diuretic medication) 20 milligram (mg) tablets, containing 25 tablets, was located in the bottom drawer of the medication cart for Hall 200 and Hall 300, with an expiration date of 12/03/24. Certified Medical Technician (CMT) 1 confirmed the medication expired on 12/03/24. He/she said the expired medications were given to the nurses for destruction and the carts were cleaned weekly and checked for expired medications. During an interview on 01/09/25 at 9:43 AM, the Director of Nursing said the medication carts should be cleaned twice a week and checked for expired medications.