

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Country View Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2106 West Main Bowling Green, MO 63334	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33955</p> <p>Based on observation, interview and record review, the facility failed to provide care in a dignified and respectful manner for two residents (Residents #3 and #4), in a review of eight sampled residents, when staff failed to answer call lights timely, resulting in incontinence and residents waiting in soiled briefs for staff to respond. The facility census was 41.</p> <p>Review of the facility's undated policy, Call Lights, showed the following:</p> <ul style="list-style-type: none"> <li>-All nursing personnel must be aware of call lights at all times;</li> <li>-Answer ALL call lights promptly whether you are assigned to the resident;</li> <li>-Answer all call lights in a prompt, calm, courteous manner, turn off the call light as soon as you enter the room;</li> <li>-Never make the resident feel you are too busy to give assistance, offer further assistance before you leave the room.</li> </ul> <p>1. Review of Resident #3's Care Plan, updated 6/13/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The staff checked the resident at least every two hours for incontinence, washed, rinsed, and dried soiled areas;</li> <li>-The resident had an activity of daily living (ADL) self-care performance deficit;</li> <li>-He/She required one staff participation with transfers.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 7/8/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact;</li> <li>-He/She required maximal assistance with toileting hygiene and toilet transfer;</li> <li>-He/She was occasionally incontinent of urine and continent of bowel.</li> </ul> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265419
		If continuation sheet Page 1 of 11

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/19/24 at 4:10 P.M., the resident said the following:</p> <ul style="list-style-type: none"> <li>-He/She had his/her call light on for a long time and needed help;</li> <li>-The long wait for staff to answer the call light did not happen every day, but when it did, it was upsetting because he/she did not want his/her pants to get wet.</li> </ul> <p>2. Review of Resident #4's Care Plan, updated 5/30/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The staff were to keep the call light within reach and answer it promptly;</li> <li>-The resident walked with a wheeled walker and one staff assistance;</li> <li>-He/She required one staff assistance to use the toilet.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact;</li> <li>-He/She required supervision with toileting hygiene,</li> <li>-He/She required moderate assistance with toilet transfer;</li> <li>-He/She was continent of bladder and bowel.</li> </ul> <p>During an interview on 9/19/24 at 4:10 P.M., the resident said the following:</p> <ul style="list-style-type: none"> <li>-He/She needed to use the restroom and sometimes it was too late to get to the restroom before he/she wet his/her pants;</li> <li>-It felt like this happened too often;</li> <li>-His/Her pants had been wet from waiting too long for staff assistance to the bathroom.</li> </ul> <p>3. Observation on 9/19/24 at 4:10 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Three call lights activated on 200 Hall, two call lights activated on 100 Hall, and two call lights activated on 300 Hall;</li> <li>-Licensed Practical Nurse (LPN) D and Certified Medication Technician (CMT) E were in the hallways with separate medication carts preparing medications for administration;</li> <li>-Resident #3 and Resident #4's call lights were activated;</li> <li>-One Certified Nurse Aide (CNA), CNA K, was getting supplies and going to other residents' rooms.</li> <li>-Resident #3 and Resident #4 had to wait 35 minutes for staff to answer their call lights;</li> </ul> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #3 was incontinent of urine before staff assisted him/her to the restroom.</p> <p>4. During an interview on 9/25/24 at 1:55 P.M., the Assistant Director of Nursing (ADON) said the following:</p> <p>-The nurse or CMT could answer call lights; it could be something simple;</p> <p>-The nurse or CNA were to tell the agency staff the care the resident's required.</p> <p>During an interview on 10/3/24 at 11:17 A.M., the Administrator said the following:</p> <p>-She expected the charge nurse and CMT to answer residents' call lights;</p> <p>-The policy regarding the facility's expectation for all staff to answer a call light was shared with the temporary staffing agencies, so agency staff would know the expectations prior to working in the facility;</p> <p>-Temporary agency staff could not use lack of knowledge regarding the residents as a reason for not answering call lights.</p> <p>MO241938</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46506</p> <p>Based on interview and record review, the facility failed to provide the resident's representative with a copy of the resident's medical records upon written request within 24 hours of the resident's representative request for one resident (Resident #8), in a review of 8 sampled residents. The facility census was 41.</p> <p>1. Review of Resident #8's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was admitted to the facility from the hospital on 7/30/24;</li> <li>-He/She was discharged on [DATE].</li> </ul> <p>During an interview on 9/20/24 at 8:06 A.M., the resident's power of attorney (POA) said the following:</p> <ul style="list-style-type: none"> <li>-He/She asked Licensed Practical Nurse (LPN) A to view the resident's medical records. LPN A said he/she was unable because the records were on the computer;</li> <li>-LPN A provided the POA a copy of the resident's physician orders from the facility;</li> <li>-He/She emailed the Social Services Director on 9/8/24 requesting a copy of the resident's medical records;</li> <li>-The Social Services Director emailed the POA back stating the request was forwarded to medical records staff;</li> <li>-He/She did not receive a copy of the resident's medical records from the facility.</li> </ul> <p>During an interview on 9/20/24 at 8:31 A.M., the Social Services Director said she received a request for the resident's medical records from the resident's POA via email, so she printed the email and took it to medical records office and left it to be processed.</p> <p>During an interview on 9/19/24 at 4:00 P.M., the Medical Records/Transportation Staff said the following:</p> <ul style="list-style-type: none"> <li>-She didn't know the resident's POA requested a copy of the resident's medical records;</li> <li>-No one told her or gave her the paperwork requesting a copy of the medical records;</li> <li>-If she received a request, she provided medical records within 24 hours of the request.</li> </ul> <p>During an interview on 10/3/24 at 11:17 A.M., the Administrator said when the Social Services Director printed a copy of the medical records request, the Social Service Director should follow up to ensure the medical records staff received the request.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>46506</p> <p>Based on interview and record review, the facility failed to follow facility policy to notify the resident's power of attorney for two residents (Residents #1 and #2), in a review of eight sampled residents, following a resident-to-resident altercation. The facility census was 41.</p> <p>Review of the facility's undated policy, Significant Condition Change and Notification, showed the following:</p> <ul style="list-style-type: none"> <li>-To ensure the resident's family and/or representative and medical practitioner are notified of resident changes;</li> <li>-A significant change in the resident's physical, mental, or psychosocial status, including resident-to-resident altercation, which require notification for both residents.</li> </ul> <p>1. Review of Resident #1's undated face sheet, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a power of attorney;</li> <li>-Diagnoses of dementia (a condition that causes a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life), disorientation (state of mental confusion), and anxiety disorder.</li> </ul> <p>Review of the resident's Care Plan, last updated 6/13/24, showed the resident had impaired cognitive function/dementia or impaired thought process related to diagnosis of dementia.</p> <p>Review of the facility's online abuse report form, dated 9/16/24 at 3:06 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Resident #2 reported on 9/16/24 to the Social Services Director that there was an incident on 9/13/24;</li> <li>-At approximately 8:00 P.M., Resident #1 slapped Resident #2 on the right cheek;</li> <li>-At 9:00 P.M., Resident #1 flipped a privacy curtain in Resident #2's face;</li> <li>-Resident #2 said they were verbally arguing all night;</li> <li>-Both residents were separated immediately.</li> </ul> <p>During an interview on 9/19/24 at 12:52 P.M., the resident's power of attorney (POA) said the following:</p> <ul style="list-style-type: none"> <li>-He/She was not aware the resident hit another resident;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No one from the facility contacted him/her about the altercation;</p> <p>-The facility should have let him/her know about the incident.</p> <p>2. Review of Resident #2's undated face sheet showed the following:</p> <p>-The resident had a power of attorney;</p> <p>-Diagnoses of schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania), bipolar depression (mental illness that causes extreme mood swings and shifts in energy, activity, and concentration), and anxiety.</p> <p>Review of the resident's care plan, last updated 7/25/24, showed the following:</p> <p>-The resident received psychotropic medications related to diagnoses of bipolar disorder, major depressive disorder (persistently low or depressed mood, anhedonia or decreased interest in pleasurable activities), and anxiety;</p> <p>-Routine follow up with psychiatry.</p> <p>Review of the facility's online abuse report form, dated 9/16/24 at 3:06 P.M., showed the following:</p> <p>-Resident #2 reported on 9/16/24 to the Social Services Director that there was an incident on 9/13/24;</p> <p>-At approximately 8:00 P.M., Resident #1 slapped Resident #2 on the right cheek;</p> <p>-At 9:00 P.M., Resident #1 flipped a privacy curtain in Resident #2's face;</p> <p>-Resident #2 said they were verbally arguing all night;</p> <p>-Both residents were separated immediately.</p> <p>During an interview on 9/19/24 at 11:52 A.M., the resident said the following:</p> <p>-He/She and Resident #1 had verbal arguments every night;</p> <p>-Resident #1 had never hit him/her previously;</p> <p>-He/She could not remember what the argument was about on the night of the altercation;</p> <p>-Resident #1 hit her/him on the right side of the face and flipped the privacy curtain at him/her.</p> <p>During an interview on 9/19/24 at 1:28 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-He/She worked the night of the altercation and spoke with the resident;</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident never said Resident #1 hit him/her in the face;</p> <p>-The resident said Resident #1 flipped the privacy curtain in his/her face.</p> <p>During an interview on 9/19/24 at 11:13 A.M., the resident's POA said the following:</p> <p>-The resident sent a text to him/her on Saturday morning regarding the altercation;</p> <p>-The facility did not contact him/her regarding the altercation;</p> <p>-The facility should have contacted him/her about the altercation;</p> <p>-The resident told him/her the facility was to move him/her to a different room on Monday, but no one from the facility told him/her about moving the resident to a different room.</p> <p>3. During an interview on 9/19/24 at 3:20 P.M. and 10/3/23 at 11:17 A.M., the Administrator said the following:</p> <p>-Resident #2 reported to Social Services Director that Resident #1 hit him/her in the face on 9/13/24;</p> <p>-The staff notified him/her at about 1:00 P.M. about the altercation;</p> <p>-The residents were immediately separated;</p> <p>-Either the charge nurse or Social Services Director contacted the power of attorney when there was a resident-to-resident altercation;</p> <p>-The staff told her the POAs for both residents were contacted;</p> <p>-She was not aware neither of the residents' POAs were contacted about the altercation.</p> <p>MO242162</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46506</p> <p>Based on interview and record review, the facility failed to follow hospital discharge orders for post operative appointments and administer anticoagulant medication (medicine that helps prevent blood clots) as ordered for one resident (Resident #8), in a review of eight sampled residents. The facility census was 41.</p> <p>Review of the facility's undated policy, Following Physician Orders, showed the following:</p> <ul style="list-style-type: none"> <li>-Admission orders are received from the discharging physician and communicated to the primary care physician at the time of admission;</li> <li>-Medical records will conduct chart audits on a monthly basis to help monitor correct documentation.</li> </ul> <p>1. Review of Resident #8's undated face sheet showed the resident's diagnoses included surgery on the digestive system, cholecystitis (condition that occurs when the gallbladder becomes inflamed, swollen, and red), and hemiplegia and hemiparesis (conditions that cause loss of strength or paralysis on one side of the body) following cerebral infarction (loss of blood flow to part of the brain) left non-dominant side.</p> <p>Review of the resident's undated Care Plan showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was on anticoagulation therapy;</li> <li>-He/She had hemiplegia/hemiparesis related to history of stroke.</li> </ul> <p>Review of the resident's hospital discharge orders, dated 7/30/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident needed to follow up with primary care physician in one week;</li> <li>-He/She needed to follow up with the gastroenterologist (physician who specializes in conditions affecting the digestive system) in two weeks;</li> <li>-He/She needed to follow up with the surgeon in two weeks (on 8/14/24 at 9:40 A.M.);</li> <li>-Eliquis (anticoagulant) 5 milligrams (mg) orally twice a day.</li> </ul> <p>Review of the resident's physician's order, dated July 2024, showed Eliquis 5 mg by mouth two times a day (original order dated 7/30/24).</p> <p>Review of the resident's electronic Medication Administration Record, dated July 2024, showed the resident received one dose of Eliquis 5 mg on 7/30/24. The order was discontinued on 7/31/24.</p> <p>Review of the resident's physician's orders, dated July 2024, showed no evidence the physician discontinued the order for Eliquis 5 mg two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/19/24 at 3:10 P.M., Licensed Practical Nurse (LPN) C said the following:</p> <ul style="list-style-type: none"> <li>-The hospital sent a packet with the resident containing the discharge orders;</li> <li>-The orders included medications, upcoming appointments, diet, activity, etc.;</li> <li>-He/She transcribed the resident's order for Eliquis;</li> <li>-After he/she entered the order for Eliquis, he/she saw in the discharge orders to hold the Eliquis indefinitely, so he/she discontinued the order. (Review of the resident's medical record including the hospital discharge orders showed no documentation the physician ordered to hold the Eliquis);</li> <li>-One dose of Eliquis was administered, before the order was discontinued;</li> <li>-After he/she transcribed the orders, he/she put the packet in a box for medical records to pick up;</li> <li>-He/She wrote out a list of upcoming appointments and left it for Medical Records/Transportation Staff.</li> </ul> <p>Review of the resident's physician's orders, dated August 2024, showed no order for Eliquis 5 mg two times a day from 8/1/24 through 8/10/24.</p> <p>Review of the resident's nurse notes, dated 8/10/24 at 5:59 P.M., showed the resident resumed Eliquis 5 mg twice a day starting the next day (8/11/24) per the resident's request due to history of strokes.</p> <p>Review of the resident's physician orders, dated August 2024, showed Eliquis 5 mg by mouth two times a day (started 8/11/24).</p> <p>Review of the resident's electronic Medication Administration Record, dated August 2024, showed the order for Eliquis 5 mg twice a day was started on 8/11/24.</p> <p>Review of the resident's medical record showed no documentation the resident's physician discontinued the Eliquis on 7/31/24. The resident did not receive the ordered Eliquis from 7/31/24 to 8/11/24. The medication was resumed on 8/11/24 upon the resident's request.</p> <p>Review of the resident's medical record showed no evidence staff coordinated the follow up appointments for the resident with the primary care physician, gastroenterologist or the surgeon, as directed on the hospital discharge orders, dated 7/30/24.</p> <p>During an interview on 9/19/24 at 4:00 P.M., the Medical Records/Transportation Staff said the following:</p> <ul style="list-style-type: none"> <li>-She did not schedule the resident any transportation services;</li> <li>-She did not remember anyone notifying her the resident had upcoming appointments that the resident needed transportation for;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A copy of the hospital discharge orders was not scanned into the electronic medical record;</p> <p>-She checked the documents waiting to be scanned and did not find the resident's hospital discharge summary or discharge orders.</p> <p>During an interview on 9/20/24 at 8:06 A.M., the resident's Power of Attorney (POA) said the following:</p> <p>-He/She received a copy of the resident's medical records after the resident was discharged to home. (The resident was discharged to home on 9/7/24);</p> <p>-At that time, he/she found the discharge orders to follow up with the gastroenterologist and surgeon. No facility staff told him/her about the needed appointments while the resident was still in the facility;</p> <p>-He/She noticed the facility was to give Eliquis because of the resident's history of strokes, but the resident did not receive the medication until 8/11/24.</p> <p>During an interview on 10/3/24 at 11:17 A.M., the Administrator said the following:</p> <p>-She expected staff to correctly transcribe the physician approved admission orders in the electronic medical record;</p> <p>-She expected staff to give the admission orders/summary to medical records so it could be scanned into the medical record;</p> <p>-She expected staff to notify Medical Records/Transportation Staff of scheduled follow up appointments, so transportation could be arranged.</p> <p>MO241938</p>		