STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265431	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Lake Manor Inc	600 East 7th St Lowry City, MO 64763

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents received care and treatment in accordance with professional standards of practice when facility nursing staff failed to initiate neurological assessments (evaluation of the functioning of the nervous system, identifying any abnormalities or neurological deficits) for one resident (Resident #45) after an unwitnessed fall and failed to complete neurological assessments for two residents (Residents #56 and #61) after each resident sustained a fall with potential for head injury. The facility census was 64.Review of the facility policy titled, Neurological Assessment, revised October 2010, showed the following:-Neurological assessments are indicated when ordered by a physician, following an unwitnessed fall, following a fall involving head injury, or when indicated by resident condition;-Neurological assessments include frequent vital signs;-Neurological assessments include the initial assessment, assessment every 15 minutes x 4, every 30 minutes x 2, every hour x 4, every shift x 5. 1. Review of Resident #45's face sheet (a form that provides resident details) showed:-admission date of 11/06/23;-Diagnoses included cerebral infarction (a disruption to blood supply that is severe enough and long enough in duration to result in tissue death), dementia (a progressive neurological condition affecting memory, and decision making), lack of coordination, muscle weakness, and repeated falls. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 04/28/26, showed him/her as cognitively impaired. Review of the resident's current care plan, revised on 04/28/26, showed the following: -Cognitively impaired due to disease process (dementia);-At risk of falls. Review of resident's nursing progress notes, dated 05/19/26, showed the following:-Resident had an unwitnessed fall;-Staff did not start document the start of neurological assessments. Review of resident's nursing progress notes, dated 05/19/26 to 05/21/26, showed staff did not document regarding fall follow-up assessments. During an interview on 05/20/26, at 12:20 P.M., Registered Nurse (RN) I said the following:-Neuro checks should be started on all unwitnessed falls or falls with head injuries or unless the resident can tell staff they did not hit their head;-The resident could not tell staff if he/she hit their head and staff should start neuro assessment if he/she fell. 2. Review of Resident #56's face sheet showed the following:-admission date of 03/31/26;-Diagnoses include dementia, unsteadiness on feet (lack of balance), and reduced mobility. Review of the resident's admission MDS, dated [DATE], showed him/her ascognitively intact. Review of the resident's current care plan, revised on 04/14/26, showed him/her at risk for falls and communication problems related to disease process (dementia). Review of resident's nursing progress note dated 04/23/26, at 3:05 A.M., showed the staff found resident sitting on floor, right leg tucked under left leg, with bruising and discoloration to face and arms from previous falls. Staff noted initiation of neurological checks. Review of resident's neurological assessment form, dated 04/23/26, showed staff did not document the initial assessment or neurological assessments for final three shifts of the assessment timeframe. Review of the resident's nursing progress note dated 04/25/26, at 1:05 A.M., showed the resident had a hematoma (bruise) to forehead and face from previous fall. Review of the resident's nursing progress note dated 04/25/26, at 1:48 A.M., showed (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the nurse documented the resident had complaints of head pain. 3. Review of Resident #61's face sheet showed the following:-admission date of 04/17/26;-Diagnoses included dementia. Review of the resident's admission MDS, dated [DATE], showed he/she ascognitively impaired. Review of the resident's current care plan, revised on 05/06/26, showed he/she had impaired cognitive function and communication related to neurological symptoms. Review of a resident's progress note dated 04/25/26, at 6:32 P.M showed the resident was observed on the floor with a hematoma over the right eye. Staff noted neuro checks were initiated. Review of resident's neurological assessment form, dated 04/25/26, showed staff did not document completion of three neurological assessments due every hour and five neurological assessments due every shift. Review of a resident's progress note dated 04/27/26, at 4:32 A.M, showed the nurse documented the resident had complaints of pain related to large hematoma to right eyebrow. Ibuprofen was given for pain. 4. During an interview on 05/20/26, at 12:20 P.M., Registered Nurse (RN) I said neurological assessments were important to identify possible complications of head injuries, like brain bleeds. During an interview on 05/20/26, at 1:40 P.M., RN B said the following:-Staff should start neurological checks on all residents with an unwitnessed fall or fall with head injury;-Neurological assessments should continue for 72 hours unless the resident is cleared by a physician. During an interview on 05/21/26, at 9:30 A.M., Licensed Practical Nurse (LPN) C said the following:-Staff should begin neurological checks on all unwitnessed falls;-Neurological checks continue for 72 hours unless the resident is cleared by a physician;-Neurological checks are important to identify changes in a resident. During an interview on 05/21/26, at 9:45 A.M., the Assistant Director of Nursing (ADON) said the following:-Neurological assessments should be started on residents who have an unwitnessed fall;-Neurological assessments continue for 72 hours and help identify brain injuries. During an interview on 05/21/26, at 9:55 A.M., the Director of Nursing (DON) said she expected staff to start and complete all neurological assessments for residents who have an unwitnessed fall. During an interview on 05/21/26, at 12:30 P.M., the Administrator said he expected nursing staff to initiate and continue all neurological assessments in accordance with the policy of the facility.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on record review and interview, the facility failed to ensure nurse aides (NA) were not used more than four months without completing required training and evaluations when the facility did not have an effective process in place to ensure certified nurse aide (CNA) training programs were completed timely for NAs resulting in one NA (NA A) working longer than four months in the facility without completing the CNA training course. The facility census was 64.Review of the facility policy, entitled Nurse Aide Qualifications and Training Requirements, revised October 2017, showed the following:-Nurse aides must undergo a state-approved training program;-Nurse aide is defined as any individual providing nursing or nursing-related services to residents in our facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay;-Our facility will not employ any individual as a nurse aide for more than four months full-time, temporary, per diem, or otherwise, unless:-That individual is competent to provide designated nursing care and nursing related services; and -That individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; or -That individual has been deemed competent as provided in section 483.150(a) and (b) of the Requirements of Participation;-Our facility will not use any individual as a nurse aide who has worked less than four months unless the individual: -Is a full-time employee and participating in a state-approved training and competency evaluation program; -Has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program; or -Has been determined competent as provided in section 483.150(a) and (b) of the Requirements of Participation;-Inquiries concerning nurse aide training should be referred to the Personnel Director or to the Director of Nursing Services (DNS). 1. Review of NA A's personnel file showed the following:-Date of hire on 01/12/26 (4 1/2 months prior);-Staff did not have documentation NA A completed the nurse aide training program. Review of the facility's online CNA class schedule and sign-in sheet showed NA A started classes on 04/27/26. During an interview on 05/22/26, at 1:22 P.M., NA A said the following:-He/she started working at the facility in early January 2026, but the facility did not have a CNA instructor available;-The facility said there wasn't sufficient time to find an instructor, take the classes, and get certified within the required time limit of four months;-They agreed to terminate NA A and rehire him/her on a part-time basis while he/she completed the online class;-He/she started the online class in mid to late April and worked part-time at the facility to complete the required clinical hours. During an interview on 05/20/26, at 9:35 A.M., the Administrator said the following: -The facility hired NA A in January 2026, but the facility could not arrange for a CNA instructor soon enough for NA A to complete the classes and certification within the required four months;-The NA agreed to have the facility terminate him/her for about one week and rehire him/her on a part time basis;-The facility then enrolled NA A and three other new NAs in online classes offered through the State. During an interview on 05/21/26, at 10:49 A.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said the following: -The facility could not enlist a certified CNA instructor in time for NA A to complete the classes, clinical training, and certification within the required four months;-NA A was now enrolled in the online CNA training class;-The ADON monitored the NAs for completion of the online modules and knowledge tests;-After the aides completed all modules, the facility would arrange for the NAs to take their certification tests.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food was protected from possible contamination at all times when staff failed to keep all food-contact areas clean and when staff failed to air dry dishes. The facility had a census of 64.1. Review of the Food & Drug Administration (FDA) 2022 Food Code showed the objective of cleaning focuses on the need to remove organic matter from foodcontact surfaces so that sanitization can occur and to remove soil from non-foodcontact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. Review of the facility policy titled Cleaning Rotation, Guideline and Procedure Manual, dated 2016, showed the following:-Equipment and utensils will be cleaned according to the following guidelines, or manufacturer's instructions;-Items cleaned after each use include the can opener and small food preparation equipment;-Items cleaned daily include the toaster. Review of the facility kitchen cleaning schedule showed the following: -Staff to clean the can opener twice daily;-The toaster was not on the cleaning schedule. Observation on 05/18/26, beginning at 11:00 A.M., showed the following:-The can opener was dirty with food crumbs and a grease/lint mixture:-The toaster was dirty with food crumbs, and a grease/lint mixture:-The prep table, to the right of the stove, was dirty with a grease/lint mixture. During an interview on 05/22/26, at 12:50 P.M., Dietary Aide (DA) D said the following: -The cleaning schedule was based on what staff does and if they work in an area, they are expected to clean that same area;-The can opener, toaster, or any appliances the cook used should be cleaned daily, by the cook. During an interview on 05/22/26, at 1:10 P.M., [NAME] F said the following: -He/she followed a cleaning list, but gets busy so there are days some things do not get done;-He/she was responsible to clean the toaster and can opener. During an interview on 05/22/26, at 1:25 P.M., [NAME] G said he/she cleaned up the area he/she was working at. During an interview on 05/22/26, at 1:55 P.M., the Dietary Manager (DM) said the following: -There was a cleaning schedule;-Staff were expected to follow the cleaning schedule;-If something was not on the actual schedule, he/she expected staff to clean their own area and anything that they may notice that needed cleaning;-If he/she noticed something needed cleaning, he/she will often do it. During an interview on 05/22/26, at 1:05 P.M., the Administrator said there was a cleaning schedule, and staff was expected to follow it. 2. Review of the FDA 2022 Food Code showed the following: -Items must be allowed to drain and to air-dry before being stacked or stored;-Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow;-Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. Review of the facility policy titled Dishwashing: Manual, Guideline & Procedure Manual, 2016 Edition, showed the following:- All pots and pans shall be cleaned by washing, rinsing, and sanitizing, according to the following guidelines.-The pots and pans will be drained and air-dried on the drain counter. Observation on 05/18/26, beginning at 11:00 A.M., showed the following:-A small room in the dining room and next to the kitchen, held the ice machine and two rolling carts;-The first cart had 62 large plastic water glasses, sitting upside down and with no air flow and water trapped inside;-The second cart had 46 large plastic water glasses, sitting upside down and with no air flow and water trapped inside. Observation on 05/20/26, beginning at 8:50 A.M., showed the following:-Twelve plastic coffee mugs, stacked upside down and with no air flow and water trapped inside;-Twelve plastic plate covers, stacked upside down and with no air flow and water trapped inside;-Seventeen white plastic bowls, stacked upside down and with no air flow and water trapped inside;-Twenty clear drinking glasses, stacked upside down and with no air flow and water trapped inside. Observation on 05/21/26, beginning at 9:55 A.M., showed the following:-Ten plastic coffee mugs, stacked upside down and with no air flow and water trapped inside;-Fourteen clear drinking glasses, stacked upside down and with no air flow and water trapped inside;-Eighteen plastic plate covers, stacked upside down and with no (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	air flow and water trapped inside. During an interview on 05/22/26, at 12:50 P.M., DA D said dishes were supposed to sit and dry for a few minutes, before being put away. During an interview on 05/22/26, at 1:10 P.M., Dishwasher (DW) E said staff should leave the dishes on the drying rack until they are dry. During an interview on 05/22/26, at 1:10 P.M., [NAME] F said if there was not time to towel dry the dishes, then they should sit in a tray to be air dried. During an interview on 05/22/26, at 1:05 P.M., the Administrator said he expected dishes to be completely dry before being put away and the kitchen staff have been trained to do this.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to an effective program to identify areas of possible resident entrapment when the facility failed to ensure the side rail gap measurements were within acceptable standards to protect the safety of residents when the zone one (within the rail) measurements for the side rails of three residents (Residents #63, #2, and # 7) were greater than the maximum allowed to prevent entrapment of a body part. The facility census was 64.Review of the United States Food and Drug Administration (FDA) document titled, Guidance for Industry and FDA staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/06, showed the following:-The head, neck, and chest are the three key body parts at risk for life-threatening entrapment in the seven zones (within the rail, under the rail between the rail supports or next to a single rail support, between the rail and the mattress, under the rail at the ends of the rail, between split bed rails, between the end of the rail and side edge of the head or foot board, and between the head or foot board and the mattress end) of a hospital bed system;-The bed system should not allow entrapment of the widest part of a small head (head breadth measured across the face from ear to ear);-A maximum head breadth gap measurement of 4 3/4 inches (in);-The bed system should not allow entrapment of the neck;-A maximum neck gap measurement of 2 3/8 in;-The bed system should not allow entrapment of the chest through split rails;-A maximum chest gap measurement of 12 1/2 inches. Review of a facility policy titled, Bed Safety and Bed Rails, dated 2001, showed the following information:-The interdisciplinary team (IDT) should evaluate the resident sleeping environment with considerations given for resident safety, medical conditions, comfort, freedom of movement, and input from the resident and family regarding sleeping habits;-Staff should check bed frames, mattresses, and bed rails for compatibility and size prior to use;-Mattresses regardless of type, width, length, or depth cannot leave gaps wide enough for entrapment of the resident's head or body;-Staff should ensure all gaps are within the safety dimensions established by the FDA;-Maintenance staff should inspect all beds and equipment routinely for entrapment risk;-Maintenance staff should provide copies of inspections to the Administrator and report results to the Quality Assurance and Performance Improvement (QAPI) committee for appropriate action;-The Administrator should maintain copies of the inspections and QAPI committee recommendations. Review of the facility policy titled, Restraints: Bed Rail Safety Check, undated, showed the following:-Facility staff should regularly inspect each of the seven areas of a bed with restraints for entrapment;-The seven areas include: within the rail, under the rail between the rail supports or next to a single rail support, between the rail and the mattress, under the rail at the ends of the rail, between split bed rails, between the end of the rail and side edge of the head or foot board, and between the head or foot board and the mattress end;-The spacing within bed rails should be small enough to prevent a resident's head from passing through the openings;-The mattress to bed rail interface should prevent entrapment and suffocation risk. Review of a facility Bed Rail Safety Check Form, dated April 2009, showed the following:-A zone one (within the rail) maximum gap measurement of 4 3/4 in;-A zone two (under the rail between the rail supports or next to a single rail support) maximum gap measurement of 4 3/4 in;-A zone three (between the rail and the mattress) maximum gap measurement of 4 3/4 in;-A zone four (under the rail at the ends of the rail) maximum gap measurement of 2 3/8 in and less than 60-degree angle;-The form did not identify gap measurement allowances for zone five (between split bed rails), zone six (between the end of the rail and side edge of the head or foot board, or zone seven (between the head or foot board and the mattress end). 1. Review of Resident #63's face sheet (basic information sheet), dated 05/22/26, showed the following:-admission date of 06/04/22;-Diagnoses included Bell's Palsy (sudden weakness in muscles on one side of the face), history of falls, lack of coordination, reduced mobility, and cognitive (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment involving function and awareness. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/21/26, showed the following:-Cognitively intact;-No impairment;-Independent mobility. Review of the resident's informed consent for bed rails, dated 05/05/22, showed verbal consent given by the resident's responsible party and signed by the Director of Nursing (DON) for bilateral upper 1/2 rails for assistance with repositioning and independence with bed mobility. Review of the resident's Physician Order Sheet (POS), dated 05/22/26, showed an order, dated 1/24/24, for one or two 1/2 siderails to aid in independence with bed mobility. Review of the resident's quarterly bed rail safety check, dated 02/18/26, showed the following:-Zone one (within the rail) measured 7 inches for each side of the bed (exceeding allowed maximum by 2 1/4 inches). Observation on 05/19/26, at 11:08 A.M., showed the following:-The resident lay in bed with the right upper side rail in the upright position;-The mattress lay crooked on the frame, separated from the bedrail, and exposing the bare metal frame underneath;-The bedrail had a large square opening in the middle. During an interview on 05/19/26, at 11:08 A.M., the resident said the following:-He/She had the bedrail for a few years;-He/She utilized one of the two upper bedrails to support him/herself while standing from bed;-The mattress slides sometimes when getting in bed, but he/she adjusts it back to normal. Observation on 05/21/26, starting at 3:25 P.M., showed the Housekeeping Supervisor assessed the resident's bedrail gap measurements. The bed had one bedrail in the upright position. The rail had a large square opening in the rail measuring 7 in by 7 in. 2. Review of Resident #2's face sheet showed the following:-admission date of 11/21/24;-Diagnoses included cellulitis of left lower limb, Alzheimer's disease, dementia, osteoarthritis in both knees, violent behaviors, muscle weakness, fracture to right tibia (one of the lower leg bones), and reduced mobility. Review of the resident's annual MDS, dated [DATE], showed the following:-Severely impaired cognition for decision making;-Functional limitation on range of motion: lower limbs, one side impaired;-Required substantial/maximal assistance for rolling left/right, sitting to lying down, lying to sitting on side of bed, sitting to standing, and chair/bed transfers. Review of the resident's care plan, updated 03/24/26, showed the following:-Activities of Daily Living (ADL) self-care performance deficit related to dementia and right leg fracture;-Resident needed maximum assistance from one staff for repositioning and turning in bed at least every two hours and as necessary;-Half side-rails up x 2 per physician orders for safety during care provision to assist with bed mobility; observe for injury or entrapment related to side rail use; and reposition at least every two hours and as necessary to avoid injury. Review of the completed form titled Restraints: Bed Rail Safety Check, dated 03/02/26, showed the following:-Zone 1 - Pass if less than 4 3/4 inches;-Measurements for the bed rails on each side of the bed documented as 7 inches (exceeding allowed maximum by 2 1/4 inches);-Pass/fail not indicated. Review of the resident's POS, current as of 05/22/26, showed an order, dated 03/17/26, for resident may have one to two 1/2 siderails up to aid in independence with bed mobility. Observation on 05/20/26, at 7:17 A.M., showed the resident rested in bed with his/her eyes closed. The side rail on each side of the bed was in the raised position. Each side rail had a large square opening in the middle. During an interview on 05/20/26, at 4:00 P.M., the resident said he/she used the side rails to help reposition him/herself in bed. Observation on 05/21/26, at 10:29 A.M., showed the resident rested in bed. The side rail on each side of the bed was in the raised position. Observation on 05/21/26, starting at 3:25 P.M., showed the Housekeeping Supervisor assessed the resident's bedrail gap measurements. The bed had bedrails on each side in the upright position. Both rails had one large square opening in each upper rail measuring 7 in by 7 in. 3. Review of Resident #7's face sheet showed the following:-admission date of 11/20/25;-Diagnoses included quadriplegia (the partial or total loss of sensory and motor function in all four limbs (both arms and legs) and the torso), anxiety, and depression. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact for decision making;-Functional limitation on range of motion: lower limbs, one side impaired;-Substantial/maximal assistance required for rolling left/right, sitting to lying down, lying to sitting on side of bed, sitting to (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stand, and chair/bed transfers. Review of the resident's care plan, last updated 02/21/26, showed the following:-ADL self-care performance deficit related to quadriplegia;-Resident needed maximum assistance from one staff for repositioning and turning in bed at least every two hours and as necessary;-Half side-rails up x 2 as per physician orders for safety during care provision to assist with bed mobility; observe for injury or entrapment related to side rail use and reposition at least every two hours and as necessary to avoid injury. Review of the resident's Informed Consent for Use of Bed Rails, dated 11/21/25, showed the following:-Half partial rail to be used at all times when the resident is in bed;-Both the left and right side approved but only one used at a time, as the resident preferred his/her bed up against the wall. Review of the resident's POS, current as of 05/22/26, showed an order, dated 01/18/26, for 1/2 siderails up x 2 to aid in independence with bed mobility related to a diagnosis of quadriplegia. Review of a completed form titled, Restraints: Bed Rail Safety Check, dated 02/18/26, showed the following:-Zone 1 - Pass if less than 4 3/4 inches: measurements for the bed rail on the left side of the bed documented as 7 inches (exceeding allowed maximum by 2 1/4 inches); pass/fail not indicated. Observation on 05/19/26, at 2:45 P.M., showed the following:-The resident's bed was pushed up against his/her wall;-There was a 1/2 bedrail on the left side of the bed and none on the side against the wall. Observation on 05/21/26, starting at 3:25 P.M., showed the Housekeeping Supervisor assessed the resident's bedrail gap measurements. The bed had one bedrail in the upright position. The rail had a large square opening in the rail measuring 7 in by 7 in. During an interview on 05/21/26, at 4:25 P.M., the resident said the following: -He/she used the side rails every night to help reposition him/herself in bed;-Someone comes into his/her room every so often to take measurements. 4. During an interview on 05/21/26, at 3:50 P.M., Certified Nursing Assistant (CNA) N, said the following:-He/she did not know who took measurements of the bedrails but thought it was maintenance;-He/she did not know what the measurements should be but knew there could be harm if there was too much of a gap. During an interview on 05/21/26, at 4:05 P.M., Certified Medication Technician (CMT) O, said the Housekeeping Supervisor was the one taking the gap measurements. During an interview on 05/19/26, at 3:52 P.M., Licensed Practical Nurse (LPN) F said maintenance installs side rails and the laundry/housekeeping supervisor was responsible for doing the safety gap measurements on installed side rails. During an interview on 05/21/26, at 4:15 P.M., Registered Nurse (RN) B said housekeeping completed all the measurements. There was a book where all the measurements were kept. During an interview on 05/21/26, at 4:46 P.M., the MDS Coordinator said the following:-The Housekeeping Supervisor completed gap rail assessments quarterly and on installation;-The Housekeeping Supervisor gave him the completed assessments, and he placed them in a binder;-He did not know the gap requirements for siderails;-He had not reviewed the gap rail assessments for issues;-He was responsible for compliance. During an interview on 05/21/26, at 4:45 P.M., the Assistant Director of Nursing (ADON) said the following:-Once the measurements are completed by the housekeeping supervisor, they are given to the ADON;-These are placed into the black book, where they are kept;-He/she looked at the national standards and found that the gap between bedrail and mattress should be 2.375 inches or less, and the bedrail gaps should be 4.75 inches or less. During an interview on 05/21/26, at 3:34 P.M., the Housekeeping Supervisor said the following:-She completed gap rail assessments on initial implementation and quarterly;-She gave the completed gap rail assessment forms to the MDS Coordinator;-She did not know the specific gap requirements. She thought it was around 4 in maximum;-The facility has bedrails measuring around 7 in;-She followed the check sheet form and assessed the zones indicated;-Some of the hospital beds were old and did not meet requirements;-She did not know who was responsible for compliance. During an interview on 05/21/26, at 4:32 P.M., the Administrator said the following:-The facility had old hospital beds;-He did not know the gap allowance for bedrails;-The Housekeeping Supervisor assessed the bedrails quarterly and gave the completed form to nursing;-Staff should report issues with bedrails to maintenance for repair;-The bedrails should not have gaps large enough for a resident to become entrapped;-The MDS Coordinator, Director of Nursing (DON), and himself were responsible for compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265431	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Truman Lake Manor Inc	600 East 7th St Lowry City, MO 64763

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a process was in place to clearly and consistently documented each resident's code status preference (if resident wished to receive cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when a person's heartbeat or breathing stops)) when two resident's records (Residents #9 and #8) had inconsistent code status documentation. A sample of 22 was reviewed in a facility with a facility census of 64.Review of the facility's policy entitled Advance Directives (2001 MED-PASS, Inc.), showed the following:-Do not resuscitate (DNR) indicates in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no CPR or other life-sustaining treatments or methods are to be used;-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 for each resident is consistent with their documented treatment preferences and/or advance directive;-The interdisciplinary team (IDT) will review annually with the resident their advance directives to ensure such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record;-The IDT will be informed of changes and/or revocations so that appropriate changes can be made in the resident's medical record and care plan; Review of the facility's policy entitled Emergency Procedures - Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) (2001 MED-PASS, Inc.), showed the following:-If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is certified in CPR for healthcare providers/BLS will administer CPR unless it is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual;-If the resident's CPR status is unclear, CPR will be initiated and continued until it is determined there is a DNR or a physician's order not to administer CPR. Review of the facility's policy entitled Do Not Resuscitate (DNR) Order (2001 MED-PASS, Inc.), showed the following:-Facility staff will not initiate DPR or related emergency measures on a resident when there is a DNR order in effect;-The DNR orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record;-The DNR order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and placed at the front of the resident's medical record;-Should the resident be transferred to the hospital, a photocopy of the DNR order form must be provided to the personnel transporting the resident to the hospital;-DNR orders remain in effect until the resident (or legal representative) provides the facility with a signed and dated request to end the DNR order. 1. Review of Resident #9's electronic face sheet (gives basic profile information at a glance), dated [DATE], showed the following:-admission date of [DATE];-A DNR code status. Review of the resident's comprehensive/significant change Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated [DATE], showed the resident as cognitively intact. Review of the resident's current electronic physician order sheet (POS) showed an order, dated [DATE], for DNR code status. Observation on [DATE], at 12:01 P.M., showed a green dot (indicating resident wished to receive CPR) on the wall mounted nameplate next to the entrance of the resident's room. Review of the resident's care plan, as of [DATE], showed staff care planned he resident as a full-code status with interventions to administer life-saving measures if found without a pulse or respiration. Observation on [DATE], at 9:40 A.M., showed a green dot on the wall mounted nameplate next to the entrance of the resident's room. Observation and review on [DATE], at 10:00 A.M., of the resident's physical chart located in the nurses' station medication room showed the following:-A green sticker with Full Code (wished to receive CPR) written on the spine of the (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	binder;-A signed DNR sheet dated [DATE];-A POS, dated [DATE], showed an order, dated [DATE], for full code. During an interview on [DATE], at 10:23 A.M., Certified Nursing Assistant (CNA) K said the resident's code status recently changed from a full code to DNR. He/She did not know when the code status changed. During an interview on [DATE], at 12:44 P.M., Registered Nurse (RN) I said the resident #9's code status recently changed to DNR, but he/she did not know when this change occurred. During an interview on [DATE], at 12:16 P.M., Hospice RN J said the following: -The resident was DNR status as required for hospice admission;-The resident re-admitted to hospice services when he/she returned from the hospital on [DATE];-He/She did not know of any discrepancies in code status in the resident's record. During an interview on [DATE], at 12:29 P.M., the Activity Director said she did not know of the resident's change in code status until identified by surveyors. During an interview on [DATE], at 2:25 P.M., the Social Worker (SW) said the following:-The resident's code status changed to DNR in [DATE];-She did not know why staff did not update the resident's code status documentation for each area. 2. Review of Resident #8's face sheet showed the following:-admission date of [DATE];-Code status of DNR. Review of the resident's POS, current as of [DATE], showed an order, dated [DATE], for DNR. Review of the resident's annual MDS, dated [DATE], showed the resident had severely impaired cognition for decision making. Review of the resident's care plan, last updated [DATE], showed the following:-Resident wished to be a DNR; -Wishes will be honored through next review;-If found without pulse or respiration notify the nurse and do not initiate CPR. During an observation and interview on [DATE], at 3:47 P.M., the SW said the binder that contained all residents' DNR documentation did not have a copy of the resident's DNR documentation. The SSD located a copy of the resident's signed DNR card in his/her admission packet. During an observation and interview on [DATE], at 3:50 P.M., LPN F could not locate a signed DNR card in the resident's hard chart binder. The binder had a green Full Code label on its spine. LPN F said if the resident was in medical crisis he/she would refer to the binder. He/she would provide CPR since there was no indicator for DNR. 3. During an interview on [DATE], at 10:23 A.M., CNA K said the following:-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-Nursing staff document the code status in the electronic record and physical chart;-The Activity Director places the code status stickers outside the resident rooms;-The code status should be the same for all areas;-He/She did not know who was responsible for verifying all areas reflected the correct code status. During an interview on [DATE], at 11:56 A.M., CNA M said the following:-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-The Activity Director places the code status stickers outside resident rooms;-He/She did not know who documented code status in the physical chart or electronic chart;-Code status should be the same for the physical chart, electronic chart, and match the sticker outside the resident's room;-He/She did not know who was responsible for overall compliance;-He/She would report conflicts in code status to the charge nurse immediately. During an interview on [DATE], at 11:33 A.M., Certified Medication Technician (CMT) L said the following:-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-Resident code status is in the physical chart, electronic record, and color sticker outside their room;-Code status should be the same for all areas;-The Director of Nursing (DON) was responsible for compliance;-He/She did not know how often the DON checked resident code status for accuracy;-He/She would report discrepancies in code status immediately to the charge nurse and DON. During an interview on [DATE], at 12:29 P.M., the Activity Director said the following:-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-She places the stickers outside the resident's room on admission and replaces as needed with changes;-Department heads discuss code status changes daily Monday through Friday;-Nursing staff document code status in the face sheet, POS, and attachments in the electronic charting;-Administrative staff were responsible for monitoring resident (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	code status and ensuring accuracy for all areas reflecting code status. During an interview on [DATE], at 1:06 P.M., LPN C said the following:-Nursing staff document code status in the electronic face sheet and physical chart;-He/She did not know what specific locations of code status documentation in the electronic and physical records;-He/She did not know how often staff checked code status documentation;-The Activity Director places a code status sticker outside the resident rooms when they admit;-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-He/She would report discrepancies in code status to the DON immediately;-The DON was responsible for checking code status. During an interview on [DATE], at 12:44 P.M., RN I said the following:-Nursing staff document the code status based on the code sheet;-Nursing staff document the code status on the face sheet in the electronic medical record, electronic POS, save the code sheet in the attachments tab of the electronic medical record, and physical chart;-Nursing staff place the code sheet in the physical chart;-The Activity Director places a code status sticker outside resident rooms;-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-Code status should be the same for the physical chart, electronic chart, and match the sticker outside the resident's room;-Nursing staff were responsible for compliance. During an interview on [DATE], at 2:25 P.M., the SW said the following:-She obtains resident code status on admission, gives to the physician to sign, makes copies, and saves copies in the electronic and physical chart;-She saves the electronic code status on the face sheet and in the attachments;-She places a copy of the code status in the physical chart and places a code status sticker on the spine of the physical chart;-She or the Activity Director place a code status sticker outside the resident's room;-The green door sticker outside the resident's room indicated full code status;-The red door sticker outside the resident's room indicated DNR status;-Her, the DON, and Activity Director were responsible for verifying accuracy of resident code status and addressing changes as needed. During an interview on [DATE], at 2:44 P.M., the DON said the following:-Nursing staff should document resident code status in the face sheet, POS, attachments tab, and care plan of the electronic medical record;-Nursing staff should document resident code status on the spine of the physical chart and advanced directive section of the physical chart;-The Activity Director or SW place a code status sticker outside the resident's room;-The green door sticker outside the resident's room indicates full code status;-The red door sticker outside the resident's room indicates DNR status;-The SW checks code status on admission;-Department heads verify code status during quarterly care plan meetings and MDS assessments. During an interview on [DATE], at 1:45 P.M., the Administrator said the social worker starts the code status preference process when a resident is admitted . After the resident or resident representative signs the DNR card, it is given to the physician for signature. Medical Records then scans the signed card into the electronic medical record (EMR) and puts the signed card into the resident's hard chart. The Activities Director places the code status indicator dot on the resident's room nameplate; green for Full Code or red for DNR. Staff can check the code status on the EMR, in the facility DNR binder kept by the social worker, or in the resident's hard chart. A copy of the DNR card should be sent with EMS if the resident is sent to the hospital.