

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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> 38016</p> <p>Based on interview and record review, the facility failed to provide care in a manner that enhanced resident dignity for one resident (Resident #63), in a review of 24 sampled residents, and for one additional anonymous resident (Resident #100). The facility census was 67.</p> <p>Review of the undated facility policy, Resident Rights, showed the resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility.</p> <p>1. Review of Resident #63's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 4/18/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact;</li> <li>-He/She had limited functional range of motion to bilateral upper and lower extremities;</li> <li>-He/She required maximal assistance with upper body dressing;</li> <li>-He/She required moderate assistance with personal hygiene;</li> <li>-He/She was dependent for toileting hygiene and lower body dressing;</li> <li>-He/She was always incontinent of bladder and bowel.</li> </ul> <p>Review of the resident's care plan, last updated 4/24/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident needed assistance with personal hygiene and bathing, and he/she participated in bed mobility but did need assist;</li> <li>-He/She received antipsychotic medication for the treatment of bipolar disorder (mood disorder that can cause intense mood swings).</li> </ul> <p>During an interview on 5/22/24 at 9:10 A.M., the resident said the following:</p> <ul style="list-style-type: none"> <li>-When the facility was short of nursing staff, everyone was busy and in a rush;</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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>-The nursing staff told him/her they were busy and would get to him/her eventually;</p> <p>-A few times, the nursing staff answered his/her call light and said, What do you want now?</p> <p>-The nursing staff also said, Let's get this done. I have several things to do;</p> <p>-The nursing staff's comments makes him/her feel like a burden;</p> <p>-He/She didn't want to be a burden but needed help.</p> <p>2. Review of Resident #100's quarterly MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Review of the resident's care plan, revised 3/18/24, showed the resident made his/her own decisions.</p> <p>During an interview on 5/22/24, at 5:15 P.M., the resident said the following:</p> <p>-The social service director (SSD) does not treat residents with dignity and respect;</p> <p>-He/She does not know if the SSD was aware, but she would scold residents and speak to them like they were children;</p> <p>-The resident said he/she has been scolded by the SSD in front of others and it was humiliating. He/She felt embarrassed and angry;</p> <p>-He/She has seen the SSD scold and talk down to several residents and it really bothered him/her; the SSD's behavior was intimidating;</p> <p>-He/She had reported this to a previous Director of Nursing.</p> <p>During an interview on 5/22/24 at 10:15 A.M., the SSD said staff are expected to treat residents with respect. Staff should not scold residents or talk down to residents in any way.</p> <p>During an interview on 5/23/24 at 10:34 A.M., the Director of Nursing said the following:</p> <p>-Staff are expected to treat resident's with dignity and respect;</p> <p>-Staff are expected to speak to resident's like adults and not scold residents;</p> <p>-She was not aware of any concerns with the SSD.</p> <p>46506</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</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 consistently address and respond to concerns brought forth by the resident council. The facility census was 67.</p> <p>Review of the undated facility policy, Grievance Protocol, showed the following:</p> <p>-Purpose: to provide a written record of each resident and family concern and to insure proper follow-up through the appropriate discipline;</p> <p>-The Social Services Director (SSD) is responsible for the program, although the administrator is ultimately responsible for the proper implementation of the program. The SSD informs the administrator of each incident;</p> <p>-Any member of the social services staff can complete the grievance complaint report. The appropriate situations for use of the grievance complaint report are:</p> <ul style="list-style-type: none"> <li>a. Resident articles that are lost or cannot be located - continual concern of lost resident items</li> <li>b. Resident care or personal hygiene issues that cannot be immediately resolved;</li> <li>c. Resident or family concerns with dietary issues - diet or temperature of meals;</li> <li>d. Any resident or family concern with a staff member;</li> <li>e. Any resident or family issue that would require a resolution;</li> </ul> <p>-The SSD will:</p> <ul style="list-style-type: none"> <li>a. Obtain the original grievance complaint report;</li> <li>b. Record the grievance on the monthly grievance log;</li> <li>c. Inform the administrator of the grievance;</li> <li>d. Forward a copy of the grievance to the appropriate discipline;</li> </ul> <p>-That administrator and SSD evaluate the monthly grievance log for trends or patterns and devise an action plan to correct the issues;</p> <p>-A new grievance log should be completed each month. It should be presented at the Quality Assurance meeting quarterly.</p> <p>1. Review of the facility's Resident Council Meeting Minutes, dated 2/13/24, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Evening meal: Need to follow recipes, appropriate portions, silverware left off hall trays, and no condiments given out;</p> <p>-Train staff on how to order food; tired of running out of food;</p> <p>-Bariatric sheets (bed sheets) still not being returned to right people;</p> <p>-Activity calendar review: keep horse racing and more crafts;</p> <p>-Maintenance: New cap on floor on A Hall; no safety bar on A Hall door.</p> <p>Review of the facility's Resident Council Meeting Minutes, dated 3/12/24, showed the following:</p> <p>-No documentation on the follow up or resolution to the concern/requests made during last meeting;</p> <p>-Food is not good; very bland, no flavor, mashed potatoes not cooked, grated cheese not properly cooked, and dinner rolls unevenly cooked;</p> <p>-Cooks don't care and not paying attention;</p> <p>-Nursing-not being taken care of properly, tired of medications running out, look into new pharmacy, no ice water passed during evenings/nights;</p> <p>-Laundry-same problems as always (bleach spots, holes, missing);</p> <p>-Housekeeping-not enough help;</p> <p>-Activities-find new vice president for resident council, new store trip times, and look into other stores for shopping.</p> <p>Review of the facility's Resident Council Meeting Minutes, dated 4/9/24, showed the following:</p> <p>-Previous meeting minutes missing due to Activity Director out of building;</p> <p>-No documentation on the follow up or resolution to the concern/requests made during last meeting;</p> <p>-Food concerns-tasteless, orders not matching menu, not enough condiments, bread is stale, potatoes burnt, and bacon not served on weekend;</p> <p>-Nursing concerns: room [ROOM NUMBER]'s bed not changed for months, and blood sugars taken too early;</p> <p>-Laundry-missing clothes;</p> <p>-Activity calendar review: residents need to agree on activities, stick with scheduled activities, things being canceled, and more things to do;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Maintenance-room [ROOM NUMBER]-D bed was broken, a resident's wheelchair brakes broke, a resident's bed not locking, and air conditioner filters need to be replaced.</p> <p>During an interview on 5/21/24 at 2:26 P.M., Resident #34, a member of the Resident Council, said the following:</p> <p>-The department supervisors did not always provide a response with an answer to the Resident Council's questions or recommendations;</p> <p>-This problem occurred for the past five to six months.</p> <p>During an interview on 5/21/24 at 2:26 P.M., Resident #48, a member of the Resident Council, said the following:</p> <p>-The staff did not provide a copy of the meeting minutes to the Resident Council;</p> <p>-If the department supervisors responded to a resident's requests or grievances, the staff did not provide the Resident Council with the department supervisors' response.</p> <p>During an interview on 5/22/24 at 9:24 A.M., the Activities Director said the following:</p> <p>-He/She kept the Resident Council meeting minutes;</p> <p>-He/She reviewed the previous months meeting minutes, but did not know to provide a copy to the residents;</p> <p>-He/She notified the department supervisors about the grievances or recommendations made at the Resident Council meetings, but did not follow up for a response.</p> <p>During an interview on 5/23/24 at 4:45 P.M., the Administrator said the following:</p> <p>-He expected the department supervisors to provide the Resident Council with an answer as soon as possible;</p> <p>-He expected the department supervisors to keep the Resident Council up to date on what was going on with the grievances/recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>42592</p> <p>Based on record review and interview, the facility failed to notify the resident and/or resident representative when the resident's trust account reached \$200 less the Supplemental Security Income (SSI) resource for one resident that received Medicaid benefits for one resident (Resident #4), in a sample of 24 residents. The facility census was 67.</p> <p>Review of an undated blank sampled letter for notification of fund balance, provided by the facility, showed the facility would notify the resident and/or resident representative of the resident's current balance when the balance was within \$200.00 of the Medicaid resource limit. If the amount in the fund exceeded the Medicaid resource limit of \$5,726.00, the resident may lose eligibility for Medicaid or SSI.</p> <p>Review of Resident #4's face sheet showed the resident has family member as the responsible party and Durable Power of Attorney for financial and health care decisions.</p> <p>Review of the resident trust fund account balance report, dated 4/30/24 showed the resident to have an account balance of \$5887.24.</p> <p>Review of the facility provided resident trust fund account binder for the month of April showed no evidence that a notice was given to the resident/legal representative that the resident's trust fund balance was over the maximum amount a Medicaid recipient can have in cash assets for Medicaid Eligibility Limit.</p> <p>Review of the facility provided resident trust fund account balance report, dated 5/20/24, showed the resident to have an account balance of \$5748.24.</p> <p>Review of the facility provided resident trust fund account binder for the month of May showed no evidence that a notice was given to the resident/legal representative that the resident's trust fund balance was within, or approaching, \$200 of the maximum amount a Medicaid recipient can have in cash assets for Medicaid Eligibility Limit.</p> <p>During an interview on 05/22/24 at 5:10 P.M. and 05/23/24 at 11:50 A.M., the BOM said the following:</p> <ul style="list-style-type: none"> <li>-She did not realize that Resident #4 was over his/her limit of maximum a Medicaid resident can have in cash assets;</li> <li>-She had not sent a notice to the resident's durable power of attorney (DPOA) informing them the resident was approaching his/her maximum amount in the resident trust fund;</li> <li>-She was not sure how the balance was missed by herself or the resident fund manager.</li> </ul> <p>During an interview on 05/23/24, at 11:45 A.M., the regional resident fund manager said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-She relies on the bookkeeper at the facility to monitor the resident trust fund for balances that are approaching the spend down limit;</p> <p>-She runs a balance report at the end of the month and if we see there is a balance within \$200 we try to spend that excess to provide things like clothes, equipment, or anything the resident might need;</p> <p>-It was not only the facility's responsibility to monitor the balance, but was also the family's responsibility to monitor that trust fund balance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on record review and interview, the facility failed to give appropriate Centers of Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) (CMA-10055) in writing to one Resident (Resident #63) reviewed when the facility initiated discharge from Medicare Part A services and the resident remained in the facility. The facility census was 67.</p> <p>Review of the facility undated admission agreement related to ABN showed when a resident is not covered Medicare Part A because daily skilled service is not needed:</p> <ol style="list-style-type: none"> <li>1. Approval of Quality Assurance Nurse is required;</li> <li>2. SNF-ABN (form CMS-10055) is issued;</li> <li>3. Generic notice of Medicare Non-Coverage (form CMS-10123) is issued.</li> </ol> <p>Review of the SNF Notices of Non-Coverage Cheat Sheet, date 3/19/14, provided by the facility as their policy for ABN, showed if a beneficiary drops to a non-skilled level of care, benefits have not exhausted, and the beneficiary remains in the facility, the facility is to provide the SNF-ABN and Notice of Medicare Provider Non-Coverage (CMS-10123) no later than two days before covered services end.</p> <p>1. Review of Resident #63's face sheet showed the resident admitted to the facility on [DATE] from an acute care hospital.</p> <p>Review of the resident's medical record showed the resident admitted on [DATE] and received skilled services. The resident discharged from skilled services on 11/23/23 and remained in the facility with a different pay source. (Review showed no documentation the facility provided the resident with the SNF-ABN when his/her skilled services were ending and he/she remained in the facility.)</p> <p>During an interview on 5/22/24 at 12:15 P.M. the Social Services Designee said the following:</p> <ul style="list-style-type: none"> <li>-Nursing does the Medicare discharge notices;</li> <li>-She was not aware that she had to complete the notices and she did not complete one.</li> </ul> <p>During an interview on 5/22/24 at 12:20 P.M., the Administrator said he expected staff to issue an SNF-ABN notice in a timely manner and per the facility policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on observation, interview and record review, the facility failed to keep the floors and walls in good repair and failed to maintain a homelike environment in the facility. The facility census was 67.</p> <p>Review of the undated facility policy, Housekeeping Department, Seven Steps of Cleaning a Resident Room, showed tasks to be completed included the following:</p> <ul style="list-style-type: none"> <li>-Emptying trash;</li> <li>-Clean and disinfect the bathroom;</li> <li>-Sanitize floor;</li> <li>-Report any needed maintenance work;</li> <li>-The policy did not identify how often the tasks were to be completed.</li> </ul> <p>Request for a homelike environment policy was requested of the facility but none provided.</p> <p>1. Observation on 5/19/24 at 4:04 P.M., in occupied resident room [ROOM NUMBER] (area near window), showed the following:</p> <ul style="list-style-type: none"> <li>-Resident #59 resided in this room; he/she was lying in his/her bed;</li> <li>-A musty odor was present in the room;</li> <li>-A trash can sat on the floor between the resident's bed and the wall;</li> <li>-Two urinals hung on the lip and inside the trash can;</li> <li>-One urinal held approximately 900 milliliters (ml) of urine (full is 1000 ml) and the other was empty but had a thick, yellow brown sediment at the bottom of the urinal;</li> <li>-Both urinals had caps to close the urinals that were in place and dated 5/10/24.</li> </ul> <p>During an interview on 5/19/24 at 4:06 P.M., the resident said if the urine odor got too bad, he/she had to empty the urinals. Sometimes the staff who cleaned his/her room emptied them.</p> <p>Review of the resident's May 2024 physician order sheets (POS) showed an order to change urinal weekly; label with date and initials (it had been nine days since staff changed the urinals).</p> <p>2. Observation on 5/19/24 at 4:21 P.M., in occupied resident room [ROOM NUMBER] (area near the door) showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Resident #38 resided in this room; he/she sat in a recliner in the room, the resident was noted to have an above the knee amputation;</p> <p>-A musty odor was present in the room;</p> <p>-A trash can sat on the floor behind the resident's recliner;</p> <p>-One urinal hung on the lip and inside the trash can and one urinal hung on the lip and outside the trash can;</p> <p>-One urinal held approximately 400 ml of urine and the other approximately 700 ml of urine;</p> <p>-Both urinals had caps to close the urinals that were in place and dated 5/10/24.</p> <p>During an interview on 5/19/24 at 5:25 P.M., the resident said staff were to empty the urinals and replace them and it stinks in here when they don't.</p> <p>Review of the resident's May 2024 POS showed an order to change urinal weekly; label with date and initials (it had been nine days since staff changed the urinals.)</p> <p>During an interview on 5/22/23 at 1:18 P.M., the Director of Nursing (DON) said the following:</p> <p>-Urinals should be checked often and emptied when there was any urine present in them. Any staff are capable of doing this task and should be doing it when entering the resident room multiple times daily;</p> <p>-Urinals should be replaced weekly;</p> <p>-When staff do these things, odors are better controlled.</p> <p>3. Observation on 5/19/24 at 5:00 P.M., in occupied resident room [ROOM NUMBER], showed the wall area under the air conditioner with a black substance the length of the air conditioner; the wall area also had a brown circular ring, approximately two feet by one foot and had a warped appearance as if it had been wet and then dried.</p> <p>4. Observation on 5/19/24 at 3:54 P.M., showed occupied resident room [ROOM NUMBER], with paint missing on the walls by the resident's bed, a missing closet handle and the toilet grout was thick with dark brown sediment.</p> <p>5. Observation on 5/19/24 at 3:59 P.M., showed occupied resident room [ROOM NUMBER]'s closet door with many scuffs in the wood and chips in the paint.</p> <p>6. Observation on 5/20/24 at 10:26 A.M., showed occupied resident room [ROOM NUMBER] with deep gouges into the bathroom door.</p> <p>7. Observation on 5/19/24 at 5:07 P.M., in occupied resident room [ROOM NUMBER], showed the middle of the tile floor had chips and cracks in the tile with missing pieces of tile in the flooring.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>8. Observations on 5/19/23 at 4:00 P.M. showed the following:</p> <ul style="list-style-type: none"> <li>-In occupied resident room [ROOM NUMBER], the first bed in the room was unmade, the mattress was dirty with white spots and flakes of a whitish substance. The metal bed frame was rusty. The privacy curtain between the first and second bed was dirty;</li> <li>-In occupied resident room [ROOM NUMBER], the wall by the first bed was gouged with dry wall exposed and a hole in the corner above the baseboard, the foot board of the second bed had a piece of the particle board off the end of the foot board and there were dirty clothes on the floor in the bathroom.</li> </ul> <p>During an interview on 5/19/21 at 4:15 P.M., Resident #13, who resided in room [ROOM NUMBER], said the following:</p> <ul style="list-style-type: none"> <li>-He/She waited weeks to get his/her bed changed due to no linen to change the bed;</li> <li>-He/She checked the closets daily for the linen;</li> <li>-If he/she found the linen, he/she changed his/her own bed.</li> </ul> <p>9. Observation on 5/20/24 at 10:20 A.M., in occupied resident room [ROOM NUMBER], showed the following:</p> <ul style="list-style-type: none"> <li>-Two residents occupied the room;</li> <li>-Two uncovered bed pans were stored on the bathroom sink;</li> <li>-A graduated cylinder (used to measure the volume of a liquid, such as urine) was stored on the bathroom shelf and was uncovered with the resident's personal hygiene supplies;</li> <li>-The ceiling vent in the bathroom was soiled with debris.</li> </ul> <p>10. Observation on 5/20/24 at 10:27 A.M., in occupied resident room [ROOM NUMBER], showed the following:</p> <ul style="list-style-type: none"> <li>-Two residents occupied the room;</li> <li>-The bathroom floor around the toilet was stained an orange, brown color;</li> <li>-A pile of clothes lay on the shower floor;</li> <li>-An uncovered pillow was on the shower floor next to the clothes.</li> </ul> <p>11. Observation on 05/22/24 at 10:39 A.M., in occupied resident room [ROOM NUMBER], showed the following:</p> <ul style="list-style-type: none"> <li>-The bathroom door had multiple gouges exposing the wood underneath;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The door frame to the bathroom had multiple black marks toward the bottom of the door frame;</p> <p>-The bathroom floor had multiple brown stains;</p> <p>-The tile under the bathroom sink was stained a pink/orange color;</p> <p>-The bathroom sink had a large amount of white to light green sediment covering the base of the faucet and the knobs to turn the water on and off.</p> <p>12. Observation on 5/21/24 at 5:30 A.M., showed CNA W assisted Resident #49 from his/her bed to the bathroom. Observations showed feces on the floor under the resident's bed and on every other floor tile (12 inch floor tiles) from the bed to the bathroom. Feces were present on the bathroom floor and toilet seat.</p> <p>Observation on 5/22/23, at 8:30 A.M., showed the feces remained on Resident #49's floor under his/her bed, on the floor tiles to the bathroom, on the bathroom floor and the toilet seat.</p> <p>Observation on 5/22/23, at 2:30 P.M., showed the feces remained on Resident #49's floor under his/her bed, on the floor tiles to the bathroom, on the bathroom floor and the toilet seat.</p> <p>During an interview on 5/23/24, at 1:54 P.M., the Housekeeping Supervisor said the following:</p> <p>-Staff are assigned to clean every room every day;</p> <p>-Staff are expected to clean all toilets in the facility every day;</p> <p>-The housekeeping department was short staffed;</p> <p>-Staff, housekeeping and nursing, are expected to keep the rooms clean; feces should not be left on the floor or on the toilet.</p> <p>13. Observation on 5/21/25 at 9:00 A.M., of the facility linen rooms, showed the following:</p> <p>-No linens in the linen room on E hall;</p> <p>-No linens in the linen closet on B hall; the linen cart on the hall did not contain any linen;</p> <p>-The linen cart on F hall contained only pads and gowns.</p> <p>During an interview on 5/21/24 at 9:00 A.M., Certified Nurse Assistant (CNA) C said the following:</p> <p>-He/She had no linen to use to give resident care;</p> <p>-He/She could not make any of the beds.</p> <p>14. Observation on 5/22/24 at 10:55 A.M. showed the following:</p> <p>-The linen cart on the E hall contained several wash clothes, three sheets and two gowns;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The linen cart on A hall contained three pads, several sheets, a couple of blankets and a gown. The cart did not contain any wash cloths or towels;</p> <p>-The linen closet on B hall contained eight bed spreads and one blanket. The closet did not contain any towels, wash cloths, sheets, or gowns;</p> <p>-The small linen cart on B hall contained two pads, five wash cloths and three towels;</p> <p>-The linen room on B hall contained four gowns, two pads, three pillow cases, five wash cloths and three towels;</p> <p>-The linen cart on D hall contained three gowns and three pillow cases;</p> <p>-The main linen closet on the F hall contained seven towels, 12 hand towels and wash cloths, 12 sheets, several pads and six gowns;</p> <p>-The small linen cart on F hall contained disposable incontinence briefs, three wash cloths and a open package of wipes.</p> <p>During an interview on 5/22/24 at 11:15 A.M., the Laundry Supervisor said the following:</p> <p>-She noticed in the last several months that washcloths and towels had disappeared. There had not been a lot of linen to put out on the floor;</p> <p>-She thought the agency staff was throwing the linen away and not rinsing them out;</p> <p>-She told the old administrator they were short on linen;</p> <p>-The linen supplier will only fill according to their census.</p> <p>During an interview on 5/23/24, at 1:54 P.M., the Housekeeping Supervisor said the following:</p> <p>-She does not know how much linen the facility is supposed to have on hand;</p> <p>-She has never done an inventory on linens she has never been told to;</p> <p>-Many of the linen carts were empty when she was checking the linen.</p> <p>15. Observation and interview on 5/23/24 at 9:00 A.M. showed the Laundry Supervisor said the following:</p> <p>-She got the dirty linen barrels several times a day to keep the linen washed so the aides had linen on the floor;</p> <p>-There was not a lot of linen to wash and there was not a lot of linen to put out;</p> <p>-In the clean side of the laundry there was three and half packages of wash cloths, three of which were not open, and one package of hand towels not open;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-There were no sheets, no bath towels, no pillow cases, or any blankets noted on the shelves.</p> <p>During an interview on 5/22/24 at 12:15 P.M. the Administrator said the following:</p> <p>-There should be enough linen to provide resident care and to ensure bed linen was changed as needed;</p> <p>-The facility did not have a policy for linens;</p> <p>-The linen was contracted through an outside contractor;</p> <p>-The linen provider filled a linen order based on current census, but would provide linen if requested. He did not know if anyone has requested any linens.</p> <p>16. Observations on 5/20/24 between 9:44 A.M. and 4:45 P.M., showed the following:</p> <p>-In occupied resident room [ROOM NUMBER], the right-hand wardrobe handle was loose and missing a screw. The bathroom floor was discolored gray and there were several scraped areas on the wall;</p> <p>-In occupied resident room [ROOM NUMBER], the left handle of the wardrobe was missing one screw and was loose;</p> <p>-At the end of the A hall, an approximate 3-foot by 3-foot section of flooring was approximately 0.25 inches lower than the rest of the flooring;</p> <p>-In the B hall medication room, a 2-inch by 4-inch rectangular hole in the drywall (on the right side when entering through the door) and there was no cover on the ceiling light fixture;</p> <p>-In the B hall shower room, the shower handle was missing and the surrounding tile was broken in an approximate 8-inch by 18-inch area;</p> <p>-In the B hall dirty utility room (the sign on the room door read 'spray room'), there was a 3-inch hole in the ceiling that was surrounded by an approximate 2-foot by 3-foot area of flaking paint and exposed drywall and the drywall tape hung down from the ceiling;</p> <p>-In occupied resident room [ROOM NUMBER], there were several large brown stains on the white textured ceiling in a 3-foot by 3-foot area;</p> <p>-In the E hall medication room, there was a 2-inch by 4-inch open hole in the wall on the right side of the room (when entering the room);</p> <p>-In the E hall spa room, there was a moderate accumulation of dust and debris on a 12-inch by 12-inch ceiling vent. There was a 3-foot by 8-foot patched area of wall that was unpainted and a 2-inch circular area of paint on the ceiling that was loose and flaking from the painted surface;</p> <p>-In the E hall, there was an approximate 6-foot by 6-foot area of unpainted and untextured ceiling;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-In occupied resident room [ROOM NUMBER], the cove base trim located under the HVAC unit was pulled away from the wall in an approximate 4-foot section and pulled away from the wall approximately 2-inches. The bathroom sink sprayed water out onto the floor when the faucet was turned on. The resident in the room said the water got on the floor after he/she used the sink because the faucet sprayed out water so bad;</p> <p>-In occupied resident room [ROOM NUMBER], one of two bulbs in the bathroom ceiling light fixture was not working;</p> <p>-In the hallway outside resident rooms [ROOM NUMBERS], two light fixtures were missing the light covers;</p> <p>-In occupied resident room [ROOM NUMBER], an approximate 5-foot piece of cove base trim was missing under the HVAC unit. The wardrobe handle was missing one screw and the handle was loose;</p> <p>-In occupied resident room [ROOM NUMBER], two small white tiles were missing along the trim in the bathroom. One of two bulbs in the bathroom ceiling light fixture was not working;</p> <p>-In occupied resident room [ROOM NUMBER], a 3-foot piece of cove base trim under the HVAC unit was missing. There was a 3-inch by 6-inch brown stained area on the ceiling outside of the bathroom;</p> <p>-In occupied resident room [ROOM NUMBER], one of two bulbs in the bathroom ceiling light fixture was not working;</p> <p>-In occupied resident room [ROOM NUMBER], there was a 2-inch hole in the wall behind the door handle. One of two bulbs in the bathroom ceiling light fixture was missing;</p> <p>-In occupied resident room [ROOM NUMBER], there was an approximate 1-foot by 1-foot area of wall that had gouges located on the right side wall (when entering the room) and a 2-inch by 12-inch scrape on the inside right wall of the bathroom. The cold water at the bathroom faucet was not working. The resident in the room said it had not worked since he/she moved into the room a couple weeks ago;</p> <p>-In occupied resident room [ROOM NUMBER], the left side wardrobe door was missing the screw and the handle was loose</p> <p>-In occupied resident room [ROOM NUMBER], three pieces of duct tape held the HVAC unit vent cover on;</p> <p>-In unoccupied resident room [ROOM NUMBER], there was a 3-inch by 1- inch bubbled area on the bathroom wall and two of two bulbs in the ceiling light fixture were missing;</p> <p>-In unoccupied resident room [ROOM NUMBER], there was a 3-foot by 5-foot bubbled area with cracks in the ceiling texture and the ceiling in the left-side closet was unfinished and unpainted;</p> <p>-Above the northwest exit dining door, the cover for a light fixture was missing;</p> <p>-In the main dining room, two covers for light fixtures were missing and one bulb in one of these fixtures was not working;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-In the beverage and serving area, located between the kitchen and dining room, the wall behind the ice machine had pieces of broken drywall and missing cove base trim in an approximately 2-foot by 4-foot area;</p> <p>-In the activity director's office, the cover for a light fixture was missing;</p> <p>-In the water heater room, located near the private dining room, there was a moderate accumulation of dust and cobwebs on the 6-inch by 6-inch ceiling vent;</p> <p>-In the copy room, located across from the dining room, there was a moderate accumulation of dust on the 12-inch by 12-inch ceiling vent;</p> <p>-In the central supply room, there was a heavy accumulation of dark gray debris on the 12-inch circular metal ceiling vent and on the nearby curtain and ceiling;</p> <p>-In the library, there was a 3-foot by 6-foot area of ceiling that was discolored a light brown and the textured ceiling was drooping slightly. There was an approximate 2-foot long crack in one of the windows;</p> <p>-In the private dining room, the plastic soap dispenser was cracked;</p> <p>-In the sitting area by the nurses station, two 12-inch round metal ceiling vents had a moderate accumulation of dark gray buildup and debris;</p> <p>-In the bathroom to the right (as entering the building) of the main entrance, the floor was discolored yellow and had an approximate 8-inch cut in a triangular shape at one corner of the flooring;</p> <p>-In the bathroom to the left (as entering the building) of the main entrance, the plastic soap dispenser was cracked;</p> <p>-In the front entryway, an approximately 6-inch by 3-foot area of white floor tile at the door threshold was cracked and broken across approximately 50% of the tile surface.</p> <p>17. Observations on 5/21/24 between 7:51 A.M. and 9:03 A.M., during an exterior tour of the facility, showed the following:</p> <p>-At the front entrance, to the left of the front door, an approximate 1-inch by 2-foot trim board was loose and hung down approximately 3 inches;</p> <p>-At the right of the front entrance, an approximate 3-inch by 2-foot board hung loose with exposed nails visible and the board hung down from the soffit approximately 6 inches;</p> <p>-At the front entrance overhang, two areas of an approximate area of 3-foot by 3-foot had dried brown splatters across the surface of the exterior ceiling;</p> <p>-At the end of the A hall, the trim boards were severely rotted and missing paint in approximately 50 percent (%) of the surface. Three window screens were badly worn and one window screen was missing from a window;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-At the corner of the A and B halls, there was an approximate 3-inch by 6-inch hole in the soffit;</p> <p>-Above unoccupied resident room [ROOM NUMBER], the soffit vent was loose and hung down approximately 0.5 inches;</p> <p>-At the end of the B hall, the wood siding and trim boards were coming loose from the building and in some areas were missing as much as 50% of the paint on the boards;</p> <p>-There was a white cloth towel hanging outside of the HVAC unit for occupied resident room [ROOM NUMBER] that was pinched in between the HVAC cover and the inner portion of the HVAC unit;</p> <p>-No exterior cover was on the HVAC units for unoccupied resident rooms [ROOM NUMBERS], occupied resident rooms [ROOM NUMBER];</p> <p>-Above occupied resident room [ROOM NUMBER], the gutter was slightly twisted and there was a 0.5 inch gap at the gutter seam;</p> <p>-At the E hall portion of the building, there was an approximate 4-inch by 6-inch hole in the wood near the gutter downspout. At the end of the E hall, there was an approximate 2-inch by 4-inch hole in the fascia board near the gutter downspout;</p> <p>-Above occupied resident room [ROOM NUMBER], the wooden fascia and soffit had multiple holes including an approximate 3-inch by 3-inch hole in the fascia, an approximate 4-inch by 8-inch hole in the soffit, and an approximate four-inch by 20-inch hole in the soffit with a two-foot long board that was nailed at one end and hanging loosely and resting on the nearby gutter downspout;</p> <p>-Between occupied resident rooms [ROOM NUMBERS], a vent in the soffit was missing approximately 50% of its fins and there was a two-inch by two-inch hole near the vent;</p> <p>-Along the F hall, there was a three-inch by six-inch piece of trim that was missing and the wooden siding in this area was coming loose from the building and hung away from the building approximately one-inch;</p> <p>-Above the director of nursing office, an approximate 12-inch by 12-inch area of wooden siding was decayed across approximately 25% of its surface and was coming away from the surface of the building;</p> <p>-In the area outside the dining room, the wooden trim board located near a gutter downspout was severely rotted and had an approximate 3-inch by 12-inch hole in the soffit;</p> <p>-Near the kitchen, a wooden trim and soffit board was severely rotted in an approximate 3-inch by 2-foot section.</p> <p>During interviews on 5/21/24 at 7:51 A.M., 8:00 A.M., and 8:33 A.M., the maintenance director said the following:</p> <p>-He had asked previous facility administrators about replacing the rotted trim and fascia boards on the exterior of the facility but was told it was not in the budget at that time;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He was aware of the missing HVAC covers on the exterior of the building and had asked a previous administrator about replacing the covers but was told the units did not need covers;</p> <p>-He was unaware why the cloth towel was in the HVAC unit of occupied resident room [ROOM NUMBER];</p> <p>During an interview on 5/20/24 at 11:34 A.M., 11:41 A.M., and 3:21 P.M. and on 5/21/24 at 2:45 P.M., the maintenance director said the following:</p> <p>-He put down a new section of flooring at the end of the A hall and failed to level it properly;</p> <p>-He was waiting on new drywall to come from the facility's vendor so he could repair the damaged wall in the E hall spa room;</p> <p>-The 6-foot by 6-foot damaged area of ceiling on the E hall was a result of a contractor stepping through the ceiling prior to him becoming maintenance director;</p> <p>-If staff noticed items that needed repaired, he expected staff to fill out a work order and place it in the maintenance binder for him to address.</p> <p>During an interview on 5/22/24 at 7:22 A.M., the housekeeping supervisor said staff cleaned the vents in the residents' rooms once a month but she was considering cleaning them more frequently such as once per week.</p> <p>During an interview on 5/22/24 at 7:31 A.M., Housekeeping Aide U said the following:</p> <p>-He/She cleaned the floors during the week (Monday through Friday);</p> <p>-When he/she started employment at the facility, about a month ago, the buffer was broken;</p> <p>-He/She had to delay stripping and buffing certain floors, such as bathrooms that had tight spaces, because he/she needed the buffing machine to complete the work.</p> <p>During an interview on 5/22/24 at 9:33 A.M., the administrator said he expected equipment and items to be in safe condition and good working order.</p> <p>38016</p> <p>41412</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>46506</p> <p>Based on interviews and record review, the facility failed to ensure one resident (Residents #39), in a review of 24 sampled residents, and one additional resident (Resident #48), were able to voice grievances to the facility without discrimination, fear of discrimination, or reprisal. The facility failed to assist two sampled residents (Residents #36 and #46) and one additional resident (Resident #34) on how to file a grievance or complaint. The facility census was 67.</p> <p>Review of the facility's admission packet showed the following:</p> <ul style="list-style-type: none"> <li>-Any person(s) who believes that he/she or any class of individuals has been subjected to discrimination as prohibited by section 504 of the Rehabilitation Act of 1973 may file a complaint pursuant to the procedures set forth below, on his/her own behalf, on behalf of another person or on behalf of handicapped person as a class;</li> <li>-All persons are encouraged to file grievance in order to resolve any disputes arising under section 504;</li> <li>-Filing a complaint will not subject you to any form of adverse action, reprimand, retaliation or negative treatment by the facility;</li> <li>-Accordingly, the facility has adopted an internal grievance procedure providing for the prompt and equitable resolution of complaints alleging any action prohibited by the United States Department of Health and Human Service regulations;</li> <li>-Complaint processing procedure is as follows: <ul style="list-style-type: none"> <li>1. All complaints involving matters prohibited by section 504 shall first be filed with the facility administrator, who shall render an initial determination and resolution within seven days of receipt of the complaint;</li> </ul> </li> <li>-The director of operations or designee shall take steps to insure an appropriate investigation of each complaint to determine its validity;</li> <li>-The following agencies may be contacted for assistance if a concern is not handled to resident satisfaction and/or the resident wished to file a complaint concerning abuse, neglect or misappropriation of resident property in the facility: compliance hotline, Ombudsman for nursing home residents, state survey and certification agency, Missouri Department of Health and Senior Services and the hotline.</li> </ul> <p>Review of the undated facility policy, Grievance Protocol, showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: to provide a written record of each resident and family concern and to insure proper follow-up through the appropriate discipline;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The Social Services Director (SSD) is responsible for the program, although the administrator is ultimately responsible for the proper implementation of the program. The SSD informs the administrator of each incident;</p> <p>-Any member of the social services staff can complete the grievance complaint report. The appropriate situations for use of the grievance complaint report are:</p> <ul style="list-style-type: none"> <li>a. Resident articles that are lost or cannot be located - continual concern of lost resident items;</li> <li>b. Resident care or personal hygiene issues that cannot be immediately resolved;</li> <li>c. Resident or family concerns with dietary issues - diet or temperature of meals;</li> <li>d. Any resident or family concern with a staff member;</li> <li>e. Any resident or family issue that would require a resolution;</li> </ul> <p>-The SSD will:</p> <ul style="list-style-type: none"> <li>a. Obtain the original grievance complaint report;</li> <li>b. Record the grievance on the monthly grievance log;</li> <li>c. Inform the administrator of the grievance;</li> <li>d. Forward a copy of the grievance to the appropriate discipline;</li> </ul> <p>-That administrator and SSD evaluate the monthly grievance log for trends or patterns and devise an action plan to correct the issues;</p> <p>-A new grievance log should be completed each month. It should be presented at the Quality Assurance meeting quarterly.</p> <p>1. During an interview on 5/21/24 at 2:26 P.M., Resident #48 said the following:</p> <p>-Staff was not changing his/her roommate or providing his/her roommate with attention in a timely fashion;</p> <p>-He/She reported this grievance with administration;</p> <p>-After he/she reported the grievance to administration, the staff said out loud, Look out, the resident will tell on you;</p> <p>-Some staff stopped talking to the resident afterwards;</p> <p>-The grievance resulted in a negative response from staff toward his/her roommate related to him/her not receiving needed care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an interview on 5/21/24 at 2:26 P.M., Resident #39 said he/she was afraid to file a grievance or complaint because of retaliation. The staff already retaliated when he/she asked for something.</p> <p>3. During an interview on 5/21/24 at 2:26 P.M., Resident #34 said he/she did not know how to file a grievance at the facility or where the information was posted to file a grievance.</p> <p>4. During an interview on 5/21/24 at 2:26 P.M., Resident #36 said he/she did not know how to file a grievance at the facility, did not know he/she could file a grievance directly with State, or where the information was posted to file a grievance with the state agency.</p> <p>5. During an interview on 5/21/24 at 2:26 P.M., Resident #46 said he/she did not know how to file a grievance at the facility, that a grievance could be filed directly with the state agency, or where the information was posted to file a grievance with the state agency.</p> <p>6. During interview on 05/22/24 at 1:30 P.M., the social services director said the following:</p> <ul style="list-style-type: none"> <li>-She was the grievance officer for the facility and was the first step of investigation related to grievances;</li> <li>-She kept a grievance book for review;</li> <li>-She was unable to locate the grievance book.</li> </ul> <p>Observation on 05/22/24, at 1:30 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The SSD located the grievance book in a resident room in the resident's toilet bowl;</li> <li>-The grievance book was saturated and wet. The information within the book was not readable as multiple pages were stuck together and the ink had run on some pages.</li> </ul> <p>During an interview on 5/23/24 at 11:10 A.M., the social services director said she was not aware of Resident #48's concerns or that the staff responded negatively to the resident after he/she made a grievance.</p> <p>During an interview on 5/23/24 at 4:45 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-He expected staff to provide information to all residents how to file a grievance and to encourage and show residents how to do so;</li> <li>-When a resident filed a complaint, he expected the staff to be accepting of the resident, because all residents have the right to voice a grievance without fear of reprisal.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>50675</p> <p>Based on interview and record review, the facility failed to complete a thorough investigation of an allegation of abuse per facility's policy after one resident (Resident #55), of 24 sampled residents, reported an allegation of abuse. The resident alleged Certified Nurse Assistant (CNA) DD slapped him/her in the face while providing cares. The facility census 67.</p> <p>Review of an undated facility policy, titled, Abuse Prohibition Protocol Manual, Investigation Section 7, showed the following:</p> <ul style="list-style-type: none"> <li>-It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated;</li> <li>-Procedure: The investigation is the process used to try and determine what happened. The designated facility personnel will begin the investigation immediately. A root cause and analysis will be completed. The information gathered will be given to administration;</li> <li>-When an incident or a suspected incident of abuse is reported, the Administrator or Designee will investigate the incident with the assistance of the appropriate personnel. The investigation will include: <ul style="list-style-type: none"> <li>-i. Who was involved;</li> <li>-ii. Residents' statements;</li> <li>-iv. Interviews obtained from three to four residents who received care from the alleged staff;</li> <li>-v. Interviews obtained from 3-4 department staff (if applicable);</li> <li>-vi. Involved staff and witness statements of events;</li> <li>-vii. A description of the resident's behavior and environment at the time of incident;</li> <li>-viii. Injuries present including a resident assessment.</li> </ul> </li> </ul> <p>1. Review of the staffing schedule for night shift (6:00 P.M. to 6:00 A.M.) on 5/10/24, showed the following staff who worked:</p> <ul style="list-style-type: none"> <li>-Charge: Licensed Practical Nurse (LPN) AA;</li> <li>-CNA (no specific assignment): CNA Z;</li> <li>-CNA (no specific assignment): CNA Y;</li> <li>-CNA (no specific assignment): CNA W;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CNA (no specific assignment): CNA DD;</p> <p>-CNA (no specific assignment): CNA V.</p> <p>2. Review of the staffing schedule (staff who worked) for day shift (6:00 A.M. to 6:00 P.M.) on 5/11/24 showed the following staff who worked:</p> <p>-Charge: LPN EE;</p> <p>-Meds: LPN D;</p> <p>-CNA (no specific assignment): CNA C;</p> <p>-CNA (no specific assignment): CNA BB;</p> <p>-CNA (no specific assignment): CNA CC;</p> <p>-CNA (no specific assignment): CNA F; (worked 6:00 A.M. to 2:30 P.M.);</p> <p>-CNA (no specific assignment): CNA O; (worked 6:00 A.M. to 2:30 P.M.).</p> <p>3. Review of a Department of Health and Senior Services report, dated 5/11/24 at 7:59 P.M., showed the facility self-reported an allegation of abuse when a resident (Resident #55) alleged CNA (CNA DD) was abusive with him/her.</p> <p>4. Review of Resident # 55's Admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 3/26/24, showed the following:</p> <p>-Cognition was not addressed;</p> <p>-The resident has need for assistance with sit to stand, impairment of one side upper body and both sides lower body.</p> <p>Review of the resident's facility face sheet showed he/she had diagnoses that included pain, osteoarthritis (joint disease, in which the tissues in the joint break down over time) and muscle weakness.</p> <p>During an interview on 5/19/24 at 3:20 P.M., the resident said the following:</p> <p>-He/She was was in his/her bed and waiting to get up for the day (day unknown), it was around 6:00 A.M.;</p> <p>-Staff (name unknown) came in his/her room to help him/her up;</p> <p>-He/She was leaning over his/her bed, trying to reach into his/her bedside drawer;</p> <p>-The same staff thought he/she (the resident) smacked him/her (staff);</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The same staff member then smacked him/her on the face;</p> <p>-He/She fell out of bed and the staff member left him/her on the floor and left the room;</p> <p>-He/She got a skin tear to his/her arm from the fall;</p> <p>-The same staff member returned to his/her room with another staff (name unknown) and they got him/her up;</p> <p>-He/She had reported the incident to the police (through the administrator).</p> <p>Review of the resident's facility progress notes showed staff documented the following:</p> <p>-On 5/10/24 at 3:02 P.M., resident was alert and oriented times three (person, place and time), was assist times one and was able to make his/her needs know;</p> <p>-On 5/11/24 at 5:22 P.M., administration, director of nursing (DON), family member, and physician updated on resident's fall and skin tear to his/her right forearm;</p> <p>-Resident had a fall after CNA (not specific as to who) was coming into the room to get the resident up for breakfast. CNA said the resident became combative and the CNA walked out of the room. Nurse receiving day shift report (the writer of this note, Licensed Practical Nurse (LPN ) D) and nurse from previous shift (not specified) went into room noting resident sitting on bed with skin tear to right arm. Nurse from previous shift (not specified) administered first aide to the resident's skin tear. Resident said, I have cuts all over my body, nurse (not specified) assessed thoroughly, no new areas noted. Vitals obtained all entered into Matrix and are stable. Resident denied pain and placed into wheelchair. Safety measures in place, will continue to monitor;</p> <p>-There was no documentation in the notes regarding the resident's allegation of being slapped by staff.</p> <p>Review of the documents provided by the facility for their facility investigation showed the following:</p> <p>-A statement had been collected from CNA DD;</p> <p>-No documentation to show an interview or written statement from the resident's night shift nurse (LPN AA) or day shift nurse (LPN EE), who were responsible for the resident; (the incident/allegation occurred at shift change);</p> <p>-No documentation to show an interview or written statement from other staff (night shift) possibly involved, including CNA Z, CNA Y, CNA W or CNA V;</p> <p>-No documentation to show an interview or written statement from other staff (day shift) possibly involved, including CNA C, CNA BB, CNA CC, CNA F or CNA O;</p> <p>-No documentation to show interviews were obtained from residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/22/24 at 8:55 A.M., CNA F said the following:</p> <ul style="list-style-type: none"> <li>-The resident was on the floor when he/she went to the resident's room with CNA DD;</li> <li>-He/She saw the skin tear;</li> <li>-He/She did not know anything about either the resident or CNA DD allegedly slapping each other.</li> </ul> <p>During an interview on 5/21/24 at 6:21 P.M., LPN D said the following:</p> <ul style="list-style-type: none"> <li>-At morning shift change on 5/11/24, he/she was aware that the resident was on the floor and night staff, including LPN EE (this would not have been accurate per the schedule), tended to the resident;</li> <li>-He/She made the nursing note entry because he/she saw that LPN EE had not documented the fall;</li> <li>-He/She was not aware of any slapping that took place between the resident and CNA DD;</li> <li>-He/She was not the nurse for the resident on 5/11/24 and could not recall who was;</li> <li>-No one had ever asked her about any concerns he/she might have regarding CNA DD.</li> </ul> <p>During an interview on 5/21/24 at 1:17 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-She was called on 5/11/24 at about 6:00 P.M. by the agency nurse (name unknown) regarding the incident of CNA DD slapping the resident;</li> <li>-She asked the nurse to do an assessment while she was on the phone;</li> <li>-The only injury was a skin tear on the resident's right lower arm;</li> <li>-No interviews with other residents on CNA DD's assignment were completed.</li> </ul> <p>During an interview on 5/23/24 at 1:21 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-On 5/11/24, the DON called him at 6:00 P.M. and reported CNA DD slapped a resident;</li> <li>-No residents on CNA DD's assignment had been interviewed, other staff interviews and statements had only been collected from a few staff and no education to staff on abuse had been started;</li> <li>-These things would need to be included with/for a thorough investigation.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>34003</p> <p>Based on interview and record review, the facility failed to provide a notice of transfer to the resident and/or resident representative when one additional resident (Resident #6) and one closed record (Resident #56), were transferred to the hospital. The facility census was 67.</p> <p>1. Review of Resident #6's face sheet showed he/she was his/her own person.</p> <p>Review of the resident's progress notes, dated 4/5/23 at 9:13 P.M., showed staff documented the resident came to the nursing station holding his/her chest and complaining of chest pain, left jaw pain, and left arm pain at 7:40 P.M. Vitals were taken, physician and assistant director of nursing (ADON) called, and 911 called for ambulance. The resident left the facility at 8:05 P.M. via ambulance. When asking the resident who he/she wanted staff to contact, he/she said, no one at this time. The resident was taken to the hospital.</p> <p>Review of the resident's progress notes, dated 4/7/23 at 2:40 P.M., showed the resident returned to facility via public transport from the hospital.</p> <p>Review of the resident's progress notes, dated 12/08/23 at 8:09 A.M., showed the resident reported having suicidal idealizations with a plan. The resident will be evaluated at the hospital. The resident was transported to the hospital.</p> <p>Review of the resident's progress notes, dated 12/09/23 at 12:23 P.M., showed the resident was being sent back to the facility.</p> <p>Review of the resident's medical record showed no documentation facility staff provided the resident with a written notice of transfer when the resident was transferred to the hospital on 4/7/23 and 12/8/23.</p> <p>During an interview on 5/23/24 at 1:15 P.M., the resident said the facility never gave him/her any type of paperwork when he/she transferred to a hospital.</p> <p>2. Review of Resident #56's face sheet showed the resident was his/her own person.</p> <p>Review of the resident's progress notes dated 5/11/24 at 5:23 A.M. showed the resident was found on the floor and complained of extreme pain with bleeding from the head/face area. 911 called and the resident sent to a local hospital.</p> <p>Review of the resident's medical record showed no documentation facility staff provided the resident with a written notice of transfer when the resident was transferred to the hospital on 5/11/24.</p> <p>During an interview on 5/23/24 at 2:11 P.M., Licensed Practical Nurse (LPN) A said he/she did not have any knowledge of what to do with a discharge letter. He/She only sent a transfer sheet, face sheet, medication list, and code status with the residents when they were sent to the hospital.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/23/24 at 2:15 P.M., LPN B said he/she did not have any information regarding the discharge policy.</p> <p>During an interview on 5/23/24 at 2:24 P.M. the Social Services Designee (SSD) said the following:</p> <ul style="list-style-type: none"> <li>-The nurses were supposed to do the discharge letters;</li> <li>-Nursing staff sent Resident #56 to the hospital. The nurses were supposed to do the letters, as they were the ones who sent the residents out.</li> </ul> <p>During interview on 5/21/24 at 1:26 P.M. and on 5/23/24 at 2:05 P.M. and 3:04 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-The discharge letters should be in the resident's hard charts or uploaded into the Electronic Medical Record (EMR).</li> <li>-The charge nurses do not know about the discharge/transfer notices;</li> <li>-She expected the social services director to complete the transfer/discharge notices;</li> <li>-The discharge notice was not completed for Resident #56. His/Her condition was so bad, she informed the nurses not to worry about it. Social Services should have followed up the next day and completed the discharge letter. This was not done.</li> </ul> <p>38016</p> <p>41412</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>34003</p> <p>Based on interview and record review, the facility failed to inform residents and/or legal representatives of their bed hold protocol at the time of transfer for one additional resident (Resident #6) and one closed record (Resident #56), who were transferred to the hospital. The facility census was 67.</p> <p>Review of the undated facility policy for Bed Hold Policy Guidelines showed this facility will notify all residents and/or their representative of the bed hold policy guidelines. This notification shall be given upon admission to the facility, at the time of transfer to the hospital or leave, and at the time of non-covered therapeutic leave.</p> <p>1. Review of Resident #6's face sheet showed he/she was his/her own person.</p> <p>Review of the resident's progress notes, dated 4/5/23 at 9:13 P.M., showed the resident came to nursing station holding his/her chest and complaining of chest pain, left jaw pain, and left arm pain at 7:40 P.M. Vitals were taken, physician and assistant director of nursing (ADON) called, and 911 called for ambulance. The resident left the facility at 8:05 P.M. via ambulance. When asking the resident who he/she wanted staff to contact, he/she said, no one at this time. The resident was taken to the hospital.</p> <p>Review of the resident's progress notes, dated 4/7/23 at 2:40 P.M., showed the resident returned to facility from the hospital.</p> <p>Review of the resident's progress notes, dated 12/08/23 at 8:09 A.M., showed the resident reported having suicidal idealizations with a plan. The resident will be evaluated at the hospital. The resident was transported to the hospital.</p> <p>Review of the resident's progress notes, dated 12/09/23 at 12:23 P.M., showed the resident was being sent back to the facility.</p> <p>Review of the resident's medical record showed no documentation facility staff provided the resident with a written notice of the bed hold policy when the resident was transferred to the hospital on 4/7/23 and 12/8/23.</p> <p>During an interview on 5/23/24 at 1:15 P.M., the resident said the facility never gave him/her any type of paperwork when he/she transferred to a hospital.</p> <p>2. Review of Resident #56's face sheet showed the resident was his/her own person.</p> <p>Review of the resident's progress notes, dated 5/11/24 at 5:23 A.M., showed the resident was found on the floor and complained of extreme pain with bleeding from the head/face area. Staff called 911 and the resident was sent to a local hospital.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's medical record showed no documentation facility staff provided the resident with a written notice of the bed hold policy when the resident was transferred to the hospital on 5/11/24.</p> <p>During an interview on 5/23/24 at 2:11 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-He/She did not have any knowledge of what to do with a bed hold policy.</p> <p>-He/She only sent a transfer sheet, face sheet, medication list, and code status with the resident when they were sent to the hospital.</p> <p>During an interview on 5/23/24 at 2:15 P.M., LPN B said he/she did not have any information about a bed hold letter.</p> <p>During an interview on 5/23/24 at 2:24 P.M., the Social Services Designee (SSD) said the following:</p> <p>-The nurses were supposed to do the bed hold letters;</p> <p>-Nursing staff sent Resident #56 to the hospital. The nurses were suppose to do the letters, as they are the ones who were sending out the residents.</p> <p>During interview on 5/21/24 at 1:26 P.M. and on 5/23/24 at 2:05 P.M., the Director of Nursing ( DON) said the following:</p> <p>-The bed hold letters should be in the resident's hard charts or uploaded into the Electronic Medical Record (EMR).</p> <p>-If the resident is capable, the nurses will give them the bed hold notice and have the resident sign it before they are sent to the hospital. If the resident is not able to sign, the nurses should make a note in the medical record that the resident was unable to sign. This is then given to the Social Services to follow up. She was not sure if they were doing this.</p> <p>-The bed hold letter was not completed for Resident #56. His/Her condition was so bad, she informed the nurses not to worry about it. Social Services should have followed up the next day and completed the bed hold letter. This was not done.</p> <p>-The bed hold policy was not signed at times due to the resident's condition at the time of transfer.</p> <p>38016</p> <p>41412</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident when there is a significant change in condition</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment, required to be completed by facility staff, for three residents (Resident #54, #42, and #52), in a review of 24 sampled residents, within 14 days after the facility determined, or should have determined, there had been a significant change (major decline or improvement in the resident's status) in the resident's physical or mental condition which had an impact on more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The facility census was 67.</p> <p>Review of the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that:</p> <ul style="list-style-type: none"> <li>-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting;</li> <li>-Impact more than one area of the resident's health status;</li> <li>-Requires interdisciplinary review and/or revision of the care plan;</li> </ul> <p>-SCSA was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g. , two area of activity of daily living (ADL) decline or improvement);</p> <p>-An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later then the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing;</p> <p>-When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met;</p> <p>-If a significant change in status is identified in the process of completing any OBRA (Omnibus Budget Reconciliation Act of 1987) assessment except Admission and SCSA's code and complete the assessment as a comprehensive SCSA instead.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility assessment, updated 5/20/24, showed the facility resources needed to provide competent support and care for the resident population, every day and during emergencies, included MDS Coordinator coverage eight hours per day.</p> <p>1. Review of Resident #54's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 4/19/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had severe cognitive impairment;</li> <li>-He/She wandered daily;</li> <li>-He/She required setup assistance with eating;</li> <li>-He/She was independent with rolling right and left in bed and wheelchair locomotion;</li> <li>-He/She required moderate assistance with sitting to lying in bed and lying to sitting in bed;</li> <li>-No oxygen therapy.</li> </ul> <p>Review of the resident's care plan, updated on 4/22/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident required assistance of one staff member with meals, bed mobility, dressing, toileting, and personal hygiene:</li> <li>-Either mechanical lift with two assist or two with gait belt depending on how the resident was doing;</li> <li>-Used wheelchair for mobility due to limited range of motion in both legs due to being contracted;</li> <li>-May use a mechanical lift for transfers if he/she was experiencing or displaying weakness, otherwise, use less distressing measure of one to two with gait belt;</li> <li>-Eats with assistance of staff in dining room;</li> <li>-Extensive assistance required for transfers;</li> <li>-No oxygen therapy.</li> </ul> <p>Review of the resident's nurse note, dated 5/8/24 at 10:07 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Certified nurse assistant (CNA) assisted the resident with eating;</li> <li>-The resident remained on oxygen at 2 liters/minute per nasal cannula.</li> </ul> <p>Review of the resident's nurse notes, dated 5/13/24 at 6:05 P.M., showed the facility placed the resident on comfort care only with no hospitalization s.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation in the resident's room on 5/19/24 at 3:10 P.M., showed the resident received oxygen per nasal cannula and had a Broda chair (wheelchair that provides supportive positioning) in his/her room.</p> <p>During an interview on 5/21/24 at 5:40 A.M., CNA P said the following:</p> <ul style="list-style-type: none"> <li>-The resident did not move on his/her own;</li> <li>-The resident spoke to staff to let them know if he/she hurt or needed something;</li> <li>-Previously, the resident laughed, smiled, and was talkative;</li> <li>-The resident drank a few sips when staff held a glass with a straw for the resident.</li> </ul> <p>Observation in the resident's room on 5/21/24 at 6:10 A.M., showed CNA O and CNA FF rolled the resident from side to side in the bed without any assistance from the resident.</p> <p>During an interview on 5/21/24 at 6:40 A.M., CNA FF said the following:</p> <ul style="list-style-type: none"> <li>-The resident used to propel himself/herself via wheelchair around the facility;</li> <li>-The resident was a happy person and the staff had difficulty preventing the resident from trying to leave the building;</li> <li>-Since the resident first developed pneumonia, mid-April, he/she had a big change;</li> <li>-Now the resident stayed in bed all day and slept more and was dependent on all cares, but still talked to people.</li> </ul> <p>During an interview on 5/21/24 at 9:44 A.M., the resident's family member said the following:</p> <ul style="list-style-type: none"> <li>-The staff had to assist the resident with drinking;</li> <li>-The staff had to reposition the resident in bed.</li> </ul> <p>A significant change MDS was not completed to show a decline in the resident's ability to eat, locomotion via wheelchair, chair/bed-to-chair transfers, bed mobility, cessation of wandering behavior, or that the resident received oxygen therapy.</p> <p>2. Review of Resident #42's, annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Diagnosis: Alzheimer's, arthritis, fracture and chronic pain;</li> <li>-Requires partial/moderate assistance from staff for putting on/taking off footwear, and transfers;</li> <li>-Scheduled and (as needed) PRN pain medication and frequent pain;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Opioid use daily;</p> <p>-Wheelchair use;</p> <p>-Resident did not ambulate.</p> <p>Review of the resident's nurses notes, dated 12/29/24, showed the resident up in wheelchair.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-Scheduled pain medication;</p> <p>-Bed rails used as restraints daily;</p> <p>-No use of PRN (as needed) pain medications and pain assessment questions not completed;</p> <p>-Independent with transfers and walking 150 feet.</p> <p>The facility did not complete a SCSA after they documented a significant increase in cognitive ability, decrease in pain, new bed rail use and the resident independent with ambulation and transfers.</p> <p>Review of the resident's nurses notes, dated 5/15/24, showed the resident used a manual wheelchair to assist with mobility.</p> <p>Observation of the resident during the survey process, from 5/19/24 to 5/23/24, showed the resident was always in a wheelchair when out of bed. The resident did not walk independently. The resident had bed rails on his/her bed.</p> <p>3. Review of Resident #52's, admission MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnosis included dementia, chronic pain, fusion of spine (surgical connection of two bones in the spine to prevent movement) and spinal stenosis (space inside the backbone is too small that can put pressure on the spinal cord and nerves that travel through the spine, can cause pain, tingling, numbness and muscle weakness);</p> <p>-Independent with transfers, dressing and ambulation;</p> <p>-No mobility devices used;</p> <p>-Occasionally incontinent of bladder and bowel;</p> <p>-No toileting program;</p> <p>-Scheduled pain medications.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Requires supervision, touch or verbal cues for transfers and ambulating 50 feet and to make turns;</li> <li>-Requires partial/moderate assistance from staff for upper body dressing;</li> <li>-Requires substantial maximal assistance from staff for lower body dressing and put on/take off footwear;</li> <li>-Frequently incontinent of bladder, continent of bowel;</li> <li>-Two or more injury falls since last assessment</li> </ul> <p>The facility did not complete a SCSA after the resident required more assistance with ambulation, dressing, transfers, increase in incontinence and falls since the last comprehensive assessment.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnosis of depression, and Alzheimer's</li> <li>-Uses a walker;</li> <li>-Frequently incontinent of bladder and bowel;</li> <li>-Two or more no injury falls since last assessment;</li> <li>-Takes antidepressant medication daily.</li> </ul> <p>The facility did not complete a SCSA after the resident required more assistance with ambulation, dressing, transfers, increase in incontinence, falls, new diagnosis, use of a walker, and antidepressant medication since the last comprehensive assessment</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderate to severe depression;</li> <li>-Does not use a wheelchair;</li> <li>-Always incontinent of bladder and bowel;</li> <li>-Pain medication scheduled;</li> <li>-Non-verbal sounds, facial expressions that could indicate pain in five days of the seven day look back period;</li> <li>-Two or more no injury falls since last assessment.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of the resident during the survey process, from 5/19/24 to 5/23/24, showed the resident to always be in a wheelchair when out of bed. The resident did not walk independently or with staff.</p> <p>The facility did not complete a SCSA after the resident required more assistance with ambulation, dressing, transfers, increase in incontinence, falls, new diagnosis, use of a walker, antidepressant medication, increase in depressive symptoms, and physical signs of pain since the last comprehensive assessment.</p> <p>During an interview on 5/20/24 at 1:51 P.M. and 2:00 P.M., the acting MDS coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She worked at a sister facility and came over one or two days a week and helped complete the MDS's;</li> <li>-She did not know the residents, so he/she would ask the staff questions about the residents and complete the MDS's as best as he/she could;</li> <li>-She only completed what needed to be done;</li> <li>-She was not sure if residents needed a significant change assessment; she was not usually there when the interdisciplinary team was at the facility, so she did what she could.</li> </ul> <p>During an interview on 5/21/23 at 10:04 A.M., the Director of Nursing said the MDS assessments are expected to be completed according to the RAI manual. She was not sure if they are up to date as the MDS coordinator was part time and only in the facility on the weekends.</p> <p>46506</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment completed by staff, according to the Resident Assessment Instrument (RAI) manual for one sampled residents (Resident #52), in a review of 24 sampled residents. The facility census was 67.</p> <p>Review of the Resident Assessment Instrument (RAI) Manual, dated October 2023, showed the following:</p> <ul style="list-style-type: none"> <li>-Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessment of each resident's functional capacity and health status;</li> <li>-The RAI process has multiple regulatory requirements. Federal regulations require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts;</li> <li>-It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the interdisciplinary team (IDT) completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.</li> </ul> <p>Review of the facility assessment, updated 5/20/24, showed the facility resources needed to provide competent support and care for the resident population, every day and during emergencies, included MDS Coordinator coverage eight hours per day.</p> <p>1. Review of Resident #52's, admission MDS, a federally mandated assessment completed by staff, dated 6/16/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Diagnosis include: dementia, chronic pain, fusion of spine (surgical connection of two bones in the spine to prevent movement) and spinal stenosis (space inside the backbone is too small that can put pressure on the spinal cord and nerves that travel through the spine, can cause pain, tingling, numbness and muscle weakness);</li> <li>-Independent with transfers and ambulation;</li> <li>-No mobility devices used;</li> <li>-Occasionally incontinent of bladder and bowel;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No toileting program;</p> <p>-Scheduled pain medications received.</p> <p>Review of the resident's nurses notes, dated 7/11/23 at 6:39 A.M., showed the resident continues observation for recent fall.</p> <p>Review of the resident's nurses notes, dated 7/11/23 at 5:43 P.M., showed the resident had unsteady gait and lost balance causing a fall.</p> <p>Review of the resident's nurses notes, dated 7/15/23 at 7:47 A.M., showed the resident was observed sitting on the floor to the front and left side of his/her chair against the wall.</p> <p>Review of the resident's nurses notes, dated 8/16/23 at 3:24 P.M., showed the IDT note showed the resident had three falls in the month of July.</p> <p>Review of the resident's nurses notes, dated 9/12/23 at 11:45 P.M., showed the resident sustained a non-injury fall, witnessed in the dining room.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Requires supervision, touch or verbal cues for transfers and ambulating 50 feet and to make turns;</li> <li>-Requires partial/moderate assistance from staff for upper body dressing;</li> <li>-Requires substantial maximal assistance from staff for lower body dressing and putting on/taking off footwear;</li> <li>-Frequently incontinent of bladder; continent of bowel;</li> <li>-Two or more injury falls since last assessment;</li> <li>-The MDS did not include the non injury falls.</li> </ul> <p>Review of the resident's nurses notes, dated 9/25/23 at 10:23 P.M., showed the resident sustained a fall at 1:00 P.M. The resident turned and fell backward, striking his/her left posterior (back) head against the nursing station counter. The resident was immediately assessed for injury and a silver dollar sized raised area noted to his/her left posterior head.</p> <p>Review of the resident's nurses notes, dated 10/14/23 at 10:14 P.M., showed the resident sustained a fall in the dining room, witnessed by kitchen staff, striking his/her head against the piano and fell to the floor. The resident had a superficial laceration (tear or cut in the skin and underlying tissue) and a noted silver dollar sized hematoma (similar to a bruise) from the fall to the top of his/her posterior head.</p> <p>Review of the resident's nurses notes, dated 11/22/23 at 9:56 P.M., showed the resident was found to be sitting on the floor, with his/her legs crossed, going through his/her closet.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurses notes, dated 11/24/23 at 6:36 P.M., showed the resident was being sent to the emergency room for further evaluation, related to a fall. Resident had a hematoma to the left ear.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnosis of depression and Alzheimer's</li> <li>-Uses a walker;</li> <li>-Frequently incontinent of bladder and bowel;</li> <li>-Two or more no injury falls since last assessment;</li> <li>-Takes antidepressant medication daily;</li> </ul> <p>The MDS did not include the injury falls.</p> <p>Review of the resident's nurses notes, dated 12/31/23 at 10:02 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had an unwitnessed fall in his/her room; when staff arrived, he/she was sitting on the floor next to his/her wheelchair;</li> <li>-The resident was holding his/her left hand; he/she had a small cut to his/her left pinky finger and had a blood blister; areas cleansed and bandaged;</li> <li>-Abrasion noted to the resident's left lower back .</li> </ul> <p>Review of the resident's nurses notes, dated 1/6/24 at 2:29 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had witnessed fall in the living area;</li> <li>-The resident lowered him/herself to the floor; witnessed by staff;</li> <li>-Hoyer (mechanical lift) pad caught under the resident's chair.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderate to severe depression;</li> <li>-Does not use a wheelchair;</li> <li>-Ambulates with walker;</li> <li>-Always incontinent of bladder and bowel;</li> <li>-Pain medication scheduled,</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Has non-verbal sounds and facial expressions that could indicate pain five day of the seven day look back period;</p> <p>-Two or more no injury falls since the last assessment;</p> <p>-The MDS did not include the injury falls.</p> <p>Observation of the resident during the survey process, from 5/19/24 to 5/23/24, showed the resident to always be in a wheelchair when out of bed. The resident did not walk independently or with staff.</p> <p>During an interview on 5/20/24 at 1:51 P.M. and 2:00 P.M. the acting MDS coordinator said:</p> <p>-She worked at a sister facility and came over one or two days a week and helped complete the MDS's;</p> <p>-She did not know the residents, so he/she would ask the staff questions about the residents and complete the MDS's as best as he/she could;</p> <p>-She only completed what needed to be done;</p> <p>-She was not usually at the facility when the interdisciplinary team was there so does what she can.</p> <p>During an interview on 5/21/24 at 10:04 A.M., the Director of Nursing said the MDS assessments are expected to be completed according to the RAI manual. She was not sure if they were accurate or up to date as the MDS coordinator was part time and only in the facility on the weekends.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41412</p> <p>Based on interview and record review, the facility failed to have documentation of a Level I (level of care) PASARR (Pre-admission Screening and Resident Review), failed to file for a Level II PASARR (an in-depth assessment of the resident's mental health and intellectual needs) when conditions/diagnoses changed or were added, and failed to notify the appropriate state-designated authority for a significant change PASARR evaluation and determination for one resident (Resident #6), in a review of 24 sampled residents, when the resident reported suicidal thoughts and ideations and required hospitalization . The facility census was 67.</p> <p>Record review of the Missouri Department of Health and Senior Services (DHSS) guide titled, PASARR Desk Reference, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The PASARR is a federally mandated screening process for any person for whom placement in a Medicaid Title (XIX) certified bed is being sought. This is a Level I screening (completion of the DA124C form);</li> <li>-A Level II assessment is completed on those persons identified at Level I who are known or suspected to have a serious mental illness (such as schizophrenia, dementia, major depression, etc., mental retardation (MR) or related MR condition to determine the need for specialized service (completion of the DA124A/B form). The facility is responsible for completing the DA124A/B and/or DA124C forms and is also responsible for submitting completed form(s) to DHSS, Division of Regulation and Licensure, Section for Long Term Care Regulation, Central Office Medical Review Unit (COMRU);</li> <li>-PASARR screening is required to assure appropriate placement of persons known or suspected of having a mental impairment;</li> <li>-To assure that the individual needs of mentally impaired persons can be and are being met in the appropriate placement environment;</li> <li>-To be compliant with the Omnibus Budget Reconciliation Act (OBRA)/PASARR federal requirements, see 42 CFR 483.Subpart C; and</li> <li>-To assure Title XIX funds are expended appropriately and in accordance with Legislative intent.</li> </ul> <p>Request for a facility policy regarding PASARRs was made and no policy received.</p> <p>1. Review on [DATE] of Resident #6's medical record showed the following:</p> <ul style="list-style-type: none"> <li>-An admitted [DATE] (latest return) and [DATE] (current);</li> <li>-Diagnoses at admission ([DATE]) included major depressive disorder, recurrent severe without psychotic features.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's entry tracking record Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-admitted to the facility on [DATE];</li> <li>-No documentation of a PASARR being completed.</li> </ul> <p>Review of the resident's facility progress notes, dated [DATE] at 4:38 P.M., showed staff documented an admission assessment that included the following:</p> <ul style="list-style-type: none"> <li>-Alcohol: Educated no alcohol to be in the building unless it is locked up. States he/she has been sober since September of 2022. Asked resident if he/she needed any support measures such as a psychologist and resident denied at this time;</li> <li>-Mood: Recently lost a child. He/She was struggling with this loss. Offered support and psychologist to talk to. Resident again refused at this time but said maybe at a later time.</li> </ul> <p>Review of the resident's continuity of care document showed a new diagnoses of schizophrenia (mental illness) added on [DATE].</p> <p>Review of the resident's discharge MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Unplanned discharge; return anticipated;</li> <li>-Had been evaluated by Level II PASARR and determined to have a serious mental illness;</li> <li>-Diagnoses included depression and schizophrenia;</li> <li>-No behaviors or rejection of cares.</li> </ul> <p>Review of the resident's medical record showed the resident hospitalized on [DATE] and returned [DATE].</p> <p>Review of the resident's care plan showed a problem start date [DATE]: Category: psychotropic drug use; Approach: psychiatric and psychological services as needed.</p> <p>Review of the resident, facility provided, Level I PASARR, completed by the Business Office Manager, dated [DATE] (243 days since admission), showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnoses included major depressive disorder, personality disorder, bipolar disorder (mental illness) and other mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM); the box for schizophrenia was not marked;</li> <li>-To the question, Does the individual have a substance related disorder, the box was marked no; to the question, When did the most recent substance abuse occur, the unknown box was marked; (the resident's admission note showed he/she had been sober from alcohol since September of 2022);</li> <li>-admitted to the facility was [DATE].</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed a new diagnoses of anxiety added [DATE].</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident had behaviors and rejection of cares one to three days a week.</p> <p>Review of the resident's care plan showed a problem start date: [DATE]: Category: behavioral symptoms; potential for inappropriate social behavior related to episodes of sudden anger related to diagnoses of schizophrenia and mood disorder; Goal: resident will not harm self.</p> <p>Review of the resident's facility progress notes showed staff documented the following:</p> <ul style="list-style-type: none"> <li>-On [DATE] at 8:09 A.M., resident reported having suicidal idealizations with a plan. Updated physician's clinic. Resident will be evaluated at hospital. Resident 1:1 until transport to the hospital by facility transportation. Two staff escorted resident. While in transit resident pulled out a half pint of vodka with approximately six ounces of liquor remaining in the bottle. Bottle was then given to staff;</li> <li>-On [DATE] at 11:25 A.M., resident remains in hospital;</li> <li>-On [DATE] at 1:59 P.M., resident returned to the facility.</li> </ul> <p>Review of the resident's hospital discharge notes, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The resident arrived on [DATE] via long term care facility (LTCF) after making suicidal statements;</li> <li>-Presents for worsening depression and suicidal ideations;</li> <li>-According to resident, depression has gotten worse thinking about the holidays and two of his/her deceased spouses;</li> <li>-If he/she had a rope, he/she would hang him/herself;</li> <li>-Has a history of alcohol and drug abuse and prior suicide attempts;</li> <li>-Diagnoses of alcohol use disorder and had become more depressed recently following alcohol use recurrence;</li> <li>-Resident reminded alcohol use can bring on bad thoughts such as he/she has had recently;</li> <li>-Resident reported he/she was drinking three pints of alcohol per day; LTCF reported resident's family member brought him/her alcohol;</li> <li>-Discharge recommendation included to continue treatment on an outpatient basis (has outpatient psych providers through LTCF); seek substance use treatment; possible naltrexone to help with alcohol cravings.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed no updates to his/her care plan or MDS regarding the resident's suicidal thoughts, ideation and/or plan and no documentation to show the resident was set up with outpatient psych services.</p> <p>Review of the resident's facility progress notes showed staff documented on [DATE] at 9:10 A.M., Behavior: resident yelling at this nurse, who was at the nursing station, regarding the way his/her eggs were prepared; was yelling very loud, stated that he/she wanted to speak with the Administrator, resident told Administrator and later this nurse that his/her child had died from an overdose. This nurse offered understanding (no documentation that support services were offered); care plan updated.</p> <p>Review of the resident's care plan showed a problem start date of [DATE]; Category: psychosocial well being; resident has experienced the recent loss of his/her child related to overdose; child expired on [DATE]. Goal: resident will express feelings about recent loss appropriately.</p> <p>Review of the resident's facility progress notes showed staff documented the following:</p> <p>-On [DATE] at 10:09 P.M., resident walked by nurses desk and nurse at desk alerted the resident's nurse the resident had returned and could receive his/her medication. Resident wanted nurse to give him/her his/her medication in hand and said, I will take them later, it is too early for me right now. Nurse relayed he/she would keep the medications in the cart and when the resident was ready, the resident could have them. Resident started yelling at nurse, cussing screaming. This nurse walked to resident's room to talk to him/her and calm him/her down. Resident said he/she was going through a lot and he/she didn't like the nurse. While talking to resident, this nurse smelled alcohol on resident's breath. This nurse asked resident have you been drinking? Resident said, Yes, I got the ok I am my own person. Resident then said he/she was at the bar down the street;</p> <p>-On [DATE] at 2:03 P.M., resident in kitchen yelling at the cook telling cook he/she didn't want what the cook was making. Director of Nursing asked resident to step out of the kitchen area, resident then went into the ice machine and cursed staff out. Contacted physician about behaviors, resident is on multiple medications for behaviors, was advised to get alcohol (ETOH) level in the morning.</p> <p>Review of the resident's medical record showed no documentation staff obtained an alcohol level on [DATE] and no documentation staff offered support services for alcohol use.</p> <p>During an interview on [DATE] at 11:26 A.M., the resident said the following:</p> <p>-He/She was his/her own person;</p> <p>-Before coming to the facility, he/she was a heavy drinker but got help and had been sober since before coming to the facility;</p> <p>-He/She had begun drinking again; life was just stressful;</p> <p>-He/She had lost a couple of children; children were not supposed to die before their parent;</p> <p>-He/She felt guilty for having addictions because he/she must have passed it down to the child that died of an overdose; that made him/her sad; drinking made that feeling go away;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Talking to people and attending groups for addictions and problems had helped in the past;</p> <p>-He/She would consider getting help again if someone helped him/her;</p> <p>-He/She just felt like staff was not consistent at the facility to help or even care;</p> <p>-He/She felt better as a person when he/she was sober;</p> <p>-When he/she drinks, he/she sometimes makes bad decisions or treats people badly and he/she does not like to do that.</p> <p>Review of email communication from COMRU to the state agency, dated [DATE] at 4:09 P.M. showed the following:</p> <p>-COMRU does not have a valid application;</p> <p>-The last application was pending corrections and was for a Special Admission Category only (would have triggered a Level 2);</p> <p>-The SNF will need to submit an online application for processing.</p> <p>Review of email communication from COMRU to the state agency, dated [DATE] at 2:53 P.M., showed the following:</p> <p>-An application was submitted on [DATE] and correction sent on [DATE];</p> <p>-A 2nd correction was sent on [DATE] and 3rd correction on [DATE]; this application was a special admission category as well;</p> <p>-This correction indicated that the SNF would need to submit another application for the [DATE] admission.;</p> <p>-The application should have been submitted within ,d+[DATE] days of admission due the COVID 19 waiver; (The COVID 19 wavier was available until [DATE]);</p> <p>-If the suicidal ideation and plan was a new behavior, then a change in condition would have needed to be submitted;</p> <p>-The SNF does not have a current Level 1/Level of Care application.</p> <p>During an interview on [DATE] at 10:40 A.M., the Business Office Manager said the following:</p> <p>-He/She had been responsible for the PASARRs and had completed the resident's PASARR;</p> <p>-A Level I should be completed before admission;</p> <p>-There should be documentation of the PASARR in the resident's medical record;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no PASARR in the resident's medical record other than the one completed [DATE];</p> <p>-He/She thought the resident's PASARR was complete;</p> <p>-He/She did not recall getting any communication that corrections were needed,</p> <p>During an interview on [DATE] at 2:40 P.M., the Social Services Designee said she did not know she was responsible for ensuring the PASARRs were completed when they should be. She was new to her position (started in [DATE]) and had not completed the resident's PASARR, the business office manager had completed it.</p> <p>During an interview on [DATE] at 6:49 P.M., the Director of Nursing said the following:</p> <p>-Social services was responsible for ensuring the PASARRs were completed when they should be;</p> <p>-She could not find where the resident had had the alcohol level drawn; the resident was his own person and was more frequently leaving and going to a bar and returning. The resident had had a lot of life stressors which have probably caused him/her to fall back into old habits and patterns;</p> <p>-She knew on admission the resident had refused any additional services. She was not sure if any had been offered since the resident lost his/her child or since the facility became aware the resident was drinking again.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive care plan, specific to the resident, for three residents (Resident #4, #20, and #68) in a review of 24 residents. The facility census was 67.</p> <p>Review of the undated facility policy, Care Plan Comprehensive, showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being;</li> <li>-Guidelines: The interdisciplinary care plan team with input from the resident, family, and/or legal representative will develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain;</li> <li>-The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to, the MDS;</li> <li>-A well-developed care plan will be oriented to: <ul style="list-style-type: none"> <li>a. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation);</li> <li>b. Managing risk factors to the extent possible or indicating the limits of such interventions;</li> <li>c. Addressing ways to try to preserve and build upon resident strengths;</li> <li>d. Applying current standards of practice in the care planning process;</li> <li>e. Evaluating treatment of measurable goals, timetables and outcomes of care;</li> <li>f. Respecting the resident's right to decline treatment;</li> <li>g. Offering alternative treatments, as applicable;</li> <li>h. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities;</li> <li>i. Involving resident, resident's family and other resident representatives as appropriate;</li> <li>j. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs;</li> </ul> </li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>k. Involving the direct care staff with the care planning process relating to the resident's expected outcomes;</p> <p>l. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.</p> <p>1. Review of Resident #20's undated face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Code status: Do Not Resuscitate (DNR);</li> <li>-Diagnoses of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and generalized anxiety disorder (excessive worry and feeling of fear, dread, and uneasiness).</li> </ul> <p>Review of the resident's out-of-hospital DNR form, dated 10/9/23, located in the resident's paper chart, showed the physician and the resident signed the form, indicating the resident's code status was DNR.</p> <p>Review of the resident's care plan, dated 11/24/23, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident required an indwelling urinary catheter;</li> <li>-The staff were to provide catheter care every shift and as needed;</li> <li>-The resident's care plan did not identify the resident's preferred code status.</li> </ul> <p>Review of the resident's progress note, dated 4/6/24 at 1:59 P.M., showed the resident refused to allow the nurse to complete peri-care and apply a treatment to his/her groin.</p> <p>Review of the resident's progress note, dated 4/7/24 at 2:33 P.M., showed the resident refused all attempts for staff to perform peri-care.</p> <p>Review of the resident's progress note, dated 4/11/24 at 12:37 P.M., showed the resident refused all attempts for staff to perform peri-care.</p> <p>Review of the resident's MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had intact cognition;</li> <li>-The resident did not refuse care;</li> <li>-The resident was dependent with toileting and personal hygiene;</li> <li>-The resident has an indwelling urinary catheter;</li> <li>-The resident was always incontinent of bowel.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's progress note, dated 4/12/24 at 1:33 P.M., showed the resident refused his/her shower.</p> <p>Review of the resident's progress note, dated 4/17/24 at 2:40 P.M., showed the resident's physician was notified of the resident's refusal to have his/her catheter flushed.</p> <p>Review of the resident's May 2024 Physician Order Sheet (POS) showed the resident needed catheter care completed every shift.</p> <p>Review of the resident's progress note on 5/1/24 at 1:46 P.M. showed the resident refused to have his/her catheter changed as it was ordered.</p> <p>Review of the resident's care plan, dated 5/20/24, showed no documentation the resident refused care and approaches to address his/her refusal, and no documentation of the resident's preferred code status.</p> <p>During interview on 5/21/24 at 5:55 A.M., Certified Nurse Assistant (CNA) V said the following:</p> <ul style="list-style-type: none"> <li>-The resident would let him/her perform care on him/her but would often refuse care from other staff;</li> <li>-The resident often refused catheter care.</li> </ul> <p>During interview on 5/21/24 at 10:23 A.M., the resident said he/she wanted to be a DNR.</p> <p>Observation on 5/21/24 at 10:29 A.M. showed CNA E and CNA C changed the resident's incontinence brief. The resident told the staff he/she did not want catheter care performed. The staff did not provide care per the resident's request.</p> <p>2. Review of Resident #68's face sheet showed the resident's diagnoses included vascular dementia and diabetes (too much sugar in the blood stream).</p> <p>Review of the resident's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognition;</li> <li>-Usually able to make his/her needs known;</li> <li>-Diagnoses of diabetes mellitus and dementia;</li> <li>-Care Assessment Area (CAA) of cognitive loss/dementia triggered and was to be addressed on the resident's care plan.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognition;</li> <li>-Usually able to make needs known;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses of diabetes mellitus and dementia.</p> <p>Review of the resident's May 2024 physician order sheet showed the following:</p> <p>-Donepezil (a medication used to treat dementia) 10 milligrams daily at bedtime (original order dated 12/02/23);</p> <p>-Januvia (a medication used to treat diabetes) 100 milligrams once a day (original order dated 04/03/24).</p> <p>Review of the resident's care plan, revised 05/01/24, showed no problem, goal or interventions related to cognitive loss/dementia or diabetes.</p> <p>3. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 2/25/24, showed the following:</p> <p>-Substantial/Maximum assistance from staff for sit to stand transfer, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer;</p> <p>-No use of oxygen therapy indicated.</p> <p>Review of the resident's care plan, revised on 02/28/24, showed the following:</p> <p>-The resident has an activity of daily living deficit related to progression of dementia;</p> <p>-Restorative therapy three times a week for active range of motion both lower extremities;</p> <p>-The resident's care plan did not include how the resident was to transfer.</p> <p>Review of the resident's May 2024 physician order sheet showed the following:</p> <p>-Administer two liters of oxygen as needed for pulse oxygen saturation (the amount of oxygen in the blood stream measured by percentage of 100 or less) rate less than 92 percent (original order dated 12/14/23);</p> <p>-Change oxygen tubing weekly on Sunday on the night shift (original order dated 12/06/23);</p> <p>-Restorative program established for two times a week to address bilateral upper body range of motion, discontinued on 05/08/24.</p> <p>Review of the resident's care plan showed no documentation the resident was to receive oxygen as needed, no documentation as to how the resident was to transfer, and no documentation the resident was no longer to receive restorative nursing services.</p> <p>During an interview on 5/20/24 at 1:51 P.M. and 2:00 P.M. the acting MDS coordinator said:</p> <p>-She worked at a sister facility and came over one or two days a week and helped complete the MDS's;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She did not know the residents, so he/she would ask the staff questions about the residents and complete the MDS's as best as he/she could;</p> <p>-She only completed what needed to be done;</p> <p>-She did not complete the care plans that were done by the previous assistant director of nursing (ADON).</p> <p>During interview on 5/21/24 at 1:57 P.M., the Training/MDS Coordinator said the following:</p> <p>-She was temporarily helping complete MDS assessments and care plans;</p> <p>-She stopped completing care plans because the previous Assistant Director of Nursing (ADON) completed observations and the care plan;</p> <p>-She did not know who was completing the care plan after the ADON left.</p> <p>During interview on 5/23/24 at 6:49 P.M., the Director of Nursing (DON) said the following:</p> <p>-The MDS Coordinator was responsible for completing and updating care plans;</p> <p>-She had been updating care plans because the facility did not have an MDS Coordinator;</p> <p>-She read the nursing notes to determine if an addition was needed to the care plan;</p> <p>-She did not think the care plans were getting updated due to agency staffing not reporting if something needed to be added to the care plan;</p> <p>-She would expect the care plans to be complete with a comprehensive picture of how to care for the residents.</p> <p>42592</p> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to update interventions in the comprehensive care plan for three resident's (Resident #17, #52 and #42), in a review of 24 sampled residents. The facility census was 67.</p> <p>Review of the undated facility policy, Comprehensive Care Plan, showed the following:</p> <ul style="list-style-type: none"> <li>-The interdisciplinary care plan team is responsible for the periodic review and updating of care plans: <ul style="list-style-type: none"> <li>a. When a significant change in the resident's condition has occurred;</li> <li>b. At least quarterly;</li> <li>c. When changes occur that impact the resident's care (i.e., change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment).</li> </ul> </li> </ul> <p>Review of Resident #17's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 10/28/23, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had moderately impaired cognition;</li> <li>-He/She did not have any signs or symptoms of depression;</li> <li>-He/She did not have limited range of motion;</li> <li>-He/She was independent with rolling left and right in bed, sit to lying in bed, and lying to sitting;</li> <li>-He/She required supervision with oral hygiene, upper body dressing, and personal hygiene;</li> <li>-He/She required moderate assistance with bathing, toilet hygiene, lower body dressing, sit to stand, chair/bed-to-chair transfer, and toilet transfer;</li> <li>-He/She was frequently incontinent of bladder and bowel.</li> </ul> <p>Review of the resident's care plan, updated 10/31/23, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had minimal deficit in activities of daily living (ADLs) related to weakness, disease process affecting cognitive status;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Provide assistance with any ADLs as needed/indicated, daily: bladder and bowel, hygiene, hair/oral/nail/skin care, tray preparation, dressing, etc.;</p> <p>-Provide items as needed for completion of ADLs;</p> <p>-Provide non-distracting environment for grooming/personal hygiene.</p> <p>Review of the resident's significant change MDS, dated [DATE], showed the following:</p> <p>-The resident had severe cognitive impairment;</p> <p>-He/She had mild depression symptoms;</p> <p>-He/She had limited functional range of motion in bilateral lower extremities;</p> <p>-He/She required maximal assistance with oral hygiene;</p> <p>-He/She was dependent on toileting hygiene and personal hygiene;</p> <p>-He/She required moderate assistance with rolling left and right in bed,</p> <p>-He/She was frequently incontinent of bladder;</p> <p>-He/She was always incontinent bowel;</p> <p>-The care area assessment (CAA) was triggered for activities of daily living (ADL) functional/rehabilitation potential, but was not updated on the care plan.</p> <p>Review of the resident's care plan, updated on 11/15/23, showed the care plan was not updated to show a decrease in the resident's cognition from moderate to severe impairment.</p> <p>Review of the resident's nurse note, dated 11/30/23 at 1:54 P.M., showed the following:</p> <p>-The resident had some medication additions since being admitted to hospice (admitted [DATE]);</p> <p>-The resident started Zoloft for depression;</p> <p>-He/She could take morphine three times a day as needed for pain.</p> <p>Review of the resident's physician orders, dated November 2023, showed Zoloft (antidepressant) 50 milligrams (mg) give one tablet orally daily for major depressive disorder (started 11/27/23).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-The resident had severe cognitive impairment;</p> <p>-He/She had mild depression symptoms;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She had limited functional range of motion in bilateral lower extremities;</p> <p>-He/She required maximal assistance with oral hygiene;</p> <p>-He/She was dependent on toileting hygiene and personal hygiene;</p> <p>-He/She required moderate assistance with rolling left and right in bed,</p> <p>-He/She had an indwelling urinary catheter;</p> <p>-He/She was always incontinent of bowel.</p> <p>Review of the resident's care plan, updated 2/15/24, showed the following:</p> <p>-The resident had increased potential for urinary tract infection (UTI) related to presence of indwelling catheter for urinary retention;</p> <p>-Avoid lying on top of tubing;</p> <p>-Keep catheter system a closed system as much as possible;</p> <p>-Position bag below level of bladder;</p> <p>-Provide catheter care per facility policy and procedure;</p> <p>-Report signs of urinary tract infection;</p> <p>-Store collection bag inside a protective dignity pouch;</p> <p>-The care plan was not updated to address the resident's change in cognition from moderate impairment to severe impairment, addition of an antidepressant along with monitoring for specific behaviors along with potential side effects and potential for pain to include monitoring for specific symptoms and administration of PRN pain medication.</p> <p>Review of the resident's nurse note, dated 2/22/24 at 1:16 P.M., showed the resident no longer ambulated with the aid of a wheelchair.</p> <p>Review of the resident's physician order, dated March 2024, showed the following:</p> <p>-Zoloft (antidepressant) 50 milligrams (mg), give one tablet orally daily for major depressive disorder (started 11/27/23);</p> <p>-Lorazepam (antianxiety) 2 mg/milliliter (ml), give 0.25 ml orally every four hours as needed for anxiety (started on 3/26/24).</p> <p>Review of the resident's physician orders, dated April 2024, showed the following:</p> <p>-Zoloft 50 mg, give one tablet orally daily for major depressive disorder (started 11/27/23);</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Lorazepam 2 mg/ml, give 0.25 ml orally every four hours as needed for anxiety (started on 3/26/24);</p> <p>-Tramadol (opioid pain medication) 50 mg, give one tablet orally twice a day for pain (started 4/24/23).</p> <p>Review of the resident's nurse note, dated 4/12/24 at 3:20 P.M., showed the hospice nurse removed the indwelling urinary catheter during a visit earlier in the day.</p> <p>Review of the resident's care plan, last updated 4/27/24, showed the following:</p> <p>-The care plan was not updated to show the addition of an antianxiety medication with monitoring specific behaviors, and monitoring for adverse effects from medication;</p> <p>-The care plan was not updated to show the resident's indwelling urinary catheter was removed on 4/15/24;</p> <p>-The care plan was not updated to show the resident received a scheduled medication for pain;</p> <p>-The care plan did not include the resident no longer ambulated.</p> <p>Observation on 5/19/24 at 3:55 P.M. showed the following:</p> <p>-The resident sat in recliner chair in his/her room;</p> <p>-The resident was unable to have a conversation.</p> <p>Observation on 5/19/24 at 5:05 P.M. showed the resident propelled himself/herself in his/her wheelchair from his/her room to the dining room.</p> <p>2. Review of Resident #52's admission MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnoses included dementia, chronic pain, fusion of spine (surgical connection of two bones in the spine to prevent movement) and spinal stenosis (space inside the backbone is too small that can put pressure on the spinal cord and nerves that travel through the spine, can cause pain, tingling, numbness and muscle weakness);</p> <p>-Independent with transfers and ambulation;</p> <p>-No mobility devices used;</p> <p>-Occasionally incontinent of bladder and bowel;</p> <p>-No toileting program;</p> <p>-Scheduled pain medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, dated 6/27/23, documented the resident had cognitive loss. The care plan did not identify the resident was at risk for falling.</p> <p>Review of the resident's nurses notes, dated 7/11/23 at 6:39 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident continues observation for recent fall. Steri-strips to left hand intact with no drainage noted;</li> <li>-The resident's family member said the resident fell because the resident was trying to get assistance from the staff, for his/her family member (also a resident), and no one answered the call light;</li> <li>-Upon entering the room, the resident was found on top of his/her covers that were in his/her recliner, most likely due to the resident sliding to the floor while lying on top of the items;</li> <li>-The resident denied pain or discomfort and had no visible injuries;</li> <li>-Education was provided to the resident about allowing staff to assist his/her spouse to avoid future injury;</li> <li>-The resident voiced understanding but additional teaching and reinforcement is required related to his/her cognitive decline. No change in status at this time.</li> </ul> <p>The resident's care plan was not updated after the resident's fall.</p> <p>Review of the resident's nurses notes, dated 7/11/23 at 5:43 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had unsteady gait and lost balance, causing a fall when he/she tried to assist staff who were assisting the resident's family member (also a resident);</li> <li>-The resident sustained a laceration to his/her left eye;</li> <li>-The resident was transferred to the emergency room via emergency medical services (EMS).</li> </ul> <p>Review of the resident's nurses notes, dated 7/11/23 at 10:14 P.M., showed the resident's laceration above the resident's left eye required glue repair by the emergency room . No other injuries noted.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan, after he/she fell on [DATE], to include/address interventions related to helping his/her (resident) family member.</p> <p>Review of the resident's nurses notes, dated 7/15/23 at 7:47 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat on the floor to the front and left side of the chair, up against the wall;</li> <li>-The resident said he/she was getting up to help his/her family member (also a resident) and he/she slid out of the chair;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had a small abrasion to his/her lower back from sliding down the wall;</p> <p>-The resident was significantly more confused than baseline, likely related to current diagnosis of urinary tract infection and was currently on antibiotics.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan, after he/she fell on [DATE], to include/address interventions related to helping his/her (resident) family member.</p> <p>Review of the resident's care plan, updated 7/26/23, showed the following:</p> <p>-The resident was at risk for falls due to declining cognitive level and unsteady gait;</p> <p>-Ensure the resident's room was free of clutter that he/she could potentially trip over;</p> <p>-Increased staff supervision with intensity based on resident need.</p> <p>Review of the resident's nurses notes, dated 8/16/23 at 3:24 P.M., showed the following:</p> <p>-Interdisciplinary note showed the resident had three falls in the month of July;</p> <p>-All of the resident's falls were related to him/her assisting his/her family member (also a resident);</p> <p>-The resident's fall risk score was a 21, which put him/her at a high risk for falls.</p> <p>Review of the resident's Nurses Notes, dated 9/12/23 at 11:45 P.M., showed the following:</p> <p>-The resident sustained a non-injury, witnessed fall in the dining room;</p> <p>-The resident sat at the dining room table and slid out of his/her chair onto his/her bottom.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Requires supervision, touch or verbal cues for transfers and ambulating;</p> <p>-Requires partial/moderate assistance from staff for upper body dressing;</p> <p>-Requires substantial maximal assistance from staff for lower body dressing and put on/take off footwear;</p> <p>-Frequently incontinent of bladder and continent of bowel;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Two or more injury falls since last assessment.</p> <p>The resident's care plan was not updated after the resident required more assistance with ambulation, dressing, transfers, increase in incontinence and falls since the last comprehensive assessment.</p> <p>Review of the resident's nurses notes, dated 9/25/23 at 10:23 P.M., showed the following:</p> <p>-The resident sustained a fall at 1:00 P.M. The resident stood up out of his/her wheelchair and was walking toward the nursing station;</p> <p>-The resident turned around and fell backward, striking his/her left posterior head against the nursing station counter;</p> <p>-The resident was immediately assessed for injury and a silver dollar sized raised area was noted to his/her left posterior head;</p> <p>-Neurological checks initiated per facility protocol.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's nurses notes, dated 10/12/23 at 1:48 P.M., showed the following:</p> <p>-The care plan team met with the resident's family member;</p> <p>-The resident receives assistance getting into bed, but was able to get out of bed on his/her own;</p> <p>-The resident will propel his/her wheelchair around the building from time to time;</p> <p>-The resident had not had any recent falls.</p> <p>Review of the resident's nurses notes, dated 10/14/23 at 10:14 P.M., showed the following:</p> <p>-Kitchen staff witnessed the resident fall in the dining room. The resident struck his/her head against the piano and fell to the floor;</p> <p>-The resident had a superficial laceration (cut or tear to the skin) and a silver dollar sized hematoma (localized bleeding), from the fall, to top of his/her posterior (back) head;</p> <p>-The resident was assessed, a dressing was placed on the resident's head wound and neurological checks (series of tests and questions to evaluate the nervous system) initiated.</p> <p>Review of the resident's care plan, updated 10/14/23, showed the resident fell in the dining room and hit his/her head against the piano. Laceration and hematoma noted. No interventions were added or revised on the resident's care plan.</p> <p>Review of the resident's nurses notes, dated 11/22/23 at 9:56 P.M., showed the resident was found sitting on the floor with his/her legs crossed, going through his/her closet.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's nurses notes, dated 11/24/23 at 6:36 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was sent to the emergency room for further evaluation related to a fall;</li> <li>-The resident has a hematoma to the left ear.</li> </ul> <p>Review of the resident's care plan, updated 11/24/23, showed the following:</p> <ul style="list-style-type: none"> <li>-On 11/24/23, the resident was found on the floor in the television area;</li> <li>-He/She had been sitting in his/her wheelchair and fell ;</li> <li>-He/She hit his/her head on the floor;</li> <li>-The resident's left ear became red and swollen; received an order to send to the hospital for evaluation;</li> <li>-When the resident was not in his/her room, place the resident by the nurses station for close supervision.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnoses of depression and Alzheimer's disease;</li> <li>-Severe cognitive impairment;</li> <li>-Used a walker;</li> <li>-Frequently incontinent of bladder and bowel;</li> <li>-Requires supervision, touch or verbal cues for transfers and ambulating;</li> <li>-Two or more no injury falls since last assessment</li> <li>-Received an antidepressant medication daily.</li> </ul> <p>The resident's care plan was not updated after the resident required more assistance with ambulation, dressing, transfers, increase in incontinence, falls, new diagnosis, use of a walker, and antidepressant medication since the last comprehensive assessment</p> <p>Review of the resident's nurses notes, dated 12/31/23 at 10:02 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had an unwitnessed fall in his/her room; when staff arrived, the resident was sitting on the floor next to his/her wheelchair;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident did not have socks on and had spilled his/her water on the floor;</p> <p>-The resident was holding his/her left hand and had a small cut to his/her left pinky finger and a blood blister, cleansed and bandaged;</p> <p>-Abrasion noted to the resident's left lower back measuring 10 centimeters (cm) in length by 1.3 cm in width; redness to area noted;</p> <p>-Staff placed the resident on neurological checks.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's nurses notes, dated 1/6/24 at 2:29 P.M., showed the following:</p> <p>-The resident had a witnessed fall in the living area;</p> <p>-Staff witnessed the resident lower himself/herself to the floor;</p> <p>-Mechanical lift pad caught under the resident's chair.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Moderate to severe depression;</p> <p>-Does not use a wheelchair;</p> <p>-Always incontinent of bladder and bowel;</p> <p>-Pain medication scheduled,</p> <p>-Non-verbal sounds, facial expressions that could indicate pain in the five days;</p> <p>-Requires supervision, touch or verbal cues for transfers and ambulating;</p> <p>-Two or more no injury falls since last assessment.</p> <p>Review of the resident's nurses notes, dated 5/10/24 at 5:44 P.M., showed the following:</p> <p>-The resident had an unwitnessed fall in his/her room;</p> <p>-Staff observed the resident sitting on his/her buttocks on his/her fall mat;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident's bed was in the lowest position at the time;</p> <p>-The resident has a laceration to his/her right forearm;</p> <p>-Neurological checks initiated.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Observation on 5/19/24, at 4:33 P.M., showed the following:</p> <p>-The resident lay in his/her bed with the door to his/her room closed;</p> <p>-The resident's bed was low to the ground;</p> <p>-There was a fall mat propped against the dresser across the room;</p> <p>-There was no fall mat next to the resident's bed.</p> <p>Observation of the resident during the survey process, from 5/19/24 to 5/23/24, showed the resident to always be in a wheelchair when out of bed. The resident did not walk independently or with staff.</p> <p>The facility did not update the resident's care plan after the resident required more assistance with ambulation, dressing, transfers, increase in incontinence, falls, new diagnosis, use of a wheelchair, antidepressant medication, increase in depressive symptoms, and physical signs of pain since the last comprehensive assessment.</p> <p>3. Review of Resident #42's Care Plan, dated 6/28/23, showed the following:</p> <p>-The resident is at risk for injury related to a history of falls related to acute medical condition and fall within 36 hours of admission;</p> <p>-The resident will remain free from injury;</p> <p>-Analyze the resident's falls to determine a pattern/trend, which appear to be related to medical trauma and possibly delirium/confusion;</p> <p>-Give the resident verbal reminders not to transfer without assistance;</p> <p>-Keep the resident's bed in the lowest position with brakes locked;</p> <p>-Keep call light in reach at all times;</p> <p>-Keep personal items and frequently used items within reach;</p> <p>-Place fall mats by bed (both sides);</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff to provide substantial assistance for pivot transfer with a gait belt during transfers for balance/safety.</p> <p>Review of the resident's, annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderate hearing difficulties, hearing aide present;</li> <li>-Vision issues and device;</li> <li>-Severe cognitive impairment;</li> <li>-Diagnosis: Alzheimer's, Renal (kidney) disease, thyroid disorder, arthritis, fracture and chronic pain;</li> <li>-Requires set up/clean up from staff for eating and oral hygiene;</li> <li>-Requires supervision or touch assistance from staff for toilet hygiene and dressing;</li> <li>-Requires partial/moderate assistance from staff for shower/bathe and putting on/taking off footwear;</li> <li>-Scheduled and as needed (PRN) pain medication, frequent pain;</li> <li>-No natural teeth or tooth fragments.</li> <li>-Opioid use daily;</li> <li>-Wheelchair for mobility;</li> <li>-The resident did not walk.</li> </ul> <p>Review of the resident's Care plan, last updated 2/12/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident is at risk for falls due to history of falling.</li> <li>-No falls in at least the last year;</li> <li>-U-bar (small assist bed rail) on right side of bed: U bar for increased mobility/leverage in bed and for transfers;</li> <li>-Encourage and provide toileting assistance when he/she requests-usually independent;</li> <li>-Encourage resident to assume a standing position slowly;</li> <li>-Keep bed in lowest position with brakes locked;</li> <li>-Keep call light in reach at all times;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>-Keep personal items and frequently used items within reach;</li> <li>-Provide an environment free of clutter;</li> <li>-Provide proper, well-maintained footwear;</li> <li>-Remind resident to lock brakes on wheelchair before transferring to/from.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Moderate hearing difficulties, hearing aide present;</li> <li>-Independent with transfers and walking;</li> <li>-Continent of bowel and bladder.</li> </ul> <p>The resident's care plan was not updated after the resident had improvements in transfer, ambulation, continence and cognition.</p> <p>Review of the resident's nurses notes, dated 5/9/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Heard yelling from the resident's room;</li> <li>-When entering the room, the resident lay on his/her right side holding his/her arm;</li> <li>-The resident had blood dripping from his/her right eyebrow;</li> <li>-Laceration to right eyebrow, along with right shoulder that was displaced;</li> <li>-The resident was unable to move his/her right arm;</li> <li>-The resident was sent to the emergency room via EMS.</li> </ul> <p>Review of the resident's census showed the resident went to the hospital on 5/9/24 and returned on 5/10/24.</p> <p>Review of the resident's nurses notes, dated 5/10/24 at 7:36 A.M., the interim Director of Nursing documented the following:</p> <ul style="list-style-type: none"> <li>-Returned to facility at 7:32 A.M. by ambulance transport from the hospital,;</li> <li>-Laceration to right forehead, stitches noted;</li> <li>-The resident had a dislocation of his/her right shoulder; these injuries were from his/her fall in his/her room last</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>night.</p> <p>Review of the resident's nurses notes, dated 5/10/24 at 1:50 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Skin assessment performed post fall;</li> <li>-Area above right eyebrow is measuring 4.9 cm in length and 0.5 cm in width;</li> <li>-Sutures in place, left open to air;</li> <li>-Area on right cheek measures 1.6 cm in length and 0.3 cm in width, left open to air;</li> <li>-No bruising noted to right shoulder.</li> </ul> <p>Review of the resident's medication administration record, dated May 2024, showed the following:</p> <ul style="list-style-type: none"> <li>-On 5/11/24, staff documented the resident's pain score as five out of 10 (with 10 being the highest) on the evening shift;</li> <li>-On 5/12/24, staff documented the resident received PRN (as needed) Tylenol (pain reliever) 650 milligrams (mg) at 12:21 P.M. and night shift documented a pain score of four out of 10.</li> </ul> <p>The resident's care plan was not updated after a fall with injury to face requiring sutures, a dislocated shoulder and increased evidence of pain.</p> <p>Review of the resident's nurses notes, dated 5/12/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Aide reported the resident had an unwitnessed fall;</li> <li>-Upon entering the resident's room, the resident was sitting on his/her buttocks beside his/her bed and was leaning on his/her right arm;</li> <li>-When asked what happened, the resident said, I was about to wet myself;</li> <li>-The resident was educated on using the call light for safety due to previous fall.</li> </ul> <p>The resident's care plan was not updated after a fall on 5/12/24.</p> <p>Review of the resident's physician's orders, dated 5/13/24, showed hydrocodone-acetaminophen 5-325 milligrams two times daily for pain.</p> <p>Review of the resident's nurses notes, dated 5/19/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was found on the floor next to his/her bed;</li> <li>-The resident said he/she slid off the bed and onto his/her bottom;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had chronic pain complaints in his/her right shoulder due to a previous fall and dislocation.</p> <p>Review of the resident's electronic medical record showed no evidence of revision of the resident's care plan after each fall or any additional changes to prevent further injuries from falls.</p> <p>Observation and interview on 5/19/24 at 3:45 P.M., showed the resident in his/her wheelchair in the hall by the nurses desk. The resident had sutures to a laceration above his/her right eye brow approximately 4-5 centimeters in length and a black eye. During the observation, the resident said he/she is hard of hearing and said that staff lost his/her hearing aides and it would be nice to be able to hear.</p> <p>During an interview on 5/20/24 at 2:30 P.M., the resident said his/her hearing aide has been missing for a few weeks and it made it hard to communicate with staff and other residents.</p> <p>Review of the resident's care plan did not show any updates regarding the resident's missing hearing aides or how to effectively communicate with the resident.</p> <p>During an interview on 5/23/24, at 2:42 P.M., the Social Service Director said she does not update the care plans for things like hearing aides; she was not sure who did.</p> <p>During an interview on 5/20/24 at 1:51 P.M. and 2:00 P.M., the acting MDS coordinator said:</p> <ul style="list-style-type: none"> <li>-She worked at a sister facility and came over one or two days a week and helped complete the MDS's;</li> <li>-She did not know the residents, so he/she would ask the staff questions about the residents and complete the MDS's as best as he/she could;</li> <li>-She only completed what needed to be done;</li> <li>-She did not complete the care plans that were done by the previous assistant director of nursing (ADON).</li> </ul> <p>During interview on 5/21/24 at 1:57 P.M., the Training/MDS Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She was temporarily helping complete MDS assessments and care plans;</li> <li>-She stopped completing care plans because the previous ADON completed observations and the care plan;</li> <li>-She did not know who was completing the care plan after the ADON left.</li> </ul> <p>During an interview on 5/23/24 at 10:45 A.M. and 6:49 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The facility has had change over in nursing administration so all systems were not in place;</li> <li>-Ideally there would be a review of each fall the next day;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-During the review, staff would try to determine the cause of the fall, evaluate the care plan to see what can be done to prevent further falls and/or reduce injury if there is a future fall;</p> <p>-The care plans were probably not getting updated because most staff were from agency;</p> <p>-She read the day notes to determine if an addition was needed to the care plan.</p> <p>46506</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice for one sampled resident (Resident #59), in a review of 24 sampled residents and seven additional residents (Resident #45, #14, #1, #38 and #25). Staff failed to ensure medications were available for administration, did not follow physician orders when laboratory orders were not obtained as ordered, when staff left medications at bedside with residents who did not have may keep at bedside orders, and when staff administered oxygen without a physician's order. The facility census was 67.</p> <p>Review of the facility policy, Medication Administration Guidelines, revised 2/7/13, showed the following:</p> <ul style="list-style-type: none"> <li>- It is the purpose of this facility that residents receive their medications on a timely basis and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information;</li> <li>-The same person preparing the doses for administration must administer the medications;</li> <li>-Medications may not be prepared in advance and must be administered within one hour of preparation;</li> <li>-Self-administration of drugs is permitted with the written order of the attending physician;</li> <li>-Medication administration: Medications are given to benefit a resident's health as ordered by the physician;</li> <li>-Important: If the resident refuses medication, indicate failure to administer medication on the medication record by circling initials and making a notation on the back of the medication record (include date, time, what occurred, initials, and title);</li> <li>-Remain in the room while the resident takes the medication.</li> </ul> <p>Review of the undated facility policy, Medication Administration, showed the following:</p> <ul style="list-style-type: none"> <li>-Medications are given to benefit a resident's health as ordered by the physician;</li> <li>-Remain in the room while the resident takes the medication.</li> </ul> <p>Review of the undated facility policy, Physician Orders, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors;</p> <p>-Physician orders must be reviewed and renewed;</p> <p>-Oxygen Orders: Specify the rate of flow, route, and rationale (i.e., 2-3 liters/min per nasal cannula PRN for shortness of breath).</p> <p>Review of the undated facility policy, Physician Services, showed the following:</p> <p>-The medical care of each resident is under the supervision of a licensed physician:</p> <p>- Physician orders and progress notes shall be maintained in accordance with current Omnibus Budget Reconciliation Act (OBRA) regulations and facility policy.</p> <p>A policy regarding blood draws or lab work was requested but no policy received.</p> <p>1. Review of Resident #38's face sheet showed the resident's diagnoses included chronic obstructive pulmonary disease (COPD) (lung/breathing disorder), pneumonia, acute respiratory distress, seasonal allergic rhinitis, acute and chronic respiratory failure (serious condition that makes it difficult to breathe), gastroesophageal reflux disease (GERD) (stomach disorder), joint pain, shortness of breath and malignant neoplasm of bronchus or lung (tumors in the lung).</p> <p>Review of the resident's May 2024 physician order sheets (POS) showed the following:</p> <p>-Albuterol Sulfate HFA inhaler (inhaled lung medication), two puffs as needed (PRN). (The resident did not have an order allowing him/her to keep the medication at bedside.)</p> <p>-Gabapentin (nerve pain medication) 600 milligrams (mg) three times daily, scheduled for block times 5:00 A.M. to 10:00 A.M., 11:00 A.M. to 2:00 P.M. and 7:00 P.M. to 10:00 P.M. (The resident did not have an order allowing him/her to keep the medication at bedside.)</p> <p>-Tums (heartburn reliever), one to two tablets three times daily PRN. (The resident did not have an order allowing him/her to keep the Tums at bedside.)</p> <p>Observation on 5/19/24 at 4:21 P.M. of the resident's bedside table showed the following:</p> <p>-One plastic medication cup contained a white oblong tablet;</p> <p>-One plastic medication cup contained four round tablets that were red, yellow or green in color;</p> <p>-One albuterol sulfate HFA inhaler.</p> <p>During an interview on 5/19/24 at 4:29 P.M., the resident said the following:</p> <p>-The medication technician brought him/her those pills around 4:00 P.M.;</p> <p>-The white pill was his/her pain pill;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The cup of multi-colored pills were Tums he/she could take whenever he/she needed;</p> <p>-He/She used the inhaler when he/she needed them;</p> <p>-He/She could take care of himself/herself.</p> <p>Observation on 5/19/24 at 4:45 P.M. of the medication cart showed a medication card, labeled for the resident, that contained gabapentin 600 mg. The gabapentin tablets were oblong and white.</p> <p>During an interview on 5/19/24 at 4:50 P.M., Certified Medication Technician (CMT) Q said the following:</p> <p>-He/She just came on duty at 3:00 P.M. and had not administered the resident any medications;</p> <p>-The resident was usually very angry and did not allow staff to watch him/her take his/her medications. The resident demanded for staff to leave his/her medications at his/her bedside and told staff he/she will take them when he/she was ready;</p> <p>-Staff were not to leave medications at a resident's bedside unless the resident had an order to do so;</p> <p>-He/She did not know when the medications were left at the resident's bedside.</p> <p>2. Review of Resident #59's face sheet showed his/her diagnoses included pain in his/her left ankle and joints of left foot and polyneuropathy (condition that causes burning pain).</p> <p>Review of the resident's May 2024 POS showed an order for gabapentin 300 mg three times daily; scheduled for block times of 5:00 A.M. to 10:00 A.M., 11:00 A.M. to 2:00 P.M. and 7:00 P.M. and 10:00 P.M. The resident did not have an order to keep medications at bedside.</p> <p>Observation on 5/19/24 at 4:04 P.M. showed the following:</p> <p>-The resident lay in bed;</p> <p>-A plastic medication cup containing a beige capsule sat on the bedside table near the resident's bed.</p> <p>During an interview on 5/19/24 at 4:07 P.M., the resident said he/she did not know if he/she was supposed to take the capsule. He/She was not sure who or when it was brought to him/her. He/She would take it later.</p> <p>Observation on 5/19/24 at 4:10 P.M. showed the medication cart contained a pharmacy medication card, labeled for the resident, that contained Neurontin (gabapentin) 300 mg. The Neurontin was a beige capsule.</p> <p>On 5/19/24 at 4:17 P.M., the surveyor asked Licensed Practical Nurse (LPN) A to observe the resident's bedside table.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/19/24 at 4:18 P.M., LPN A said the following:</p> <ul style="list-style-type: none"> <li>-The resident had a cup of medication at his/her bedside table;</li> <li>-The CMT was responsible for the resident's medications;</li> <li>-He/She was the charge nurse for the resident and over the CMT;</li> <li>-The surveyor would have to ask the CMT about the cup of medication;</li> <li>-LPN A did not remove the cup of medications from the resident's bedside table.</li> </ul> <p>During an interview on 5/19/24 at 4:57 P.M., CMT Q said the following:</p> <ul style="list-style-type: none"> <li>-The resident did not like to be watched while taking his/her medications and asked that the medications be left at his/her bedside;</li> <li>-He/She had not administered the resident any medications since starting his/her shift today;</li> <li>-The resident should not have medications left at bedside.</li> </ul> <p>On 5/19/24 at 5:00 P.M., the surveyor asked CMT Q to observe the resident's bedside table.</p> <p>Observation and interview on 5/19/24 at 5:02 P.M. showed the following:</p> <ul style="list-style-type: none"> <li>-The cup of medication previously on the resident's bedside table was gone;</li> <li>-The resident said he/she just took the capsule.</li> </ul> <p>During an interview on 5/21/24 at 1:15 P.M., the Director of Nurses (DON) said she expected medications to only be left at a resident's bedside if they had a may keep at bedside order.</p> <p>3. Review of Resident #1's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-Date of admission 9/28/23;</li> <li>-Diagnoses included convulsions (seizures).</li> </ul> <p>Review of the resident's May 2024 POS showed the following:</p> <ul style="list-style-type: none"> <li>-Phenytoin sodium extended capsule (Dilantin) (medication to treat seizures) 300 mg twice daily;</li> <li>-Dilantin laboratory level (a blood test that checks the level of the seizure medication in the blood) the first of the month in March and September.</li> </ul> <p>Review of the resident's medical record showed no documentation the facility obtained the resident's ordered Dilantin laboratory level in March 2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/23/24 at 6:49 A.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The admitting nurse was responsible for ensuring physician ordered laboratory orders were entered into the lab tech electronic system;</li> <li>-She could not see that the resident had ever had the ordered Dilantin level drawn;</li> <li>-She was not sure how the physician ordered lab got missed.</li> </ul> <p>4. Review of Resident #25 face sheet showed the resident's diagnoses included chronic obstructive pulmonary disease (COPD) (lung disorder) and chronic respiratory failure with hypoxia (low blood oxygen levels).</p> <p>Review of the resident's admission MDS, dated [DATE], showed the resident received oxygen therapy at home and while at the facility.</p> <p>Review of the resident's care plan, dated 3/12/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had an alteration in respiratory function due to chronic obstructive pulmonary disease/chronic respiratory failure and its effects on his/her ability to perform activities of daily living (ADLs), tolerate activities without fatigue and shortness of breath (SOB);</li> <li>-Approach: oxygen as ordered and monitor for oxygen saturation (level of oxygen in the blood) as needed.</li> </ul> <p>Observation on 5/19/24 at 3:05 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat in his/her recliner in his/her room;</li> <li>-He/She had oxygen administered through a nasal cannula (prongs in the nose) and long tubing connected to an oxygen concentrator (machine that delivers oxygen);</li> <li>-The dial was set to 4 liters per minute (the amount of oxygen being delivered).</li> </ul> <p>Review of the resident's May 2024 POS on 5/22/24 at 10:38 A.M. showed no order for oxygen.</p> <p>Observation and interview on 5/22/24 at 3:05 P.M. showed LPN R went to the resident's room (at the surveyor's request) and verified the resident was on oxygen at four liters per minute. He/She checked the resident's physician orders and was unable to find an order for the oxygen.</p> <p>During an interview on 5/22/24 at 3:30 P.M., LPN R said he/she called the physician and received order for oxygen at 3.5 liters continuous.</p> <p>Review of the resident's May 2024 POS on 5/22/24 at 3:50 P.M. showed an order for oxygen at 3.5 liters.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the DON said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She expected there to be orders for all treatments performed, including oxygen;</p> <p>-Staff should not perform treatments or procedures without a physician's order.</p> <p>5. Review of Resident #14's primary care physician progress note, dated 4/25/24, showed the following:</p> <p>-The resident was having some elevated blood glucose levels with levels ranging from 168-442 (a normal non-fasting blood sugar level is less than 140 mg/dL) the last few days;</p> <p>-Diagnosis of type II diabetes mellitus (problem in the way the body regulates and uses sugar as a fuel) with diabetic chronic kidney disease (chronic loss of kidney function occurring in those with diabetes mellitus);</p> <p>-The resident was supposed to have a hemoglobin A1C (blood test that can provide information about average blood sugar levels); it was not drawn;</p> <p>-The physician wanted the lab test reordered for the next week.</p> <p>Review of the resident's physician order, dated May 2024, showed an order dated 5/2/24 for hemoglobin A1C.</p> <p>During interviews on 5/23/24 at 1:59 P.M. and 6:49 P.M., the DON said the following:</p> <p>-She was unable to find test results for a hemoglobin A1C for May 2024;</p> <p>-Staff filled out requisitions for an outside company to come to the facility and obtain the lab specimens;</p> <p>-She helped staff fill out the requisitions, because not everyone had access;</p> <p>-She did not remember if she filled out or helped staff fill out the requisition for the resident's lab order.</p> <p>6. Review of Resident #45's face sheet showed a diagnosis of type II diabetes mellitus.</p> <p>Review of the resident's May 2024 physician order sheet showed an order for Victoza pen injector (an injectable medication to treat type II diabetes mellitus) 1.2 milligrams (mg) injection once a day (original order dated 09/13/23).</p> <p>Review of the resident's May 2024 medication administration record (MAR) showed the following:</p> <p>-On 5/10/24, Victoza 1.2 mg was not administered due to drug/item unavailable;</p> <p>-On 5/11/24, the P.M. blood sugar was 253 (a normal blood sugar range is 70 - 140);</p> <p>-On 5/12/24, the P.M. blood sugar was 186;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 5/13/24, the P.M. blood sugar was 201;</p> <p>-On 5/16/24, the P.M. blood sugar was 164;</p> <p>-On 5/17/24, Victoza 1.2 mg was not administered due to awaiting prior authorization;</p> <p>Review of the resident's nursing progress notes, dated 5/7/24 at 1:21 P.M., showed Victoza was awaiting prior authorization. Paperwork was faxed to the physician.</p> <p>Review of the resident's May 2024 MAR showed the following:</p> <p>-On 5/18/24, Victoza 1.2 mg was not administered due to drug/item unavailable;</p> <p>-On 5/19/24, Victoza 1.2 mg was not administered due to drug/item unavailable, the P.M. blood sugar was 171;</p> <p>-On 5/20/24, Victoza 1.2 mg was not administered due to drug/item unavailable, the A.M. blood sugar was 151 and the P.M. blood sugar was 187.</p> <p>During an interview on 05/21/24, at 6:50 A.M., the resident said was out of Victoza for four or five days.</p> <p>During an interview on 05/21/24, at 6:55 A.M., LPN R said the following:</p> <p>-Victoza was not a medication stored in the emergency kit;</p> <p>-Staff fax the pharmacy when a medication is out; he/she will make a follow-up call to the pharmacy and will call the physician to make them aware.</p> <p>Review of the resident's May 2024 MAR showed on 5/21/24, Victoza 1.2 mg was not administered due to drug/item unavailable. Comment: will call pharmacy. The P.M. blood sugar was 195.</p> <p>Review of the resident's nursing progress notes, dated 5/21/24 at 9:39 A.M., showed Victoza insulin not in stock at this time. Pharmacy to request and ask why it is not being filled. Informed that an authorization signature was needed by the physician. Nurse called the physician to inform of the request signature needed and to send back to pharmacy. Physician was aware of the missed dose on 5/21/24 and the statement from the resident saying he/she had missed it for the past few days. Pharmacy also sent another request for signature.</p> <p>Review of the resident's May 2024 MAR showed on 5/22/24, Victoza 1.2 mg was not administered due to drug/item unavailable. The P.M. blood sugar was 208.</p> <p>During an interview on 05/23/24, at 6:49 P.M., the DON said the following:</p> <p>-She expected staff to follow physician orders as written;</p> <p>-If a medication was not available, she expected the staff to call the pharmacy as soon as they noticed the medication was needed;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	-She expected staff to call the pharmacy if a resident missed one day of medication;  -She expected staff to call the physician if a resident missed more than one day of a medication.  41412  46506  50675

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview and record review, the facility failed to ensure staff provided two residents (Resident #4 and #28) in a review of 24 sampled residents and two additionally sampled resident (Resident #26 and #61), that were unable to perform their own activities of daily living (ADL), the necessary care and services to maintain good personal hygiene. The facility census was 67.</p> <p>Review of the facility's undated policy, Activities of Daily Living (ADL), showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: To assist residents in achieving maximum function;</li> <li>-The policy did not address the frequency of showers or bathing.</li> </ul> <p>Review of the facility's undated policy, A.M. Care (Early Morning Care), showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: To provide cleanliness, comfort and neatness;</li> <li>-Take the resident to the bathroom or provide peri-care;</li> <li>-Allow resident to brush teeth, or brush teeth or dentures for the resident if he/she is not able;</li> <li>-Wash resident's face and hands and dry well;</li> <li>-Straighten and/or change all bed linen, blankets and spread, as needed.</li> </ul> <p>Review of the facility's undated policy, Shaving the Resident, showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: To remove facial hair and improve the resident's appearance and morale;</li> <li>-The policy did not address how often or when to shave residents.</li> </ul> <p>Review of the undated facility policy, Baths (showers), showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: To maintain skin integrity, comfort and cleanliness;</li> <li>-The policy did not address the frequency of showers or bathing.</li> </ul> <p>Request for a facility policy regarding proper pericare was requested and none provided.</p> <p>Request for a facility policy for linen changes was requested and none provided.</p> <p>1. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 2/25/24 showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognition;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Substantial/Maximum assistance from staff for shower/bathe;</p> <p>-Dependent on staff for personal hygiene.</p> <p>Review of the resident's care plan, revised on 02/28/24, showed the following:</p> <p>-Activities of daily living (ADLs) completion deficit related to progression of dementia;</p> <p>-The resident will have ADL needs met as evidenced by being clean, neat, appropriately groomed and with proper personal hygiene;</p> <p>-Provide assistance as needed for each ADL task.</p> <p>Observation on 05/19/24, at 4:50 P.M., showed the resident sat in the dining room and had approximately 1/4 inch long whiskers on his/her chin.</p> <p>During an interview on 05/19/24, at 4:50 P.M., the resident said he/she would rather not have whiskers.</p> <p>Observation on 05/20/24, at 10:39 A.M., showed the resident sat in his/her room in his/her wheelchair. The resident had chin whiskers approximately 1/2 inch long.</p> <p>Observation on 05/22/24, at 5:30 P.M., showed the resident sat in his/her wheelchair in the dining room and had whiskers on his/her chin, approximately 1/2 inch long.</p> <p>During an interview on 05/23/24, at 5:30 P.M., the resident said he/she would like the whiskers cut off. He/She did not like to have whiskers on his/her chin.</p> <p>2. Review of Resident #26's care plan, updated 4/17/19, showed the following:</p> <p>-Resident was incontinent of bowel and bladder;.</p> <p>-Resident frequently experiences loose stools;</p> <p>-Resident chooses not to use a bed pan and can be resistant to care at times;</p> <p>-At very high risk of recurrent urinary tract infections;</p> <p>-Assist of one to two staff with toileting and hygiene;</p> <p>-Encourage use of bedpan;</p> <p>-Provide incontinence care after each incontinent episode.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Requires substantial/maximal assistance for upper body dressing and to roll left and right;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Dependent on staff for toileting hygiene;</p> <p>-Always incontinent of bowel and bladder.</p> <p>Observation on 5/21/24 at 6:03 A.M., showed the following:</p> <p>-The resident was in his/her bed;</p> <p>-Certified Nurse Assistant (CNA) W and CNA FF donned gloves;</p> <p>-CNA FF cleaned the resident's front perineal care with one wipe down each side; he/she did not clean the resident's skin folds between the perineum (patch of skin between the genitals and anus) and the legs;</p> <p>-The CNA's rolled the resident onto his/her side which showed the resident's bed pad was saturated and soiled with feces;</p> <p>-The CNA's rolled the saturated and feces soiled pad under the resident; under that pad was another pad that was wet with urine; the CNA's rolled the wet pad under the resident along with the first pad; there was a third pad under the resident that was wet with a yellow to brown color;</p> <p>-CNA FF cleaned the feces from the resident's buttock;</p> <p>-CNA FF did not clean the resident's lower buttock or top of the resident's legs (where they meet the buttock) where skin had come in contact with urine.</p> <p>3. Review of Resident #28's, admission MDS, dated [DATE], showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-Requires supervision or cues from staff for oral hygiene;</p> <p>-Requires partial or moderate assistance from staff for upper body dressing;</p> <p>-Requires substantial or maximum assistance from staff for toileting hygiene, lower body dressing, going from sitting to standing and transfers;</p> <p>-Dependent on staff to put on/take off footwear;</p> <p>-Occasionally incontinent of bladder and frequently incontinent of bowel.</p> <p>Review of the resident's care plan, dated 6/28/23, showed the following:</p> <p>-Deficit in ADLs completion related to limited mobility, pain, and frozen shoulders/neck from medical diagnoses;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis of nerve injury of cervical (neck region) spine, arthralgia (joint stiffness) of bilateral (both) temporomandibular joint (joint connecting lower jaw to skull) and degeneration of the spinal cord;</p> <p>-Resident will have ADL needs met daily by being clean, appropriately dressed, groomed and with adequate hygiene;</p> <p>-Assist daily and as needed with hygiene needs;</p> <p>-Place items such as toothbrush/toothpaste/towels within reach for him/her to use;</p> <p>-Assist or perform dressing steps he/she cannot;</p> <p>-Because of neck/shoulder range of motion (ROM) limits, give physical assist or perform the ADL tasks he/she cannot perform during cares, including hair care;</p> <p>-Assist with perineal/personal hygiene needs.</p> <p>Observation on 5/21/24 at 5:30 A.M., showed the following:</p> <p>-The resident lay in his/her bed wearing socks and a shirt;</p> <p>-CNA W donned gloves and assisted Resident #28 with perineal care;</p> <p>-CNA W cleaned down the resident's front perineal area three times with the same area of one cloth and did not clean the folds between the resident's legs and the perineal area;</p> <p>-CNA W rolled the resident to his/her side;</p> <p>-The pad under the resident was wet with urine;</p> <p>-CNA W cleaned down the center of the resident's buttock; the CNA did not clean the resident's entire buttock that was in contact with urine;</p> <p>-CNA W put a clean brief and pants on the resident;</p> <p>-CNA W assisted the resident to sit on the side of the bed and changed the resident's shirt;</p> <p>-CNA W transferred the resident to his/her wheelchair;</p> <p>-The resident's hair was unkempt and the resident had dried matter around his/her eyes;</p> <p>-CNA W did not offer or perform hair care, wash the resident's face, offer deodorant or provide oral care for the resident;</p> <p>-CNA W propelled the resident in his/her wheelchair out of his/her room and to the dining room table.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #61's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-No rejection of care;</li> <li>-Requires supervision or touching assistance from staff for shower/bathe and personal hygiene;</li> <li>-Requires partial or moderate assistance from staff for tub/shower transfers.</li> </ul> <p>Review of the resident's care plan, dated 3/15/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Self care deficit in ADLs related to debilitation/weakness, physical discomfort from significant ascites (build up of fluid in the abdomen), episodes of shortness of breath, supervision to partial assist depending on his/her physical feeling at the time;</li> <li>-Resident will have assistance with his/her ADLs as needed during periods of weakness/fatigue;</li> <li>-Encourage the resident to allow staff to perform tasks that may require bending at the waist to reduce pressure/pain to abdomen;</li> <li>-Allow resident to make decisions about his/her care;</li> <li>-The care plan did not provide direction on how often to bathe or shower the resident.</li> </ul> <p>Review of the resident's shower sheets, dated April 2024, showed staff documented the resident had a shower on the following days:</p> <ul style="list-style-type: none"> <li>-On 4/10/24 (first one documented for April);</li> <li>-On 4/16/24 (six days since last shower);</li> <li>-On 4/26/24 (10 days since last shower);</li> <li>-On 4/29/24;</li> <li>-No documentation the resident refused the offering of a shower;</li> <li>-No documentation to show how often the resident was to be offered a shower or what day/s his/her shower was scheduled.</li> </ul> <p>Review of the resident's shower sheets, dated May 2024, reviewed on 5/20/24, showed staff documented the resident had a shower on the following days:</p> <ul style="list-style-type: none"> <li>-On 5/2/24;</li> <li>-On 5/9/24 (seven days since last shower);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-No documentation the resident refused the offering of a shower;</p> <p>-No documentation to show how often the resident was to be offered a shower or what day/s his/her shower was scheduled;</p> <p>-At the time of review, it had been 11 days since the resident's last documented shower.</p> <p>Observation on 5/19/24 at 4:16 P.M., showed the following:</p> <p>-The resident sat in his/her wheelchair in his/her room;</p> <p>-The resident had long facial hair on his/her chin and had body odor.</p> <p>During an interview on 5/19/24 at 4:16 P.M., the resident said the following:</p> <p>-He/She often goes a week without a shower;</p> <p>-He/She would like at least two showers a week;</p> <p>-He/She does not want whiskers on his/her chin; they are long because staff only trim his/her facial hair during baths and he/she has not had one this week (it had been 10 days since the last documented shower);</p> <p>-He/She has asked for his/her sheets to be changed, but it has been weeks because there were not enough staff to do those kinds of things.</p> <p>During an interview on 5/21/24, at 6:15 A.M., CNA W said the following:</p> <p>-Staff are expected to keep residents clean, dry, and well groomed;</p> <p>-When providing perineal care, staff should use a clean part of the wipe with each wipe and clean the resident from the front to the back or clean to dirty;</p> <p>-Staff are expected to wipe all areas where urine or feces touch the resident's skin;</p> <p>-Resident's should have all of their clothing changed everyday;</p> <p>-When getting resident's up in the morning, staff offer perineal care, oral care, brush their hair, apply deodorant and basic grooming;</p> <p>-Residents are expected to get showers on shower days, but sometimes there was not enough staff.</p> <p>During an interview on 5/21/24, at 8:45 A.M., CNA FF said the following:</p> <p>-Staff are expected to change the resident's bed linens with showers, but sometimes there was not enough linen or staff to complete linen changes;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Every morning staff are expected to wash resident's faces, hands, comb their hair, brush teeth, wash perineal area, arm pits and apply deodorant;</p> <p>-Staff are expected to clean incontinent residents everywhere urine or feces touch;</p> <p>-Clean perineal area's front to back with one wipe per swipe;</p> <p>-Residents should not have three pads on the bed, not sure why Resident #26 had three.</p> <p>During an interview on 05/23/24 at 6:49 P.M., the Director of Nursing (DON) said the following:</p> <p>-Staff should provide showers per the resident's preference;</p> <p>-She expected staff to provide routine oral care and shaving; this would be for all residents;</p> <p>-Staff should provide peri-care which includes all areas that are soiled, including the buttocks.</p> <p>42592</p> <p>50851</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on interview and record review, the facility failed to ensure systems were in place to clearly document residents' choice for code status. The facility also failed to clearly communicate the choice of code status to direct care staff so staff knew immediately what actions to take in the event of an emergency for six residents (Residents #8, #9, #20, #59, #66 and #68), in a review of 24 sampled residents, for nine additional residents (Residents #1, #16, #18, #25, #32, #34, #45, #58 and #64), and for one closed record (Resident #71). This had the potential to result in a resident who wished to be full code status not receiving cardiopulmonary resuscitation (CPR) (an emergency lifesaving procedure performed when the heart stops beating) in the event of an emergency, or residents receiving CPR who wished to be a do-not-resuscitate (DNR) (when a person elects to not have CPR attempted on them if their heart or breathing stops). The facility failed to ensure a staff member with required CPR certification was scheduled for each shift. The facility failed to ensure staff had adequate training in CPR when the certification for seven staff did not meet the requirements for CPR certification for basic life support (BLS)/Healthcare providers with a hands on skills test. The facility census was 67.</p> <p>The surveyors requested a facility policy regarding staff CPR certification, scheduling for CPR coverage and code status documentation and no received no policies.</p> <p>During an interview on [DATE] at 11:10 A.M., the Director of Operations said the following:</p> <p>-If the state agency requested any policy and one was not received, the facility did not have one;</p> <p>-The facility did not have policies on CPR certification for staff or how staff are to identify a resident's code status.</p> <p>1. Review of Resident #1's face sheet (located in the electronic health record in the computer), showed the following:</p> <p>-He/She had a listed responsible party;</p> <p>-No documentation of the resident's code status.</p> <p>Review of the resident's care plan showed the following:</p> <p>-Problem Start Date: [DATE];</p> <p>-Category: Psychosocial Well-Being;</p> <p>-In absence of written directives, the resident is a full code and the resident will have wishes followed;</p> <p>-In case of no pulse and no respirations, start CPR and call 911;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Review quarterly with resident, responsible party and with significant changes to ensure wishes remain the same.</p> <p>Review of the resident's [DATE] Physician Order Sheet (POS) (located in the electronic health record in the computer) showed the resident had elected a full code status.</p> <p>Review of the resident's paper chart showed the front page of the chart showed the resident was a full code.</p> <p>Review of the facility 24-hour daily nursing report (a communication sheet for staff (typically the charge nurse) that gives a quick overview of the resident's care), dated [DATE], showed the resident was a DNR.</p> <p>During an interview on [DATE] at 2:09 P.M., the resident's responsible party said he/she wanted the resident to be a full code.</p> <p>(The resident's code status on the 24-hour daily nursing report was inconsistent with the resident's code status identified on his/her care plan, POS, and paper chart. The resident's face sheet did not identify his/her preferred code status.)</p> <p>2. Review of Resident #8's face sheet showed the following:</p> <p>-He/She had a listed responsible party;</p> <p>-The resident elected a full code status.</p> <p>Review of the resident's care plan showed the following:</p> <p>-Problem Start Date: [DATE];</p> <p>-The resident's code status is a full code;</p> <p>-Staff will be aware of the resident's code status and honor his/her wishes;</p> <p>-Code status will be reviewed quarterly and with a change of condition.</p> <p>Review of the resident's paper chart showed the following:</p> <p>-The front page of the chart showed the resident was a DNR;</p> <p>-The chart contained an Emergency Medical Treatment &amp; Labor Act (EMTALA), out-of-hospital DNR form. The resident signed the form on [DATE] and the resident's physician signed the form on [DATE].</p> <p>Review of the resident's [DATE] POS showed the resident was a full code.</p> <p>Review of the facility 24-hour daily nursing report, dated [DATE], showed the resident was a full code.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(The resident's code status on his/her face sheet, care plan, POS, and 24-hour daily nursing report was inconsistent with the resident's code status identified on his/her out-of-hospital DNR form.)</p> <p>3. Review of Resident #18's face sheet showed the resident's code status was DNR. The resident had a Durable Power of Attorney (DPOA) for health care/responsible party.</p> <p>Review of the resident's care plan, revised on [DATE], showed the resident's code status was DNR.</p> <p>Review of the resident's [DATE] physician order sheet showed no order for code status.</p> <p>Review of the resident's paper chart showed an EMTALA out-of-hospital physician signed DNR, purple sheet, in the medical record behind the red DNR sheet.</p> <p>Review of the facility 24-hour daily nursing report sheet, dated [DATE], showed the resident was a full code.</p> <p>During an interview on [DATE], at 9:51 A.M., the resident's responsible party said he/she would expect for all areas of the medical record to match and for a physician order to be present for the code status. The resident's code status was to be DNR.</p> <p>(The resident's code status on the 24-hour daily nursing report was inconsistent with the resident's code status on his/her face sheet, care plan, and out-of-hospital DNR form. The resident did not have a code status identified on his/her physician orders.)</p> <p>4. Review of Resident #20's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-An admitted [DATE];</li> <li>-The resident elected a Do Not Resuscitate (DNR) code status.</li> </ul> <p>Review of the resident's out-of-hospital DNR form, dated [DATE], printed on white paper in the resident's paper chart, showed the physician and the resident signed the form, indicating the resident's code status was DNR.</p> <p>Review of the resident's [DATE] POS showed the resident was a full code.</p> <p>Review of the resident's paper chart showed the the front page was red and said DNR in large letters.</p> <p>Review of the 24-hour daily nursing report dated [DATE] showed the resident was a full code.</p> <p>During interview on [DATE] at 10:23 A.M., the resident said he/she wished to be a DNR.</p> <p>(The resident's code status on the 24-hour daily nursing report and physician's orders was inconsistent with the resident's preferred code status on his/her face sheet and out-of-hospital DNR form.)</p> <p>5. Review of Resident #32's face sheet showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The resident elected a DNR code status;</p> <p>-He/She had a DPOA.</p> <p>Review of the resident's care plan showed the following:</p> <p>-Problem Start Date: [DATE];</p> <p>-The resident had a DNR code status;</p> <p>-No cardiopulmonary resuscitation/no 911 for cardiac arrest;</p> <p>-Review quarterly and as needed to ensure the resident's wishes were as he/she chose.</p> <p>Review of the resident's physician orders, dated [DATE], showed the resident had elected a full code status.</p> <p>Review of the resident's paper chart showed the following:</p> <p>-The front page of the chart showed the resident was a DNR;</p> <p>-The chart had a signed out-of-hospital DNR form.</p> <p>Review of the facility 24-hour daily nursing report, dated [DATE], showed the resident was a DNR.</p> <p>(The resident's code status on the resident's physician orders was inconsistent with his/her code status on his/her face sheet, care plan, paper chart and the 24-hour daily nursing report.)</p> <p>6. Review of Resident #34's face sheet showed the following:</p> <p>-The resident was his/her own responsible party;</p> <p>-The resident's code status was DNR.</p> <p>Review of the resident's care plan, revised [DATE], showed a code status of full code.</p> <p>Review of the resident's [DATE] physician order sheet showed an order for full code (dated [DATE]).</p> <p>Review of the resident's paper chart showed an EMTALA out-of-hospital physician signed DNR, purple sheet, in the medical record behind the red DNR sheet.</p> <p>Review of the facility 24-hour daily nursing report sheet, dated [DATE], showed the resident was a full code.</p> <p>During an interview on [DATE] at 12:50 P.M., the resident said he/she wanted to be a DNR and understood what DNR status meant. He/She would expect his/her code status to be the same throughout his/her medical record.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(The resident's code status on the care plan, physician's orders and 24-hour daily nursing report was inconsistent with the resident's preferred code status on his/her face sheet and out-of-hospital DNR form.)</p> <p>7. Review of Resident #45's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-No documented code status;</li> <li>-The resident was his/her own person.</li> </ul> <p>Review of the resident's care plan, revised on [DATE], showed it did not include a code status for the resident.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Review of the resident's [DATE] POS showed no physician's order to address the resident's code status.</p> <p>Review of the resident's paper chart showed no EMTALA out-of-hospital physician signed DNR purple sheet in the medical record behind the red DNR sheet.</p> <p>Review of the facility 24-hour daily nursing report sheet, dated [DATE], showed the resident's code status was full code.</p> <p>(The resident's medical record did not indicate the resident's code status.)</p> <p>8. Review of Resident #58's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-He/She had a legal guardian;</li> <li>-He/She had elected a DNR code status.</li> </ul> <p>Review of the resident's paper chart showed the following:</p> <ul style="list-style-type: none"> <li>-The front page of the chart showed the resident was a DNR;</li> <li>-The chart contained an out-of-hospital DNR form signed and dated [DATE].</li> </ul> <p>Review of the resident's care plan showed the following:</p> <ul style="list-style-type: none"> <li>-Problem Start Date: [DATE];</li> <li>-Category: Psychosocial Well-Being:</li> <li>-The resident chose to be a DNR and his/her wishes would be followed;</li> <li>-No CPR/No 911 for cardiac arrest;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Review quarterly and as needed to ensure the resident's wishes are as he/she chooses.</p> <p>Review of the resident's May POS showed the resident was a DNR.</p> <p>Review of the facility 24-hour daily nursing report, dated [DATE], showed the resident was a full code.</p> <p>During an interview on [DATE] at 11:20 A.M., the resident's legal guardian said he/she and the resident would want the resident to be a DNR.</p> <p>(The resident's code status on the 24-hour daily nursing report was inconsistent with the resident's preferred code status on his/her face sheet, out-of-hospital DNR form, care plan and POS.)</p> <p>9. Review of Resident #59's face sheet showed the following:</p> <p>-He/She had an emergency contact/POA;</p> <p>-He/She elected a full code status.</p> <p>Review of the resident's care plan showed the following:</p> <p>-Problem Start Date: [DATE];</p> <p>-Category: Psychosocial Well-Being:</p> <p>-Resident chooses to be a full code;</p> <p>-In case of no pulse and no respirations, start CPR and call 911;</p> <p>-Review quarterly with resident and responsible party and with significant changes to ensure wishes remain the same.</p> <p>Review of the resident's [DATE] POS showed the resident had an order for a full code.</p> <p>Review of the resident's paper chart showed the front page of the chart showed the resident was a full code.</p> <p>Review of the facility 24-hour daily nursing report, dated [DATE], showed the resident was a DNR.</p> <p>During an interview on [DATE] at 3:00 P.M., the resident's POA said he/she wished for the resident to be a full code. That is what the resident had always told him/her.</p> <p>(The resident's code status on the 24-hour daily nursing report was inconsistent with the resident's preferred code status on his/her face sheet, care plan, paper chart, and POS.)</p> <p>10. Review of Resident #64's face sheet showed the following:</p> <p>-He/She had a DPOA for health care;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/She had elected a DNR code status.</p> <p>Review of the resident's paper chart showed the following:</p> <p>-The front page of the chart showed the resident was a DNR;</p> <p>-The chart contained an out-of-hospital DNR form on white paper; the form was signed and dated [DATE].</p> <p>Review of the resident's care plan showed the following:</p> <p>-Problem Start Date: [DATE];</p> <p>-Category: Psychosocial Well-Being:</p> <p>-The resident chose to be a DNR and his/her wishes would be followed;</p> <p>-No CPR/No 911 for cardiac arrest;</p> <p>-Review quarterly and as needed to ensure the resident's wishes are as he/she has chosen.</p> <p>Review of the resident's [DATE] POS showed the resident was a DNR.</p> <p>Review of the facility 24-hour daily nursing report, dated [DATE], showed the resident was a full code.</p> <p>During an interview on [DATE] at 2:18 P.M., the resident's DPOA said the resident would want to be a DNR, but to ask the resident to confirm.</p> <p>During an interview on [DATE] at 3:22 P.M., the resident said he/she would want to be a DNR.</p> <p>(The resident's code status on the 24-hour daily nursing report was inconsistent with the resident's preferred code status on his/her face sheet, care plan, paper chart, and POS.)</p> <p>11. Review of Resident #9's face sheet showed an advanced directive of DNR. The resident had a durable power of attorney for health care (DPOA/HC)/responsible party.</p> <p>Review of the resident's care plan, revised on [DATE], showed an advanced directive of DNR.</p> <p>Review of the resident's [DATE] POS showed a code status of DNR (original order dated [DATE]).</p> <p>Review of the facility 24-hour daily nursing report sheet, dated [DATE], showed a code status of DNR.</p> <p>Review of the resident's paper chart showed the first page of the chart was a red piece of paper that read DNR. The body of the chart showed no EMTALA, out-of-hospital physician signed DNR on purple paper.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE], at 3:23 P.M., the resident's DPOA/HC said he/she would expect the resident's chart to contain the purple EMTALA sheet for staff to review. The resident's code status was to be a DNR.</p> <p>(The resident did not have a signed EMTALA form in his/her medical record.)</p> <p>12. Review of Resident #16's face sheet on [DATE] at 10:07 A.M., showed no documentation of the resident's preferred code status, the resident has family as responsible party for accounts receivable. The face sheet did not indicate if the resident is his/her own party for health care decisions.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Review of the resident's care plan, revised on [DATE], showed the resident's code status was DNR.</p> <p>Review of the resident's [DATE] POS showed no physician's order to address the resident's code status.</p> <p>Review of the resident's paper chart showed the first page of the chart was a red page with the word DNR. The body of the chart contained no physician signed EMTALA out-of-hospital form on purple purple paper.</p> <p>Review of the facility 24-hour daily nursing report sheet, dated [DATE], showed code status of DNR.</p> <p>During an interview on [DATE], at 10:00 A.M., the resident said he/she did not want CPR in the event his/her heart stops or he/she stops breathing.</p> <p>(The resident did not have a physician ordered code status or a signed EMTALA form in his/her medical record.)</p> <p>13. Review of Resident #25's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-He/She had a responsible party;</li> <li>-He/She had elected a DNR code status.</li> </ul> <p>Review of the resident's care plan showed the following:</p> <ul style="list-style-type: none"> <li>-Problem Start Date: [DATE];</li> <li>-Category: Psychosocial Well-Being;</li> <li>-The resident has a DNR code status;</li> <li>-Staff will be aware of and follow the resident's wishes;</li> <li>-Do not call 911;</li> <li>-Review quarterly and as needed to ensure patients wishes are as he/she chooses.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's [DATE] POS showed no code status listed for the resident.</p> <p>Review of the resident's paper chart showed the following:</p> <ul style="list-style-type: none"> <li>-The front page of the chart showed the resident was a DNR;</li> <li>-The chart contained a purple, out of hospital DNR form. The form had not been signed by the resident or physician.</li> </ul> <p>Review of the 24-hour daily nursing report, dated [DATE], showed the resident was a DNR.</p> <p>(The resident did not have a physician ordered code status or a signed EMTALA form in his/her medical record.)</p> <p>14. Review of Resident #66's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-He/She was his/her own responsible party;</li> <li>-He/She had elected a DNR code status.</li> </ul> <p>Review of the resident's care plan showed the following:</p> <ul style="list-style-type: none"> <li>-Problem Start Date: [DATE];</li> <li>-Category: Psychosocial Well-Being;</li> <li>-The resident chose to be a DNR and his/her wishes would be followed;</li> <li>-No CPR/No 911 for cardiac arrest;</li> <li>-Review quarterly and as needed to ensure patients wishes are as he/she chooses.</li> </ul> <p>Review of the resident's [DATE] POS showed no code status listed for the resident.</p> <p>Review of the resident's paper chart showed the following:</p> <ul style="list-style-type: none"> <li>-The front page of the chart showed the resident was a DNR;</li> <li>-The chart contained a purple, out-of-hospital DNR form, dated and signed [DATE] by the resident and physician.</li> </ul> <p>Review of the facility 24-hour daily nursing report, dated [DATE], showed the resident was a DNR.</p> <p>During an interview on [DATE] at 3:30 P.M., the resident said he would want to be a DNR in the event of an emergency.</p> <p>(The resident did not have a physician ordered code status.)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>15. Review of Resident #68's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-An advanced directive of DNR;</li> <li>-The resident has a DPOA for health care/responsible party.</li> </ul> <p>Review of the resident's [DATE] POS showed no code status listed for the resident.</p> <p>Review of the resident's care plan, revised on [DATE], showed an advanced directive of DNR.</p> <p>Review of the resident's paper chart showed an EMTALA out-of-hospital physician signed DNR purple sheet in the medical record behind the red DNR sheet.</p> <p>Review of the facility 24-hour daily nursing report sheet, dated [DATE], showed a code status of DNR.</p> <p>During an interview on [DATE], at 3:36 P.M., the resident's DPOA for health care said he/she would expect the resident's medical chart to have a physician order code status. The resident's code status was to be a DNR.</p> <p>(The resident did not have a physician ordered code status.)</p> <p>16. Review of Resident #71's medical record showed the the resident was admitted to the facility on [DATE] with a diagnosis of lung cancer, hospice care and comfort measures only with an order from the discharging hospital for DNR, No CPR, no shock, dated [DATE], DNR with comfort measures only.</p> <p>Review of the resident's admission agreement showed an outside-the-hospital DNR order, dated [DATE] and signed by the resident. The form was not signed by the physician.</p> <p>Review of the resident's face sheet showed the resident was a full code.</p> <p>Review of the resident's [DATE] POS showed a physician ordered code status of DNR.</p> <p>Review of the resident's baseline care plan, dated [DATE], showed the resident was a full code.</p> <p>(The resident's code status on the face sheet and baseline care plan was inconsistent with the resident's code status on his/her hospital discharge orders, POS, and out-of-hospital DNR form.)</p> <p>17. Review of the facility staffing sheets showed day shift, 8 hour shifts, were from 6:00 A.M.-2:30 P.M., 8 hour evening shifts from 2:30 P.M. to 10:30 P.M., and 8 hour night shift from 10:30 P.M. to 6:00 A.M.; 12 hour day shifts were from 6:00 A.M., to 6:00 P.M., and night shift 12 hour shifts are from 6:00 P.M. to 6:00 A. M. The staffing sheets did not indicate which staff members were CPR certified or who should respond to an emergency cardiac or respiratory event.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility provided a list of agency staff names and CPR certification cards that had worked since February 2024. The facility used agency nurses and had no full time nurse. Of the 56 CPR cards reviewed, 27 could be confirmed valid CPR for BLS/Healthcare providers, with hands on skills test. There were seven cards that did not meet the requirements for CPR certification for BLS/Healthcare providers with a hands on skills test. The staffing sheets were compared with the employees that had valid CPR certifications.</p> <p>The seven CPR cards that were invalid included the following staff members, agency staff GG, agency staff HH, agency staff II, agency staff JJ, agency staff KK, agency staff LL and agency LPN R.</p> <p>During an interview on [DATE] at 10:22 A.M., the Director of Nursing said the facility had residents that elected a full code status; she just was not sure how many were full code and how many were DNR.</p> <p>Review of the facility staffing sheets, dated [DATE]-[DATE], showed the following shifts without a staff member with required CPR certification:</p> <p>-[DATE] , evening and night shift;</p> <p>-[DATE], day shift;</p> <p>-[DATE], evening shift;</p> <p>-[DATE], night shift;</p> <p>-[DATE], evening and night shift.</p> <p>Review of the facility staffing sheets, dated [DATE]-[DATE], showed the following shifts without a staff member with required CPR certification:</p> <p>-[DATE], evening and night shift;</p> <p>-[DATE], evening and night shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift;</p> <p>-[DATE], no certified staff from 2:30 P.M. to 6:00 P.M. on the evening shift;</p> <p>-[DATE], evening shift;</p> <p>-[DATE], evening shift;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-[DATE], no certified staff from 2:30 P.M. to 6:00 P.M. on the evening shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift;</p> <p>-[DATE], no certified staff from 6:00 P.M. on the evening shift and on the night shift.</p> <p>Review of the facility staffing sheets, dated [DATE]-[DATE], showed the following shifts without a staff member with required CPR certification:</p> <p>-[DATE], night shift;</p> <p>-[DATE], evening shift;</p> <p>-[DATE], evening shift;</p> <p>-[DATE], evening and night shift;</p> <p>-[DATE], evening shift;</p> <p>-[DATE],night shift.</p> <p>During an interview on [DATE] at 8:44 A.M., Certified Nurse Assistant (CNA) G said the following:</p> <p>-He/She was CPR certified;</p> <p>-In the event he/she found someone unresponsive and not breathing, he/she would have to check the computer or hard (paper) chart or ask the nurse for the resident's code status;</p> <p>-If he/she saw (in documentation) or was told the resident's code status was a full code, he/she would start CPR;</p> <p>-If he/she saw (in documentation) or was told the resident's code status was a DNR, he/she would not start CPR.</p> <p>During interview on [DATE] at 11:09 A.M., CNA C said the following:</p> <p>-A resident had a red paper in the front of his/her paper chart if he/she was a DNR.</p> <p>-A resident had a green paper in the front of his/her paper chart if he/she was a Full Code.</p> <p>During an interview on [DATE] at 8:51 A.M., Certified Medication Technician (CMT) M said the following:</p> <p>-He/She was not CPR certified;</p> <p>-In the event he/she found someone unresponsive and not breathing, he/she would yell for the nurse to help;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-If he/she was ever asked to confirm a resident's code status, he/she would check the resident's face sheet for the information.</p> <p>During an interview on [DATE] at 8:46 A.M., Licensed Practical Nurse (LPN) N said the following:</p> <p>-He/She was CPR certified;</p> <p>-In the event he/she found someone unresponsive and not breathing, he/she would check the 24-hour daily nursing report, because he/she always carried it with him/her and it would be faster than checking the computer to confirm a resident's code status;</p> <p>-If he/she saw the resident's code status was a full code, he/she would start CPR;</p> <p>-If he/she saw (in documentation) the resident's code status was a DNR, he/she would not start CPR;</p> <p>-At the beginning of his/her shift, he/she always checked the 24-hour daily nursing report against the resident's face sheet to make sure they matched;</p> <p>-He/She had not found any discrepancies in the residents he/she was responsible for today; he/she was responsible for residents on D and E halls. (Residents #1, #8, #35, #58, #59, #64, and #66 resided on the D hall and had inconsistent documentation of their code status in their medical records.)</p> <p>During an interview on [DATE] at 3:30 P.M., the Social Service Director (SSD) said he/she took over staffing and scheduling for the nursing department recently. She made sure the agency software said the staff were CPR certified before she scheduled those staff, but does not look at their certification to ensure it meets requirements on hands on skills test or BLS/for healthcare providers.</p> <p>During interviews on [DATE] at 1:31 P.M. and [DATE] at 10:00 A.M. and 6:49 P.M., the Director of Nursing (DON) said the following:</p> <p>-The staff should look in the paper chart for a red or green paper and a purple sheet for a DNR to determine a resident's code status;</p> <p>-She expected staff to look on the purple Out of Hospital DNR EMTALA form for the resident's code status first, then the resident's face sheet;</p> <p>-All residents were to have a code status on their POS;</p> <p>-If there was no physician ordered code status, that could mean the resident was a full code;</p> <p>-The admitting nurse was responsible for obtaining the resident's code status on admission;</p> <p>-The resident's code status should be consistent throughout the electronic medical record and paper chart;</p> <p>-She did not expect staff to follow the report sheet (24-hour daily nursing report) because it was not accurate;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The report sheets was something the staff do; they are not reconciled or checked by anyone for accuracy. Since the facility has all agency nurses, the 24-hour daily nursing report was not always correct; she wouldn't trust the report sheet;</p> <p>-If there was no purple sheet in the hard chart, she considered the resident's code status to be full code;</p> <p>-She refers to the purple Out of Hospital DNR EMTALA form in the hard chart; the resident would be a Full Code status and would receive CPR if there was no purple out of hospital EMTALA form;</p> <p>-The facility does not identify which staff are CPR certified on the staffing sheets;</p> <p>-All agency nurses are required to be properly CPR certified, which would include the hands on portion of the training;</p> <p>-She did not know if agency CPR certifications met regulatory requirements;</p> <p>-The facility did not verify credentials with the agency, it (agency report) just says they have CPR certification; the facility would have to go in (the agency computer system) to review their credentials to see their CPR certification;</p> <p>-She did not know some of the CPR certifications may not meet regulatory requirements.</p> <p>38016</p> <p>41412</p> <p>42592</p> <p>46506</p> <p>50675</p> <p>50851</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to design an activity program to meet the needs, interests, physical, mental and psychosocial well being for two residents (Resident #22 and #52), in a review of 24 sampled residents and one additional resident (Resident #44). Staff failed to ensure evening and weekends, as well as activities focusing on dementia residents were occurring. The facility census was 67.</p> <p>During an interview on 5/22/24 at 11:00 A.M., the Director of Nursing (DON) said the facility did not have a specific policy related to the activities program.</p> <p>1. Observation of the posted activity calendar for the month of May 2024, on 5/19/24 at 5:45 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Every Saturday: weekend packet and Bingo at 2:00 P.M.;</li> <li>-Every Sunday: devotionals with a resident at 10:30 A.M. and Bingo at 2:00 P.M.;</li> <li>-No evidence of any evening activities scheduled;</li> <li>-No evidence of activities for dementia residents or one on one activities scheduled.</li> </ul> <p>2. Review of Resident #22's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-He/She had a guardian;</li> <li>-Diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning).</li> </ul> <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 6/23/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognitive skills for daily decision making;</li> <li>-Makes self understood;</li> <li>-Sometimes understands others;</li> <li>-Short term and long term memory problems;</li> <li>-No behaviors or rejection of cares;</li> <li>-Likes participating in favorite activities.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Severely impaired cognitive skills for daily decision making;</p> <p>-Makes self understood;</p> <p>-Sometimes understands others;</p> <p>-Short-term and long-term memory problems;</p> <p>-No behaviors or rejection of cares.</p> <p>Review of the resident's care plan, revised on 03/28/24, showed the following:</p> <p>-The resident likes to socialize with staff and other residents;</p> <p>-He/She enjoys participating in ice cream socials and wandering the halls;</p> <p>-Adjust the intensity, frequency, and/or duration of activities to accommodate the resident's energy level and tolerance;</p> <p>-Encourage the resident to become involved with activities, adapt to his/her current abilities;</p> <p>-Inform the resident of upcoming activities by providing activities calendar, verbal reminders, escort, encouragement, etc.;</p> <p>-Involve the resident with those who have shared interests.</p> <p>Daily observation during the facility's annual survey, from 5/19/24 to 5/23/24, showed the resident had no involvement in activities. The resident frequently sat in the day room with minimal interaction from staff or residents.</p> <p>3. Review of Resident #44's annual MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnosis of dementia;</p> <p>-Wandering present one to three days;</p> <p>-No hallucinations or delusions;</p> <p>-No rejection of care;</p> <p>-Interview for activities, the resident said favorite activities and religious services were very important to him/her and music, pets and going outside when the weather is good was somewhat important to him/her.</p> <p>Review of the resident's care plan, last reviewed 2/14/24, showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident has impaired memory due to diagnosis of dementia;</p> <p>-Resident will sometimes become agitated, cursing at others and wandering halls, or revert back to his/her childhood and believe he/she is living in that time;</p> <p>-Provide reality orientation when necessary, but don't argue or try to force resident to believe;</p> <p>-Sometimes it may be best to allow resident to live in his/her own world with his/her beliefs for a period of time;</p> <p>-Provide reassurance when frustration and fear is present.</p> <p>The care plan did not provide guidance to staff on the resident's activity needs.</p> <p>The resident's medical record did not include evidence of any activity assessments, activity notes, attendance in activities or one on one activities.</p> <p>Daily observation during the facility's annual survey, from 5/19/24 to 5/23/24, showed the resident had no involvement in activities. The resident frequently sat in his/her wheelchair at the end of the hallway looking out a window.</p> <p>4. Review of Resident #52's, admission MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Diagnosis of dementia;</p> <p>-Unable to answer depression questions;</p> <p>-Activity preferences include it was very important for the resident to have: things to read, music he/she likes, animals/pets. It is somewhat important to keep up with news, do things with groups of people, go outside and religious activities.</p> <p>Review of the resident's care plan, last reviewed/revised 4/24/24, showed the following:</p> <p>-Potential for unmet needs (physical/cognitive nutritional/hydration) related to cognitive deficit,</p> <p>-Encourage resident to socialize, participate in activities of interest and getting exposure to sunlight, either through the window or outside when the weather allows.</p> <p>The care plan did not provide guidance to staff on the resident's activity needs.</p> <p>The resident's medical record did not include evidence of any activity assessments, activity notes, attendance in activities or one on one activities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Daily observation during the facility's annual survey, from 5/19/24 to 5/23/24, the resident had no involvement in activities. The resident frequently sat in his/her wheelchair in the living room/television area with his/her head on the table or in his/her bed. He/She went to the dining room for meals.</p> <p>During an interview on 5/20/24 at 10:52 A.M., the resident's responsible party said the following:</p> <ul style="list-style-type: none"> <li>-He/She was at the facility four to five days a week, sometimes three times a day;</li> <li>-There were not enough activities for dementia residents;</li> <li>-No one at the facility completed activities with the dementia residents;</li> <li>-There were no activities for any residents on the weekend except what the residents do themselves.</li> </ul> <p>5. During an interview on 5/20/24 at 11:03 A.M., Resident #41 said the following:</p> <ul style="list-style-type: none"> <li>-The facility has Bingo on Monday, Wednesday and Friday; another resident organized this activity and calls the Bingo and will call Bingo on the weekend as well;</li> <li>-The facility hardly ever had weekend activities;</li> <li>-He/She would like more variety in activities;</li> <li>-Many activities got canceled if the activity director had transportation responsibilities, which was weekly;</li> <li>-The activity director was not enthusiastic about activities and always complained about his/her job because they pull him/her to transportation a lot.</li> </ul> <p>During an interview on 5/23/24 at 11:20 A.M., the Activity Director said the following:</p> <ul style="list-style-type: none"> <li>-She was a new Activity Director;</li> <li>-She did not receive any training and she does not know how or what to chart;</li> <li>-There was a state Activity Director class, but she was not scheduled for it;</li> <li>-She was not able to do the activities every day because she also does transportation;</li> <li>-She splits her time as best she can with 1/2 activities and 1/2 transportation, but if there are too many appointments, she may not get as much time in activities;</li> <li>-She was the only employee in the activities department;</li> <li>-If she has to go on transport, and there was supposed to be an activity, the activity doesn't get done, unless a resident does it for her;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility did not arrange for her to have a resource person to call with questions about activities that she knew of;</p> <p>-She does not know much about dementia or what kind of activities to do for the residents with dementia;</p> <p>-The Social Service designee has tried to teach her about one on one activities and dementia, but she has not had time to do any;</p> <p>-There were no activities scheduled the 2nd and 4th Thursday's, so staff play music during dinner;</p> <p>-She has a few activities where she documents attendance, but didn't know she was supposed to;</p> <p>-She does not know what an activity assessment is and has not done any;</p> <p>-The residents with dementia do not come to many activities;</p> <p>-Bingo was held several times a week because a resident will call the Bingo numbers.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Director of Nurses said the following:</p> <p>-She would expect activities to be offered to all residents, including the dementia residents;</p> <p>-Weekend activities are usually things like bingo and games the residents initiate;</p> <p>-She is not sure what specific activities occur in the evening.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>41412</p> <p>Based on interview and record review, the facility failed to employ a qualified activity professional to oversee the activity program for the facility. The facility employed an activity director but she has not completed an approved activity professional training program. This practice affected all residents in the facility. The facility census was 67.</p> <p>Request was made for the activity director job title responsibilities and qualifications and none were provided. The facility provided a job description for an assistant activity director.</p> <p>Review of the employee list with job titles, showed the activity director department head was the activity director.</p> <p>1. Review of the Activities Director's employee file on 5/22/24, showed no current certification in therapeutic recreation or activities professional. The employee also did not have a state certification.</p> <p>During an interview on 5/23/24 at 11:20 A.M., the Activity Director said the following:</p> <ul style="list-style-type: none"> <li>-She has not had any activities training;</li> <li>-She does activities half of the time and transportation for the residents the other half of her time;</li> <li>-There was no one else in the activity department and no one else assisted her with activities;</li> <li>-She did not have an activity director for a resource person available to her;</li> <li>-She did not know what kind of activities were appropriate for residents with dementia.</li> </ul> <p>During an interview on 5/23/24 at 6:49 P.M., the Director of Nursing said the administrator was responsible to ensure the staff have their certifications.</p> <p>During an interview on 5/23/24, at 2:45 P.M., the Administrator said he would expect the Activity Director to be certified by the state certification. If the Activity Director was not supervised, he would expect a certified Activity Director to train, oversee and be a resource until she was certified. He had not been at the facility long enough to know everyone's certifications, he did not know if the facility Activity Director was certified or not.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview and record review, the facility failed to ensure proper treatment and care to maintain foot health for two residents (Resident #9 and #36) in a sample of 24 residents and one additional sampled resident (Resident #34). The facility census was 67.</p> <p>Review of the facility's undated policy, Nail Care of (FINGERS AND TOES), showed the following:</p> <p>-Purpose: To provide cleanliness, comfort, prevent spread of infection;</p> <p>-The Nursing assistants may perform nail care on the residents who are not at risk for complications of infection. The licensed nurse or podiatrist must perform nail care on residents suffering from diabetes or vascular disease.</p> <p>Review of the facility assessment, updated 5/20/24, showed the facility out-sourced providers included one average visit per month by a podiatrist.</p> <p>1. Review of Resident #36's undated face sheet showed his/her diagnoses included congestive heart failure (build up of fluid in the heart), end stage kidney disease (on dialysis), and diabetes mellitus (inability to control blood sugar levels).</p> <p>Review of the resident's care plan, last revised 4/25/24, showed the resident may need assistance with his/her ADL's.</p> <p>Review of the resident's skilled nursing facility (SNF)/dialysis communication form, dated 4/26/24, showed orders from the dialysis clinic that a foot check was done at the clinic, big toe toe nails need trimmed as soon as possible. Licensed Practical Nurse (LPN) N documented his/her initials to the side of the order on this form, indicating the order had been noted.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/13/24, showed the following:</p> <p>-Cognitively intact;</p> <p>-No rejection of cares or behaviors;</p> <p>-Diagnosis of end stage renal (kidney) disease and diabetes mellitus;</p> <p>-Receives insulin injections and anticoagulants (blood thinners) daily;</p> <p>-Receives dialysis (filtration of the blood to perform the function of the kidneys).</p> <p>Review of the resident's SNF/Dialysis communication form, dated 5/15/24, showed the toe nails must be cut as soon as possible.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's SNF/Dialysis communication form, dated 5/17/24, showed to please trim toe nails.</p> <p>Review of the resident's SNF/Dialysis communication form, dated 5/20/24, showed to trim the resident's toenails.</p> <p>Observation on 5/23/24, at 2:15 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident's toenails were long and uneven, the resident's big toe nails were thick and long;</li> <li>-His/Her toe nails showed signs of pressure on the sides of his/her nails.</li> </ul> <p>During an interview on 5/23/24 at 2:15 P.M., the resident said he/she felt pressure on his/her toes when his/her shoes were on and it was uncomfortable. He/She has not seen a podiatrist in a long time. He/She would like to get his/her toe nails trimmed.</p> <p>2. Review of Resident #9's face sheet showed diagnoses included heart failure.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderately impaired cognition;</li> <li>-No behaviors or rejection of cares;</li> <li>-Partial/Moderate assistance from staff for personal hygiene;</li> <li>-Substantial/Maximum assistance from staff for shower/bathe self and putting on/taking off footwear.</li> </ul> <p>Review of the resident's care plan, revised on 03/11/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident is at risk for deterioration in completing activities of daily living (ADL) related to tardive dyskinesia (a condition affecting the nervous system, often caused by long-term use of some psychiatric drugs);</li> <li>-His/Her needs will be met through next review;</li> <li>-Provide assistance in performing ADLs as needed.</li> </ul> <p>Review of the resident's May 2024 physician order sheet showed an order for a podiatry consult and evaluate to treat with an order start date of 05/09/24.</p> <p>During an interview on 05/19/24, at 4:30 P.M., the resident said he/she would like to see the podiatrist, he/she was not sure when he/she saw one last, but it had been a long time.</p> <p>3. Review of Resident #34's face sheet showed the diagnosis of diabetes mellitus.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Makes self understood and understands others;</p> <p>-Cognitively intact;</p> <p>-No behaviors or rejection of cares;</p> <p>-Set up or clean up assistance only for personal hygiene and shower/bathe self.</p> <p>Review of the resident's care plan, revised 04/14/24, showed no problem, goal or interventions related to foot care.</p> <p>Review of the resident's May 2024 physician order sheet showed the following:</p> <p>-The resident requires diabetic shoe insoles with an order start date of 02/27/20;</p> <p>-Podiatry evaluation to consult and treat with an order start date of 05/04/24.</p> <p>During an interview on 05/19/24, at 3:55 P.M., the resident said he/she had not seen a podiatrist for over a year. He/She was diabetic and would like to see one as soon as possible.</p> <p>During an interview on 5/21/24 at 6:10 A.M., Certified Nurse Assistant (CNA) W said the CNA's are not allowed to clip resident's toe nails if they are diabetic and some of the residents' toe nails were too thick to cut. The night shift CNA's started a list for the podiatrist six weeks ago, but a podiatrist still had not come to the facility.</p> <p>During an interview on 5/22/24, at 1:42 P.M., LPN R said the following:</p> <p>-The aides started a list for residents who need to see the podiatrist several weeks ago;</p> <p>-Some of the residents' nails are too thick for the nurses to cut and they need to see a podiatrist;</p> <p>-There was also an issue with agency nurse staffing as some were only in the facility for short assignments and facility staff were always assisting them. This resulted in little time to trim nails;</p> <p>-He/She tries to cut resident's toe nails that he/she can, but cannot get to all of them, or they are too thick for him/her to cut.</p> <p>During an interview on 05/22/24, at 11:12 A.M., the social services director said the following:</p> <p>-She has been responsible for making outside appointments and obtaining podiatry services for the facility for about a month;</p> <p>-Prior to a month ago, a medical records staff member was responsible for outside appointments and obtaining podiatry services, but he/she no longer worked with the facility;</p> <p>-The prior podiatrist resigned and the facility obtained a new podiatrist a couple weeks ago;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility sent out consent forms and got permission from the residents who could sign for themselves to see the new podiatrist;</p> <p>-As soon as all the forms were returned to the facility, the podiatrist would see everyone in the facility.</p> <p>During an interview on 05/23/24, at 6:49 P.M., the Director of Nursing said the following:</p> <p>-Having a foot care provider had been a problem recently;</p> <p>-The last provider they had did not work out well;</p> <p>-She thought a new podiatrist has been contracted;</p> <p>-Nursing should keep nails trimmed if possible.</p> <p>42592</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to provide restorative services to assist three residents (Resident #28, #41 and #68), in a review of 24 sampled residents, with mobility and/or limited range of motion, to attain or maintain their highest level of functioning. The facility census was 67.</p> <p>Review of the facility's undated policy, The Restorative Nursing (RNA) Program, showed the following:</p> <ul style="list-style-type: none"> <li>-The restorative nursing program is an integral part of maximizing the daily restorative care process for the residents;</li> <li>-A pro-active approach is necessary to prevent future negative outcomes;</li> <li>-It is the purpose of this facility to see that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. (OBRA 1987);</li> <li>-It is the entire staff's responsibility to prevent deterioration and further functional loss of each resident in the facility. The objective of the RNA program is to provide restorative care necessary to meet the needs of all residents to enable them to achieve the standard of care as described by OBRA 1987;</li> <li>-Goals: <ul style="list-style-type: none"> <li>-1. Clear lines of authority, expectations and responsibilities are necessary for implementation of the RNA program;</li> <li>-2. Restorative services are to be made available per residents' assessed needs;</li> <li>-3. Criteria for resident entry to, movement within and discharge from the RNA program must be clearly established;</li> <li>-4. A mechanism for monitoring and on-going evaluation of the RNA programs must be established;</li> <li>-5. Restorative Nursing Aides (RNAs) must be adequately trained and provided with on-going training and consultation.</li> </ul> </li> </ul> <p>Review of the facility's undated policy, Role of the Restorative Nurse Aide (RNA), showed the following:</p> <ul style="list-style-type: none"> <li>-The Restorative Nurse Aide will be given specialized training by the nursing and therapy departments;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The training and documentation of training will be done internally;</p> <p>-This training will enable the RNA to carry out instructions for specialized care as identified below for those residents assessed by nursing, physical therapy (PT), occupational therapy (OT) and speech therapy (ST) as requiring such services;</p> <p>-The RNA will perform services to assigned residents based on an individual plan, using restorative approaches and motivational techniques that promote independence, self-help and active participation;</p> <p>-The RNA will perform the duties as assigned by the nurse management and therapist. The duties may include:</p> <ul style="list-style-type: none"> <li>- Body alignment and positioning;</li> <li>-Eating independence/retraining;</li> <li>-ADL's - bathing, dressing, grooming and toileting;</li> <li>-Range of motion;</li> <li>-Transfers;</li> <li>-Ambulation;</li> <li>-Prosthetic management;</li> <li>-Whirlpools;</li> <li>-Restorative adaptive devices;</li> </ul> <p>-The RNA will communicate significant changes in the resident's condition to the appropriate staff;</p> <p>-The RNA will document the progress of residents on the restorative case load as stated in the Resident Treatment Plan;</p> <p>-The RNA will report to nursing, PT, OT and ST any problems, referrals or needed reassessments as needed;</p> <p>-The RNA will attend the weekly interdisciplinary team (IDT) meetings and any in-services offered.</p> <p>A request was made for a restorative nursing program log book and none was provided.</p> <p>During an interview on 6/25/24, at 8:59 A.M., the administrator said the facility's restorative aide was terminated on 3/19/24.</p> <p>1. Review of Resident #28's care plan, dated 6/28/23, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had range of motion (ROM) limits of his/her neck/shoulder;</p> <p>-Give physical assist or perform the activity of daily living (ADL) tasks he/she cannot perform;</p> <p>(The approaches on the resident's care plan did not include a restorative nursing program.)</p> <p>Review of the resident's physician's order sheet, dated 12/6/23, showed the resident discharged from skilled physical and occupational therapy services.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-Requires partial or moderate assistance from staff for oral hygiene;</p> <p>-Requires substantial or maximum assistance from staff for shower/bathe, toileting hygiene, upper and lower body dressing, put on/take off footwear, going from sitting to standing and transfers;</p> <p>-Limited range of motion in both upper extremities;</p> <p>-No restorative nursing.</p> <p>Review of the resident's Nursing-Restorative Program Referral, dated 2/21/24, showed the following:</p> <p>-Goal: Maintain upper body strength and stand tolerance;</p> <p>-Restorative nursing two times weekly;</p> <p>-Upper body strength with minimum to moderate resistance;</p> <p>-Standing tolerance with upper body support.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 3/17/24, showed the resident had limited range of motion to both upper extremities and did not receive restorative nursing.</p> <p>Review of the resident's medical record showed no evidence the resident received restorative nursing services.</p> <p>Observation on 5/21/24 at 5:30 A.M., showed the following:</p> <p>-The resident was in his/her bed;</p> <p>-The resident was unable to assist the staff with his/her upper body;</p> <p>-The resident did not move his/her neck or arms;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident required maximum assist from a staff member for a pivot transfer, the resident was unable to stand upright.</p> <p>During an interview on 5/21/23 at 5:59 A.M., Certified Nurse Assistant (CNA) W said the following:</p> <p>-The resident used to walk with assist until a few months ago.;</p> <p>-The facility used to have a restorative aide, but he/she left and the facility had not replaced him/her;</p> <p>-He/She had not been instructed to complete restorative services and would not have time to do them unless the facility increased staffing.</p> <p>2. Review of Resident #41's face sheet, showed he/she had diagnoses that included chronic kidney disease, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, cellulitis (infection) of right lower limb, cellulitis of left lower limb, complete traumatic amputation (removal) of the leg at level between the right knee and ankle and diabetes mellitus (inability to regulate blood sugar) with diabetic neuropathy (nerve disease cause numbness and or weakness).</p> <p>Review of the resident's physician orders, dated 3/6/23, showed restorative plan of care for bilateral upper extremity and lower extremity strengthening as tolerated and sit to stand at grab bar or parallel bar to maintain modified independence for transfers.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Cognitively intact;</p> <p>-Independent with eating and oral hygiene;</p> <p>-Requires partial/moderate assistance from staff for upper body dressing;</p> <p>-Requires substantial/maximal assistance from staff to shower/bathe, to go from sitting to lying flat and lying to sitting on the side of the bed;</p> <p>-Dependent on staff for toilet hygiene, lower body dressing and footwear, to roll left and right and to transfer;</p> <p>-Wheelchair use;</p> <p>-No impairments to range of motion;</p> <p>-No restorative nursing minutes.</p> <p>Review of the resident's Nursing-Restorative Program Referral, dated 11/14/23, showed the following:</p> <p>-Goal: Maintain upper body and lower body strength;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Restorative Nursing two times weekly;</p> <p>-Upper body strength with approximately 6 lbs. resistance;</p> <p>-Lower body strength with moderate resistance;</p> <p>-Precaution: watch skin integrity on legs.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed functional limitation in range of motion to one lower extremity. No restorative nursing minutes.</p> <p>Review of the resident's medical record showed no evidence the resident received restorative nursing services.</p> <p>During an interview on 5/22/24 at 2:04 P.M., the resident said he/she would like restorative nursing but the facility has not had the staff to do restorative nursing.</p> <p>3. Review of Resident #68's continuity of care document showed the resident's diagnoses included cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain that could include blood clots and strokes) and vascular dementia (brain damage caused by multiple strokes that causes memory loss).</p> <p>Review of the resident's physical therapy treatment encounter note, dated 01/23/24, showed the following:</p> <p>-Discharge summary completed and established a restorative program;</p> <p>-Issued written handout to restorative.</p> <p>Review of the resident's nursing-restorative program referral, dated 01/23/24, showed the following:</p> <p>-Goals for restorative included for the resident to maintain/improve bilateral lower extremities range of motion and strength and transfers with stand-by to minimal assist with grab bar;</p> <p>-Approach/techniques included therapeutic exercises bilateral lower extremities all planes for range of motion and strengthening and transfers at grab bars or parallel bars with stand-by to minimal assist.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-No behaviors or rejection of cares;</p> <p>-Substantial/maximum assist from staff for sitting to lying and lying to sitting on the side of the bed position changes;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Dependent on staff for sit to stand, chair/bed-to-chair and tub transfers, lower body dressing and putting on/taking off footwear;</p> <p>-Partial/moderate assist from staff for rolling left to right in bed and upper body dressing;</p> <p>-Uses a wheelchair for mobility;</p> <p>-No restorative nursing program documented.</p> <p>Review of the resident's May 2024 physician order sheets showed the resident was discontinued from skilled occupational therapy on 01/22/24. (The resident did not have an order for a restorative nursing program.)</p> <p>Review of the resident's care plan, revised 05/01/24, showed the resident required assistance with activities of daily living (ADLs) and mobility due to functional limitations following a stroke. (The approaches on the resident's care plan did not include a restorative nursing program.)</p> <p>Observation on 05/22/24, at 6:18 A.M., showed the following:</p> <p>-CNA E and CNA C assisted the resident to sit on the side of the bed from a lying position. CNA E moved the resident's legs to have his/her feet touch the floor;</p> <p>-The resident did not participate in lifting his/her legs from the bed to the side of the bed;</p> <p>-CNA E placed the resident's walker at the side of the resident's bed;</p> <p>-CNA C placed a gait belt around the resident's waist;</p> <p>-CNA E and CNA C instructed the resident to stand and assisted the resident to a standing position by lifting on the gait belt with the resident pushing up to a standing position using the walker;</p> <p>-CNA C instructed the resident to pivot to his/her wheelchair and assisted to a sitting position;</p> <p>-CNA C transported the resident to the dining room.</p> <p>During an interview on 05/23/24, at 1:35 P.M., the therapy director said the following:</p> <p>-She was the director at the facility since late February;</p> <p>-When she first started, there was a RA for the restorative program;</p> <p>-The RA quit not to long after she started at the facility (late February) and there was currently no restorative program;</p> <p>-The Director of Nursing (DON) discharged everyone from the RA program due to no current RA.</p> <p>During an interview on 05/23/24 at 6:49 P.M., the DON said the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility currently did not have a restorative nursing program due to there being no trained restorative aide available for the program;</p> <p>-The RA quit, and when he/she quit, all of the residents who were on the restorative nursing program were discontinued from the program;</p> <p>-CNAs could do the walk to dine program for any resident;</p> <p>-CNAs could perform range of motion;</p> <p>-She expected any resident who needed to have restorative nursing, to receive it;</p> <p>-The facility had not been able to hire an RA since the last RA quit several months ago.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to have a system in place to ensure staff served hot beverages at an appropriate temperature, in an appropriate cup and placed within one resident's (Resident #63), of 24 sampled residents, reach. The resident sustained a third degree burn and required treatment for the burn. The facility failed to consistently evaluate, implement, and modify interventions, in accordance with current standards of practice, and as necessary, to reduce the risk of falls for two residents (Resident #42, and #52). Resident #42 was sent to the emergency room after he/she experienced a dislocated right shoulder and a laceration above his/her right eye requiring sutures, injuries requiring treatment at the hospital. Resident #52 was sent to the emergency room for a laceration above the left eye requiring glue repair by the emergency room. The facility failed to safely transport two sampled residents (Resident #22, and #68) and two additional residents (Resident #1 and #14) when staff pushed them in wheelchairs without foot pedals and the resident's feet drug the floor. The facility census was 67.</p> <p>Request for a hot liquid or food service policy was made with no policies provided.</p> <p>Review of the facility policy, Fall Prevention, taken from the facility's Fall Prevention Manual, dated 06/2006, showed the following:</p> <p>-Falls are a serious health risk for older persons. Much can be done to prevent falls. Because of the high incidence of falls in the elderly, skilled nursing facilities (SNF) have an important role to play in preventing falls. SNF are in a unique position to identify patient risks and to coordinate a fall prevention and fall reduction program. Moreover, falls can be prevented, and their severity reduced without an increased use of restraints;</p> <p>-Most falls are the result of a complex interaction of environmental, medical, and physical factors. Therefore, one intervention alone is less likely to be as successful as a combination of interventions. This quality improvement project incorporates a patient fall risk assessment, care planning and an exercise component;</p> <p>-Assessment is the cornerstone of a fall prevention program. Literature supports that a fall risk assessment that incorporates a focused history, environmental and physical risks to persons has a positive impact on reduction in fall rates, deaths from falls, and hospitalization rates among residents of long-term residential facilities;</p> <p>-Research shows that care planning by an interdisciplinary team soon after admission, with revisions as conditions change, is the most effective way to provide individualized care. Risk factors identified in the risk assessment should be the basis for an individualized care plan;</p> <p>-A performance-improvement approach to falls and injuries requires interdisciplinary involvement. Therefore, a resident safety management committee should be composed of members from each of the facility's departments and each member should have specific duties and obligations in the fall-management process;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-The three steps the committee should take are to collect data, implement both facility-wide and individualized plans, and evaluate those plans;</p> <p>-The fall policy did not address transporting residents in wheelchairs without foot pedals.</p> <p>Review of the undated facility policy, Use of Wheelchairs, showed the following:</p> <p>-Do not remove footrests unless the resident uses feet on floor to enable mobility;</p> <p>-Lower footrests and place the resident's feet on footrests if used; position feet and legs in good body alignment, and elevate leg(s) as ordered.</p> <p>1. Review of Resident #63's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 4/18/24, showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-He/She had limited range of motion to bilateral upper and lower extremities;</p> <p>-The resident required setup assistance with eating;</p> <p>-He/She was independent with rolling left and right in bed.</p> <p>Review of the resident's nurse notes, dated 4/28/24 at 1:12 PM, showed the following:</p> <p>-The resident said that very morning he/she received hot water for tea;</p> <p>-The Certified Nurse Assistant (CNA) sat the breakfast tray down and walked out of the room;</p> <p>-The resident moved the bedside tray closer so he/she could eat;</p> <p>-The hot water tipped over and spilled onto the resident's left leg;</p> <p>-The resident's left leg had redness and some raised areas to the back of the left leg;</p> <p>-Staff applied a cool towel, and the resident received Norco (opioid pain medication) and alprazolam (antianxiety) at 10:00 AM;</p> <p>-At 10:00 A.M., the nurse reassessed the resident and found five blisters to the back of the left leg behind the knee;</p> <p>-The nurse received orders to apply Silvadene (topical antibiotic) twice a day, wrap loosely with gauze and apply cool compress;</p> <p>-At 2:10 P.M., the resident rated his/her pain an eight out of 10 (one a scale of one to 10 with 10 being the most pain) to bilateral knees and burn.</p> <p>During an interview on 5/23/24 at 8:30 A.M., CNA C said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She worked the shift when the resident was burned on the back of his/her leg with hot liquid (4/28/24);</p> <p>-He/She was in the kitchen getting the room trays ready on the cart;</p> <p>-The dishwashing machine was broken, so the kitchen used disposable (Styrofoam) cups;</p> <p>-The kitchen staff instructed him/her to fill the cup and put aluminum foil cover over the cup.</p> <p>During an interview on 5/20/24 at 12:50 P.M., the resident said the following:</p> <p>-On 4/28/24, the CNA brought in the breakfast tray and sat it on the overbed table out of his/her reach;</p> <p>-Staff brought the hot water for tea in a large Styrofoam cup;</p> <p>-He/She started to pull the overbed table closer to him/her in order to eat;</p> <p>-The cup of hot water fell off the tray and onto the bed;</p> <p>-He/She was covered with a blanket, but the hot water still contacted his/her skin;</p> <p>-He/She tried to get the wet items away from him/her and it burned every time he/she moved anything;</p> <p>-The burn caused constant pain with it being severe most of the time;</p> <p>-The staff told the resident it was his/her fault because he/she won't get out of bed for meals;</p> <p>-He/She experienced pain, however, it was worse with the burn on his/her leg;</p> <p>-He/She preferred pain be less than five out of 10.</p> <p>Review of the resident's medication administration record (MAR), dated April 2024, showed staff administered pain medication as follows::</p> <p>-Hydrocodone/acetaminophen (opioid pain medication) 5/325 milligrams (mg) on 4/28/24 at 6:45 P.M. for pain at 8/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 4/29 at 3:00 P.M. for left leg pain at 7/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 4/29 at 9:58 P.M. for pain at 6/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 4/30 at 10:30 P.M. for pain at 7/10.</p> <p>Review of the resident's nurse note, dated 4/30/24 at 1:12 P.M., showed the following:</p> <p>-Wound type: third degree burn to posterior left lower extremity, inferior to knee;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-Measurements: 2.2 centimeters (cm) by 11 cm by 0.2 cm;</p> <p>-Moderate amount of serous drainage (clear fluid that leaks out of wounds) present;</p> <p>-Updated treatment: cleanse with wound cleanser gently, apply skin prep to peri wound, apply Silvadene to wound bed, cover with non-adherent dressing, secure in place, and change daily.</p> <p>Review of the resident's physician orders, dated 4/30/24, showed an order for Silvadene cream 1%, apply to posterior left lower extremity below knee. Cleanse with wound cleanser gently, apply skin prep to peri wound, apply Silvadene to wound bed, cover with non-adherent dressing, secure in place, and change daily related to burn.</p> <p>Review of the resident's care plan, last updated 4/30/24, showed the following:</p> <p>-The resident had a burn on his/her posterior left lower extremity inferior to knee caused by hot water during mealtime;</p> <p>-Delayed healing factors: poor mobility, high body mass index (BMI) (measure of body fat based on height and weight that applies to adult men and women), spending majority of time laying in bed, incontinence, diagnoses of type II diabetes mellitus (problem in the way the body regulates and uses sugar);</p> <p>-Staff educated the resident on the importance of not consuming meals in bed including spilling hot drinks.</p> <p>Review of the resident's MAR, dated May 2024, showed staff administered the following pain medication:</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 5/2 at 7:09 A.M. for pain at 8/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 5/2 at 8:56 P.M. for pain at 6/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 5/3 at 10:57 A.M. for pain at 5/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 5/5 at 8:05 A.M. for pain at 7/10;</p> <p>-Hydrocodone/Acetaminophen 5/325 mg on 5/5 at 5:34 P.M. for pain at 6/10.</p> <p>Review of the resident's nurse note, dated 5/9/24 at 11:03 A.M., showed the following:</p> <p>-Burn to the left lateral posterior thigh currently measuring 2.4 cm by 1.5 cm, no drainage;</p> <p>-Left inferior knee measures 6.8 cm by 11.9 cm, scant exudate, yellow in color;</p> <p>-The resident reported pain with the dressing change to the knee.</p> <p>Observation on 5/19/24 at 5:44 P.M., showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident lay in bed with headphones on watching television;</p> <p>-The resident's meal tray sat covered on the over bed table;</p> <p>-The over bed table sat perpendicular to the bed with the tray on the side of the over bed table away from the resident and not within reach.</p> <p>Observation on 5/20/24 at 1:16 P.M., showed the following:</p> <p>-The kitchen staff provided hot water in a red coffee cup with a disposable lid;</p> <p>-Staff obtained the hot water from a spigot on the coffee machine for resident use:</p> <p>-The hot water temperature was 160 degrees Fahrenheit.</p> <p>Review of the National Library of Medicine, dated August 2008, showed hot beverage served at temperatures between 160 degrees Fahrenheit and 185 degrees Fahrenheit can cause significant scald burns (caused by something wet, such as hot water or steam) with brief exposure.</p> <p>Observation on 5/21/24 at 8:50 A.M., showed the following:</p> <p>-The resident lay in bed with headphones on and eyes closed;</p> <p>-The resident's meal tray sat covered on the over bed table;</p> <p>-The over bed table sat perpendicular to the bed with the tray on the side of the over bed table away from the resident, not within reach;</p> <p>-A coffee cup with a lid sat on the far end of the tray.</p> <p>During an interview on 5/22/24 at 9:40 A.M., CNA FF said the following:</p> <p>-The facility provided an in-service to staff about not using Styrofoam cups, and to only use the coffee cups in the kitchen;</p> <p>-The in-service did not include placement of trays or drinking cups within reach;</p> <p>-The in-service did not include allowing the cup to sit and cool prior to giving to a resident.</p> <p>During an interview on 5/22/24 at 9:48 A.M., CNA G said the following:</p> <p>-The facility provided staff training after the resident was burned;</p> <p>-The training included not using Styrofoam cups, only cups provided in the kitchen;</p> <p>-The training did not include where to place the trays or drinks, because staff should already know to keep things safely in the resident's reach;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-The training did not include allowing drinks to sit and cool before use.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Director of Nursing (DON) said the following:</p> <p>-The staff were supposed to use red coffee cups;</p> <p>-The staff needed to take time to hand wash the coffee cups instead of using Styrofoam;</p> <p>-No assessments were done to assess the water temperature in the kitchen for resident use;</p> <p>-CNAs are trained to put items within reach during training to become a CNA.</p> <p>2. Review of Resident #42's Care Plan, dated 6/28/23, showed the following:</p> <p>-The resident is at risk for injury related to a history of falls related to acute medical condition and fall within 36 hours of admission;</p> <p>-The resident will remain free from injury;</p> <p>-Analyze the resident's falls to determine a pattern/trend, which appear to be related to medical trauma and possibly delirium/confusion.</p> <p>-Give the resident verbal reminders not to transfer without assistance;</p> <p>-Keep the resident's bed in the lowest position with brakes locked;</p> <p>-Keep call light in reach at all times;</p> <p>-Keep personal items and frequently used items within reach;</p> <p>-Place fall mats by bed (both sides);</p> <p>-Staff to provide substantial assistance for pivot transfer, with a gait belt during transfers for balance/safety.</p> <p>Review of the resident's care plan showed staff reviewed the care plan on 5/1/24 and made no changes to the resident's care plan for fall risk.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-Scheduled pain medication;</p> <p>-Independent with transfers and walking;</p> <p>-Continent of bowel and bladder.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's nurses notes, dated 5/9/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Heard yelling from the resident's room;</li> <li>-When entering the room, the resident lay on his/her right side holding his/her arm;</li> <li>-The resident had blood dripping from his/her right eyebrow;</li> <li>-Laceration to right eyebrow, along with right shoulder that was displaced;</li> <li>-The resident was unable to move his/her right arm;</li> <li>-The resident was sent to the emergency room via emergency medical services (EMS).</li> </ul> <p>Review of the resident census showed the resident went to the hospital on 5/9/24 and returned on 5/10/24.</p> <p>Review of the resident's nurses notes, dated 5/10/24, at 7:36 A.M. the interim Director of Nursing documented the following:</p> <ul style="list-style-type: none"> <li>-Returned to facility at 7:32 A.M. by ambulance transport from the hospital;</li> <li>-Laceration to right forehead; stitches noted;</li> <li>-The resident had a dislocation of his/her right shoulder, these injuries were from his/her fall in her room last night.</li> </ul> <p>Review of the resident's nurses notes, dated 5/10/24, at 1:50 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Skin assessment performed post fall;</li> <li>-Area above right eyebrow measured 4.9 cm in length and 0.5 cm in width;</li> <li>-Sutures in place, left open to air;</li> <li>-Area on right cheek measures 1.6 cm in length and 0.3 cm in width left open to air;</li> <li>-No bruising noted to right shoulder.</li> </ul> <p>Review of the resident's medication administration record, dated May 2024, showed the following:</p> <ul style="list-style-type: none"> <li>-On 5/11/24, staff documented the resident's pain score as five out of 10 (with 10 being the highest) on the evening shift;</li> <li>-On 5/12/24, staff documented the resident received PRN (as needed) Tylenol (pain reliever) 650 milligrams (mg) at 12:21 P.M. and night shift documented a pain score of four out of 10.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's nurses notes, dated 5/12/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Aide reported the resident had an unwitnessed fall;</li> <li>-Upon entering the resident's room, the resident was sitting on his/her buttocks beside his/her bed and was leaning on his/her right arm;</li> <li>-When asked what happened, the resident said, I was about to wet myself;</li> <li>-The resident was educated on using call light for safety due to previous fall.</li> </ul> <p>Review of the resident's physician's orders, dated 5/13/24, showed hydrocodone-acetaminophen 5-325 milligrams two times daily for pain.</p> <p>Review of the resident's nurses notes, dated 5/19/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was found on the floor next to his/her bed;</li> <li>-The resident said he/she slid off the bed and onto his/her bottom;</li> <li>-The resident had chronic pain complaints in his/her right shoulder due to a previous fall and dislocation.</li> </ul> <p>Review of the resident's electronic medical record showed no evidence of analysis of the resident's falls, review or revision of the resident's care plan after each fall, or any additional changes to prevent further injuries from falls.</p> <p>Observation on 5/19/24, at 3:45 P.M., showed the resident in his/her wheelchair sitting in the hall by the nurses desk. The resident had sutures to a laceration above his/her right eye brow approximately 4-5 centimeters in length and he/she had a black eye.</p> <p>3. Review of Resident #52's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Diagnoses included dementia chronic pain, fusion of spine (surgical connection of two bones in the spine to prevent movement), and spinal stenosis (space inside the backbone is too small that can put pressure on the spinal cord and nerves that travel through the spine, can cause pain, tingling, numbness and muscle weakness);</li> <li>-Independent with transfers and ambulation;</li> <li>-No mobility devices used;</li> <li>-Occasionally incontinent of bladder and bowel;</li> <li>-No toileting program;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-Scheduled pain medications.</p> <p>Review of the resident's care plan, dated 6/27/23, documented the resident has cognitive loss. The care plan did not identify the resident was at risk for falling.</p> <p>Review of the resident's nurses notes, dated 7/11/23 at 6:39 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident continues observation for recent fall. Steri-strips to left hand intact with no drainage noted;</li> <li>-The resident's family member said the resident fell because the resident was trying to get assistance from the staff, for his/her family member (also a resident), and no one answered the call light;</li> <li>-Upon entering the room, the resident was found on top of his/her covers that were in his/her recliner, most likely due to the resident sliding to the floor while lying on top of the items;</li> <li>-The resident denied pain or discomfort and had no visible injuries;</li> <li>-Education was provided to the resident about allowing staff to assist his/her spouse to avoid future injury;</li> <li>-The resident voiced understanding but additional teaching and reinforcement is required related to his/her cognitive decline. No change in status at this time.</li> </ul> <p>Review of the resident's nurses notes, dated 7/11/23 at 5:43 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had unsteady gait and lost balance causing a fall when he/she tried to assist staff who were assisting the resident's family member (also a resident);</li> <li>-The resident sustained a laceration to his/her left eye;</li> <li>-The resident was transferred to the emergency room via EMS.</li> </ul> <p>Review of the resident's nurses notes, dated 7/11/23 at 10:14 P.M., showed the resident's laceration above the resident's left eye required glue repair by the emergency room . No other injuries noted.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan, after he/she fell on [DATE], to include/address interventions related to helping his/her (resident) family member.</p> <p>Review of the resident's nurses notes, dated 7/15/23 at 7:47 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat on the floor to the front and left side of the chair, up against the wall;</li> <li>-The resident said he/she was getting up to help his/her family member (also a resident) and he/she slid out of the chair;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had a small abrasion to his/her lower back from sliding down the wall;</p> <p>-The resident was significantly more confused than baseline, likely related to current diagnosis of urinary tract infection and was currently on antibiotics.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan, after he/she fell on [DATE], to include/address interventions related to helping his/her (resident) family member.</p> <p>Review of the resident's care plan, updated 7/26/23, showed the following:</p> <p>-The resident was at risk for falls due to declining cognitive level and unsteady gait;</p> <p>-Ensure the resident's room was free of clutter that he/she could potentially trip over;</p> <p>-Increased staff supervision with intensity based on resident need.</p> <p>Review of the resident's nurses notes, dated 8/16/23 at 3:24 P.M., showed the following:</p> <p>-Interdisciplinary note showed the resident had three falls in the month of July;</p> <p>-All of the resident's falls were related to him/her assisting his/her family member (also a resident);</p> <p>-The resident's fall risk score was a 21, which put him/her at a high risk for falls.</p> <p>Review of the resident's Nurses Notes, dated 9/12/23 at 11:45 P.M., showed the following:</p> <p>-The resident sustained a non-injury, witnessed fall in the dining room;</p> <p>-The resident sat at the dining room table and slid out of his/her chair onto his/her bottom.</p> <p>The resident's medical record showed no evidence the facility attempted to identify the root cause of the fall.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Requires supervision, touch or verbal cues for transfers and ambulating;</p> <p>-Requires partial/moderate assistance from staff for upper body dressing;</p> <p>-Requires substantial maximal assistance from staff for lower body dressing and put on/take off footwear;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-Frequently incontinent of bladder and continent of bowel;</p> <p>-Two or more injury falls since last assessment.</p> <p>Review of the resident's nurses notes, dated 9/25/23 at 10:23 P.M., showed the following:</p> <p>-The resident sustained a fall at 1:00 P.M. The resident stood up out of his/her wheelchair and was walking toward the nursing station;</p> <p>-The resident turned around and fell backward, striking his/her left posterior head against the nursing station counter;</p> <p>-The resident was immediately assessed for injury and a silver dollar sized raised area was noted to his/her left posterior head;</p> <p>-Neurological checks initiated per facility protocol.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's nurses notes, dated 10/12/23 at 1:48 P.M., showed the following:</p> <p>-The care plan team met with the resident's family member;</p> <p>-The resident receives assistance getting into bed, but was able to get out of bed on his/her own;</p> <p>-The resident will propel his/her wheelchair around the building from time to time;</p> <p>-The resident had not had any recent falls.</p> <p>Review of the resident's nurses notes, dated 10/14/23 at 10:14 P.M., showed the following:</p> <p>-Kitchen staff witnessed the resident fall in the dining room. The resident struck his/her head against the piano and fell to the floor;</p> <p>-The resident had a superficial laceration (cut or tear to the skin) and a silver dollar sized hematoma (localized bleeding), from the fall, to top of his/her posterior (back) head;</p> <p>-The resident was assessed, a dressing was placed on the resident's head wound and neurological checks (series of tests and questions to evaluate the nervous system) initiated.</p> <p>Review of the resident's medical record showed no evidence the facility attempted to identify the root cause of the fall.</p> <p>Review of the resident's care plan, updated 10/14/23, showed the resident fell in the dining room and hit his/her head against the piano. Laceration and hematoma noted. No interventions were added or revised on the resident's care plan.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's nurses notes, dated 11/22/23 at 9:56 P.M., showed the resident was found sitting on the floor with his/her legs crossed, going through his/her closet.</p> <p>Review of the resident's medical record showed no evidence the facility attempted to identify the root cause of the fall.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's nurses notes, dated 11/24/23 at 6:36 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was sent to the emergency room for further evaluation related to a fall;</li> <li>-The resident has a hematoma to the left ear.</li> </ul> <p>Review of the resident's medical record showed no evidence the facility attempted to identify the root cause of the fall.</p> <p>Review of the resident's care plan, updated 11/24/23, showed the following:</p> <ul style="list-style-type: none"> <li>-On 11/24/23, the resident was found on the floor in the television area;</li> <li>-He/She had been sitting in his/her wheelchair and fell ;</li> <li>-He/She hit his/her head on the floor;</li> <li>-The resident's left ear became red and swollen; received an order to send to the hospital for evaluation;</li> <li>-When the resident was not in his/her room, place the resident by the nurses station for close supervision.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnoses of depression and Alzheimer's disease;</li> <li>-Severe cognitive impairment;</li> <li>-Used a walker;</li> <li>-Frequently incontinent of bladder and bowel;</li> <li>-Requires supervision, touch or verbal cues for transfers and ambulating;</li> <li>-Two or more no injury falls since last assessment</li> <li>-Received an antidepressant medication daily.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's nurses notes, dated 12/31/23 at 10:02 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had an unwitnessed fall in his/her room; when staff arrived, the resident was sitting on the floor next to his/her wheelchair;</li> <li>-The resident did not have socks on and had spilled his/her water on the floor;</li> <li>-The resident was holding his/her left hand and had a small cut to his/her left pinky finger and a blood blister, cleansed and bandaged;</li> <li>-Abrasion noted to the resident's left lower back measuring 10 centimeters (cm) in length by 1.3 cm in width; redness to area noted;</li> <li>-Staff placed the resident on neurological checks.</li> </ul> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's nurses notes, dated 1/6/24 at 2:29 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a witnessed fall in the living area;</li> <li>-Staff witnessed the resident lower himself/herself to the floor;</li> <li>-Mechanical lift pad caught under the resident's chair.</li> </ul> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Moderate to severe depression;</li> <li>-Does not use a wheelchair;</li> <li>-Always incontinent of bladder and bowel;</li> <li>-Pain medication scheduled,</li> <li>-Non-verbal sounds, facial expressions that could indicate pain in the five days;</li> <li>-Requires supervision, touch or verbal cues for transfers and ambulating;</li> <li>-Two or more no injury falls since last assessment.</li> </ul> <p>Review of the resident's nurses notes, dated 5/10/24 at 5:44 P.M., showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had an unwitnessed fall in his/her room;</p> <p>-Staff observed the resident sitting on his/her buttocks on his/her fall mat;</p> <p>-The resident's bed was in the lowest position at the time;</p> <p>-The resident has a laceration to his/her right forearm;</p> <p>-Neurological checks initiated.</p> <p>Review of the resident's care plan showed no evidence staff updated the resident's care plan after he/she fell on [DATE].</p> <p>Observation on 5/19/24, at 4:33 P.M., showed the following:</p> <p>-The resident lay in his/her bed with the door to his/her room closed;</p> <p>-The resident's bed was low to the ground;</p> <p>-There was a fall mat propped against the dresser across the room;</p> <p>-There was no fall mat next to the resident's bed.</p> <p>During an interview on 5/23/24 at 10:45 A.M., the DON said the following:</p> <p>-The facility has had change over in nursing administration so all systems were not in place;</p> <p>-All of the licensed staff are agency and not full time;</p> <p>-The charge nurse would immediately assess a resident after each fall and treat or get orders to treat any injury accordingly;</p> <p>-Ideally there would be a review of each fall the next day;</p> <p>-During the review, staff would try to determine the cause of the fall, evaluate the care plan to see what can be done to prevent further falls and/or reduce injury if there is a future fall;</p> <p>-If a fall was unwitnessed, or the resident hit their head, then the staff are expected to do neurological checks;</p> <p>-Staff would notify the physician, family, and nursing administration of each fall.</p> <p>4. Review of Resident #14's care plan, last updated 1/31/24, showed the following:</p> <p>-The resident was at risk for falls due to cerebrovascular disease with hemiparesis and hemiplegia (loss of strength in the arm, leg, and sometimes face on one side of the body) of right dominant side;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-Restorative therapy for lower extremity exercise three times per week;</p> <p>-Two person staff to assist with pivot transfers.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-The resident had severely impaired cognitive skills for daily decision making;</p> <p>-He/She had disorganized thinking the fluctuated;</p> <p>-He/She was independent with wheelchair locomotion.</p> <p>Observation on 5/19/24 at 5:09 P.M. showed the following:</p> <p>-CNA O pushed the resident in a wheelchair into the dining room;</p> <p>-The wheelchair did not have foot pedals;</p> <p>-The residents feet were touching the floor and dragged along the floor while being pushed.</p> <p>Observation on 5/21/24 at 11:10 A.M., showed the following:</p> <p>-CNA O pushed the resident in a wheelchair from the common television area to his/her room;</p> <p>-The wheelchair did not have foot pedals;</p> <p>-The resident's feet touched the floor three times during locomotion; the resident wore non-skid socks.</p> <p>During an interview on 5/21/24 at 11:40 A.M., CNA O said the following:</p> <p>-He/She did not know where the resident's foot pedals were and did not see them in the resident's room;</p> <p>-The resident usually did well with keeping his/her feet up off the floor.</p> <p>5. Review of Resident #1's quarterly MDS, dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Uses wheelchair for mobility;</p> <p>-Diagnoses included traumatic brain injury.</p> <p>Observation on 5/19/24 at 5:00 P.M. showed the following:</p> <p>-CNA C pushed the resident in his/her wheelchair on the 400 hallway;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>-The wheelchair had no foot pedals; the resident's sock feet drug on the tile floor. His/Her right foot was bent back under the wheelchair seat.</p> <p>Observation on 5/20/24 at 2:55 P.M., CNA C pushed the resident in a wheelchair with no foot pedals. The resident's feet drug under the wheelchair.</p> <p>During an interview on 5/23/24 at 9:30 A.M., CNA C said all the foot pedals had been taken off the wheelchairs for unknown reasons. The pedals had been placed in a room on the B hallway. CNA C said the resident did not self propel himself/herself. CNA C said he/she pushed the resident in a wheelchair without pedals. CNA C said that it would be unsafe to transport residents without foot pedals. He/She tried to stop if a resident's feet drug on the floor and reminded the resident to lift their feet.</p> <p>6. Review of Resident #22's continuity of care document showed the resident's diagnoses included dementia and cognitive communication deficit (difficulty with memory, organization and problem solving that can make it difficult to properly speak, listen, read, write or interact in social situations).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognitive skills for daily decision making;</li> <li>-Supervision for mobility in his/her wheelchair for short distance;</li> <li>-Partial/moderate assistance from staff for wheelchair mobility for long distances.</li> </ul> <p>Review of the resident's care plan, revised on 03/28/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident is at high risk for falls related to history of falls, limited mobility and hip/knee contractures;</li> <li>-Used a wheelchair for mobility.</li> </ul> <p>Observation on 05/19/24 at 4:45 P.M., showed CNA FF pushed the resident to the dining room in a wheelchair. There were no foot pedals attached to the resident's wheelchair. Both of the resident's feet drug on the floor as CNA FF pushed the resident from the dayroom to the dining room.</p> <p>7. Review of Resident #68's continuity of care document showed the resident's diagnoses included cerebrovascular disease (a group of condit</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #20), in a review of one resident who had an indwelling urinary catheter (a flexible tube inserted into the bladder to allow urine to drain from the bladder), and who had a history of urinary tract infections (UTI), was provided with the proper care of the urinary catheter device when staff allowed the collection bag and tubing to touch the floor. The facility also failed to provide urinary incontinence care in a manner to prevent the spread of bacteria that cause infections for one resident, (Resident #28), who also had a history of UTI's, in a review of 24 sampled residents. The facility census was 67.</p> <p>Review of the undated facility policy titled, Catheter, Emptying a Urinary Drainage Bag, showed staff was to keep the drainage bag and tubing off the floor at all times to prevent contamination and damage.</p> <p>1. Review of Resident #20's care plan, dated 11/24/23, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident required an indwelling urinary catheter related to urine retention;</li> <li>-Do not allow tubing or any part of the drainage system to touch the floor. The resident at times will refuse to raise bed to ensure bag is off the floor.</li> </ul> <p>Review of the resident's progress note, dated 12/22/23 at 10:43 P.M., showed the resident received a new order for an antibiotic for a urinary tract infection (UTI).</p> <p>Review of the resident's progress note, dated 1/11/24 at 2:24 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Staff encouraged the to raise the bed off of the floor because the catheter bag was touching the floor;</li> <li>-The resident refused to raise the bed.</li> </ul> <p>Review of the resident's progress note, dated 2/4/24 at 12:38 A.M., showed the resident received a new order for Omnicef (an antibiotic) for a UTI.</p> <p>Review of the resident's May 2024 physician order sheet (POS) showed an order for an indwelling urinary catheter.</p> <p>Review of the resident's care plan, dated 5/20/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident lowers his/her bed independently causing his/her catheter collection bag to come into contact with floor;</li> <li>-The resident was educated on appropriate bed height to prevent the bag from coming into contact with the floor and the infection control risk associated with this;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff will check bed height when doing rounds to ensure the bag is not touching floor and provide the resident education as needed.</p> <p>Observation on 05/21/24 at 10:29 A.M. showed the following:</p> <ul style="list-style-type: none"> <li>-The resident lay in his/her bed;</li> <li>-The resident's urinary catheter drainage bag was attached to the side of his/her bed;</li> <li>-The urinary drainage bag was in a dignity bag and the catheter tubing was outside of the dignity bag;</li> <li>-The catheter tubing and the dignity bag both touched the floor;</li> <li>-The urine in the urinary catheter bag was brown and cloudy;</li> <li>-The urine in the urinary catheter tubing was red and filled with sediment (a substance that settles at the bottom of urine) (normal urine does not have sediment).</li> </ul> <p>During interview on 5/22/24 at 2:00 P.M., Certified Nurse Aide (CNA) E said the following:</p> <ul style="list-style-type: none"> <li>-The resident's catheter tubing should not be on the floor;</li> <li>-The resident lowered his/her bed to the floor and CNA E was unsure what to do to keep the tubing off of the floor;</li> <li>-Overnight staff removed the resident's dignity bag and he/she observed the uncovered urinary bag and tubing on the floor.</li> </ul> <p>2. Review of Resident #28's, admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 6/16/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Moderately impaired cognition;</li> <li>-Requires substantial or maximum assistance from staff for toileting hygiene, lower body dressing, going from sitting to standing and transfers;</li> <li>-Occasionally incontinent of bladder and frequently incontinent of bowel.</li> </ul> <p>Review of the resident's care plan, dated 6/28/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Deficit in activities of daily living (ADLs) completion related to limited mobility, pain and frozen shoulders/neck from medical diagnoses;</li> <li>-Diagnosis of nerve injury of cervical (neck region) spine, arthralgia (joint stiffness) of bilateral (both) temporomandibular joint (joint connecting lower jaw to skull) and degeneration of the spinal cord;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident will have ADL needs met daily by being clean and with adequate hygiene;</p> <p>-Assist daily and as needed with hygiene needs;</p> <p>-Because of neck/shoulder range of motion (ROM) limits, give physical assist or perform the ADL tasks he/she cannot perform during cares;</p> <p>-Assist with perineal/personal hygiene needs.</p> <p>Review of the resident's nurses notes, dated 12/1/23, showed the resident was transferred to the hospital on 11/29/23 and returned on 12/1/23 with a diagnosis of urinary tract infection. The hospital sent a prescription for Cipro (an antibiotic).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognitively intact;</p> <p>-UTI in the last 30 days.</p> <p>Observation on 5/21/24 at 5:30 A.M., showed the following:</p> <p>-The resident lay in his/her bed;</p> <p>-CNA W donned gloves and assisted Resident #49 (the resident's roommate), who had been incontinent of feces, to clean his/her perineal area and change his/her clothing;</p> <p>-CNA W removed his/her gloves after assisting Resident #49 and did not wash his/her hands with soap and water or cleanse them with alcohol gel;</p> <p>-CNA W donned new gloves (without washing hands) and assisted Resident #28 with perineal care;</p> <p>-CNA W cleaned down the resident's front perineal area three times, with the same area of one cloth and then down the center of the resident's perineal area with the same wipe;</p> <p>-CNA W rolled the resident to his/her side;</p> <p>-The pad under the resident was wet with urine;</p> <p>-The CNA's did not provide incontinence care in a manner to prevent the spread of contaminates that cause infection.</p> <p>During an interview on 5/21/24 at 6:15 A.M., CNA W said the following:</p> <p>-Staff are expected to clean their hands with soap and water before and after contact with each resident and before and after gloving;</p> <p>-When providing perineal care, staff should use a clean part of the wipe with each swipe and clean the resident from the front to the back or clean to dirty.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/21/24 at 8:45 A.M., CNA FF said staff are expected to clean incontinent residents perineal area from front to back with one wipe per swipe.</p> <p>During interviews on 5/23/24 at 6:49 P.M. and 6/11/24 at 3:22 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-Catheter bags should be kept in a privacy bag;</li> <li>-Catheter bags and tubing should not be kept on the floor;</li> <li>-When staff found the resident's urinary catheter bag or tubing on the floor, the staff were to educate the resident on raising his/her bed;</li> <li>-There were no other interventions provided after the resident had been educated on keeping his/her bed in a position where the urinary catheter drainage system was off the floor;</li> <li>-She had to educated the resident several times on his/her bed position and keeping the urinary drainage system off the floor.</li> <li>-Staff are to wash their hands with soap and water before applying gloves, after removing gloves and when dirty;</li> <li>-Staff should be changing gloves when dirty or after completing a procedure and between dirty and clean processes;</li> <li>-She would not expect staff to use the same cloth for wiping a resident more than once.</li> </ul> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42592</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #68), in a review of 24 residents, and one additional resident (Resident #16), received oxygen therapy consistent with professional standards of practice and the residents' plan of care. The facility census was 67.</p> <p>Review of the facility's undated policy, Oxygen Administration, showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues;</li> <li>-Nasal Cannula: Connect tubing to humidifier outlet and adjust liter flow as ordered. Place prongs of cannula into the resident's nares. Adjust the plastic slide to hold cannula in place;</li> <li>-At regular intervals, check and clean oxygen equipment, masks, tubing and cannulas;</li> <li>-At regular intervals, check liter flow contents of oxygen cylinder, fluid level in humidifier and assess resident's respiration to determine further need for oxygen therapy.</li> </ul> <p>1. Review of Resident #68's face sheet showed a diagnosis of chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and cerebrovascular disease (a group of disorders that affect the blood vessels and blood supply to the brain).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated instrument completed by facility staff, dated 03/01/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognition;</li> <li>-Able to make needs known;</li> <li>-Shortness of breath or trouble breathing with exertion and while lying flat;</li> <li>-Oxygen therapy while a resident.</li> </ul> <p>Review of the resident's May 2024 physician order sheet showed an order for oxygen at two LPM (liters per minute) per nasal cannula, continuous during the day time and four LPM per nasal cannula continuous during the bedtime hours, with an order start date of 12/13/23.</p> <p>Review of the resident's care plan, revised 05/01/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Requires continuous oxygen supplementation;</li> <li>-Oxygen as ordered and monitor for oxygen saturation rate as needed.</li> </ul> <p>Observation on 05/19/24 from 4:40 P.M. to 5:48 P.M., showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident sat up in his/her wheelchair at the dining room table;</p> <p>-During the entire observation the resident's oxygen tubing connector laid on the dining room floor;</p> <p>-Both the oxygen concentrator and supplemental oxygen tank were on with no tubing connected to either oxygen source;</p> <p>-The oxygen tubing and nasal cannula were attached to the resident's ears and in his/her nostrils.</p> <p>Observation on 05/22/24 at 6:18 A.M., showed the following:</p> <p>-Morning care provide for the resident by Certified Nursing Assistant (CNA) E and CNA C;</p> <p>-The resident's oxygen concentrator was running and set at four LPM;</p> <p>-The oxygen tubing was not attached to concentrator and the tubing lay in the bed with the resident;</p> <p>-CNA E adjusted the resident's bed so the resident lay flat to provide care;</p> <p>-The resident said, Oh come on, lets get this done. The resident's face was turning pink and the resident coughed;</p> <p>-CNA E dressed the resident while waiting for assistance from staff to bring incontinence care product supplies, all the while the resident lay flat with no oxygen;</p> <p>-The resident said, I'm choking a little bit - come on;</p> <p>-CNA C recognized the oxygen was not hooked up and did not attach to the concentrator;</p> <p>-The resident remained flat and tried to clear his/her throat. The resident said again, Come on.;</p> <p>-After CNA C and CNA E provided care, approximately 15 minutes in total, staff assisted the resident to stand and transferred the resident to his/her wheelchair;</p> <p>-CNA C attached the nasal cannula to the oxygen tank at 6:32 A.M. and took the resident to the dining room.</p> <p>During an interview on 05/22/24 at 6:35 A.M., CNA C said the following:</p> <p>-The resident requires oxygen all of the time and oxygen should be reapplied if staff notice it is not in his/her nose or not connected to the concentrator;</p> <p>-The resident has a habit of messing with his/her tubing and taking off his/her oxygen;</p> <p>-The resident does get short of breath without the oxygen on;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She should have hooked up the oxygen when he/she first noticed it was not connected.</p> <p>2. Review of Resident #16's annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Diagnosis of chronic obstructive pulmonary disease (COPD) (chronic respiratory illness);</li> <li>-No behaviors or rejection of care;</li> <li>-Oxygen therapy while a resident.</li> </ul> <p>Review of the resident's care plan, last reviewed/ revised 3/6/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Alteration in respiratory function related to COPD;</li> <li>-Encourage resident to take his/her time with activity of daily living (ADL) tasks;</li> <li>-Encourage resident to break tasks into segments to ease respiratory stress;</li> <li>-Medications as ordered whether by mouth, nebulizer or inhaler;</li> <li>-Monitor for effectiveness by assessment of respiratory ease and by asking the resident if they seem effective;</li> <li>-Oxygen as ordered and monitor for effectiveness:</li> <li>-Step in to physically assist if the resident seems short of breath or fatigued.</li> </ul> <p>Review of the resident's physician orders, dated May 2024, showed the following:</p> <ul style="list-style-type: none"> <li>-Oxygen 2 Liters per minute per nasal cannula continuous;</li> <li>-Change O2 tubing weekly on Sundays;</li> </ul> <p>Review of the resident's Medication Administration Record (MAR), dated May 2024, showed the following:</p> <ul style="list-style-type: none"> <li>-Change oxygen tubing weekly on Sundays;</li> <li>-On 5/2/24, staff documented changing the oxygen tubing as ordered;</li> <li>-On 5/5/24, staff documented changing the oxygen tubing as ordered;</li> <li>-On 5/12/24, staff documented changing the oxygen tubing as ordered.</li> </ul> <p>Observation on 5/19/24 at 3:59 P.M., showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident in his/her bed with his/her nasal cannula tubing in his/her nares;</p> <p>-The tubing was dated 5/2/24 with a piece of tape on the tubing (the oxygen tubing had not been changed as staff documented it had been on 5/5/24 or 5/12/24);</p> <p>-The resident's oxygen concentrator was set to 2 liters of oxygen.</p> <p>During an interview on 5/19/24 at 3:59 P.M., the resident said the following:</p> <p>-He/She has COPD and wears oxygen at 2 liters at all times;</p> <p>-Staff had not changed his/her tubing in a while;</p> <p>-Staff were supposed to change his/her oxygen tubing every week on Sunday, but it rarely happened;</p> <p>-When the staff do not change the tubing, the tubing got hard and rigid;</p> <p>-It was not clean and was uncomfortable;</p> <p>-The tubing he/she had now was old, rigid, and uncomfortable.</p> <p>During an interview on 5/21/24 at 11:22 A.M., Licensed Practical Nurse (LPN) R said oxygen tubing was changed weekly by night shift licensed nurses. All of the nurses are agency so he/she would not know who to ask why Resident #16's oxygen tubing had not been changed.</p> <p>During an interview on 05/23/24 at 6:49 P.M., the Director of Nurses (DON) said the following:</p> <p>-If a resident has an order for continuous oxygen, she would expect the resident to be monitored to ensure they are receiving the oxygen as ordered;</p> <p>-She would expect staff to monitor to make sure the nasal cannula is attached to the concentrator or supplemental oxygen tank to ensure the resident is getting the prescribed oxygen;</p> <p>-Oxygen tubing should be labeled and dated;</p> <p>-Staff are expected to change the tubing weekly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>41412</p> <p>Based on observation, interview and record review, the facility failed to routinely assess pain as ordered for one resident, (Resident #38), in a review of 24 sampled residents. The facility failed to make the resident aware he/she had as needed (PRN) medication available for pain and failed to offer PRN pain medications when the resident complained of pain. The resident was agitated and unable to sleep due to pain. The census was 67.</p> <p>During an interview on 05/22/24 at 11:00 A.M., the Director of Nursing (DON) said the facility did not have a specific policy related to pain management.</p> <p>1. Review of Resident #38's face sheet showed the resident had diagnoses that included joint pain, surgical amputation and acquired absence of left leg above the knee.</p> <p>Review of the resident's significant change Minimum Data Set (MDS) (a federally mandated assessment instrument), completed by facility staff and dated 4/10/24 showed the following:</p> <ul style="list-style-type: none"> <li>-Clear speech; makes self understood;</li> <li>-Cognitively intact;</li> <li>-No behaviors;</li> <li>-On a pain management program;</li> <li>-Received scheduled and PRN opioids (narcotic pain medication);</li> <li>-Did not receive non-medication interventions;</li> <li>-Pain presence; frequently;</li> <li>-Pain interferes with day to day activities.</li> </ul> <p>Review of the resident's pain assessment, dated 4/11/24 and completed by facility staff, showed the following:</p> <ul style="list-style-type: none"> <li>-Had pain or hurt in the last five days; noted as phantom leg pain of the lower left extremity;</li> <li>-Pain occasionally makes it hard to sleep;</li> <li>-Manner of expressing pain included agitation;</li> <li>-Measures taken to alleviate pain included analgesics;</li> <li>-On scheduled pain regimen that was always effective;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Receives PRN medication for pain.</p> <p>Review of the resident's care plan, last updated 4/13/24, showed the following:</p> <p>-Problem Start Date: 10/12/2023; Category: Pain; Presence of chronic pain in areas of his/her amputation site, back and in general has pain;</p> <p>-Goal: Will verbalize satisfaction with current pain management plan;</p> <p>-Approach: Administer as needed (PRN) or routine medications as ordered; monitor for adverse effects and for effectiveness; report for ineffectiveness.</p> <p>Review of the resident's May 2024 physician order sheet (POS) showed orders for the following:</p> <p>-Hydrocodone (narcotic pain medication) 5/325 milligram (mg), one tablet at 8:00 P.M. (scheduled for block time of 7:00 P.M. to 10:00 P.M.) and one tablet every 12 hours PRN; order date of 10/3/23;</p> <p>-Pain assessment every shift using pain scale of 0 - 10 every shift; scheduled for day, evening and night; order date of 11/3/23.</p> <p>Review of the resident's May monthly summary, dated 5/12/24 and completed by facility staff, showed the following:</p> <p>-Oriented times three; person, place and time;</p> <p>-Makes self understood;</p> <p>-Has not expressed pain verbally or exhibited non-verbal signs/symptoms of pain;</p> <p>-Pain management program was not necessary.</p> <p>During an interview on 5/19/24 at 4:29 P.M., the resident said the following:</p> <p>-His/Her pain was never controlled;</p> <p>-He/She only gets one pill a day.</p> <p>During an interview on 5/20/24 at 9:15 A.M., the resident yelled and said the following:</p> <p>-He/She had a terrible night; just hurt;</p> <p>-I told you my pain is never controlled!;</p> <p>-He/She did not know he/she could ask for additional, as needed, pain medication.</p> <p>Observation and interview on 5/21/24 at 6:02 A.M., showed the following:</p> <p>-The resident sat in his/her wheelchair in his/her doorway rocking back and forth;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-When asked if he/she slept better last night, the resident angrily responded, No I didn't, then yelled, because I hurt!</p> <p>-He/She said it would do no good to ask for pain medication because they wouldn't give it to him/her;</p> <p>-Certified Medication Technician (CMT) M stood in the hallway at the medication cart, two doors down from the resident, preparing and administering medications to the residents on the hall.</p> <p>Review of the resident's May 2024 medication administration record (MAR) on 5/21/24 showed the following:</p> <p>-Hydrocodone 5/325 mg, one tablet at 8:00 P.M. (scheduled for block time of 7:00 P.M. to 10:00 P.M.) and one tablet every 12 hours PRN; no documentation staff had ever administered the resident a PRN dose of his/her pain medication;</p> <p>-Pain assessment every shift using pain scale of 0 - 10 every shift; scheduled for day, evening and night; in the administration boxes, staff documented their initials but there were no pain scores documented.</p> <p>Review of the resident's May 2024 progress notes showed no documentation of pain scores.</p> <p>Review of the resident's electronic health record showed no documentation of pain scores under the vital signs tab.</p> <p>During an interview on 5/19/24 at 4:50 P.M., CMT Q said the following:</p> <p>-The resident was usually very angry and does not allow you to watch him/her take his/her medications, let alone ask about his/her pain;</p> <p>-There was a box on the MAR to assess pain; he/she has never put a pain score in the box;</p> <p>-The resident just seemed to be agitated, grumpy and mad all of the time;</p> <p>-He/She has been responsible for the resident's medications and assessments;</p> <p>-He/She has never offered the resident PRN pain medications for pain because the resident never asked for it.</p> <p>During an interview on 5/21/24 at 7:22 A.M., CMT M said the following:</p> <p>-He/She heard the resident yelling earlier that morning but did not pay attention to what he/she was yelling. The resident was always grumpy and yelled;</p> <p>-He/She was not aware there was a box on the MAR to assess pain with a pain score; he/she had never put a pain score in the box;</p> <p>-He/She, as the CMT, was always responsible for the resident's medications and assessments;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She has never offered the resident PRN pain medications for pain because the resident never asked for it.</p> <p>During an interview on 5/21/23 at 11:18 A.M., the DON said the following:</p> <p>-She expected staff to follow physician orders;</p> <p>-If the order was to enter a pain score, she expected a pain score to be entered and it should populate on the MAR;</p> <p>-If the pain score was not documented on the MAR, it could be documented in the progress notes or in the resident's electronic health record under vital signs;</p> <p>-Staff should assess pain per physician order and ask the resident to rate the pain;</p> <p>-She expected staff to offer as needed pain medication to anyone they might assess as being in pain;</p> <p>-She was not aware the resident was complaining of more frequent pain and was not able to sleep due to pain.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview and record review, the facility failed to assess residents for the use of bed rails/assist bars prior to installation, to have a system in place to obtain informed consent and educate residents and their responsible parties about the risks of bed rail use prior to use, assess residents for entrapment risk and failed to assess for continued safe use of bed rails for one resident, (Residents #39), in a review of 24 sampled residents and two additional residents (Resident #15 and #44). The facility census was 67.</p> <p>Review of the facility's undated policy, Bed Rails, showed the following:</p> <ul style="list-style-type: none"> <li>-The objective of the bed rail use policy is to determine if resident use is safe and appropriate;</li> <li>-Overview of FDA potential zones of entrapment with FDA dimension recommendations;</li> <li>-Prior to use of bed rails the facility should complete the Matrix Bed Rail Observation including the following: <ul style="list-style-type: none"> <li>-a. Observation detail;</li> <li>-b. Clinical assessment;</li> <li>-c. Alternatives attempted prior to bed rail implementation;</li> <li>-d. Bed rail details;</li> <li>-e. Assessment of potential entrapment zones;</li> <li>-f. Review the risk and benefits with resident and resident representative;</li> <li>-g. Obtain informed consent with resident and/or resident representative signature;</li> <li>-h. Obtain physician order for medical symptom assessed requiring bed rail use;</li> </ul> </li> <li>-Once the Bed Rail observation is completed, the facility will print the observation and review associated risks and benefits with the resident and/or resident representative. After the review is complete, the resident and/or resident representative will sign the consent line and the nurse will sign as well;</li> <li>-Educate the resident/legal representative on the benefits and risks of bed rail use;</li> <li>-a. A resident may try to climb through/under or over rails or footboard which could increase risk for injury;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-b. Issues that often result in bed rail use include memory disorders, impaired mobility, risk for injury, nocturia/incontinence and sleep disturbances;</p> <p>-c. Risk of entrapment;</p> <p>-d. Individuals with agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia and elimination issues are at risk for entrapment and/or suffering serious injury from a fall;</p> <p>-e. Importance of mattress and bed equipment per manufacturers guidelines to reduce risk for injury;</p> <p>-Develop a care plan that outlines the medical factors necessitating bed rails and an explanation of how the use of a bed rail is intended to treat the specific resident's condition. Care plan considerations include the following:</p> <p>-a. Identify the specific medical symptom/indication for use of the bed rail;</p> <p>-b. Explanation of how the use of a bed rail is intended to treat the specific resident's condition;</p> <p>-c. Identify and address any underlying issues causing the medical symptom/indication for usage;</p> <p>-d. Identify potential loss of autonomy, dignity and self-respect;</p> <p>-e. Identify the specific time periods of bed rail usage;</p> <p>-f. Interventions identified to mitigate resident specific risks associated with the use of a bed rail;</p> <p>-g. Individualized interventions determined to meet the resident's needs.</p> <p>Review of the Food and Drug Administration (FDA) Guide of Bed Safety, Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, revised April 2010, showed the following:</p> <p>-Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling;</p> <p>-Assessment by the patient's health care team will help to determine how best to keep the patient safe;</p> <p>-Potential risks of bed rails may include strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress, more serious injuries from falls when patients climb over rails, skin bruising, cuts, and scrapes, feeling isolated or unnecessarily restricted, and preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-When bed rails are used, perform an on-going assessment of the patient's physical and mental status and closely monitor high-risk patients;</p> <p>-A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety;</p> <p>-Reassess the need for using bed rails on a frequent, regular basis.</p> <p>1. Review of Resident #15's undated face sheet showed the following:</p> <p>-Responsible for himself/herself;</p> <p>-Diagnoses included repeated falls, generalized muscle weakness, anxiety, restless leg syndrome, morbid obesity, insomnia, and obstructive sleep apnea.</p> <p>Review of the resident's care plan, dated 12/23/23, showed the following:</p> <p>-At risk for falls related to poor balance/gait, impulsive, poor safety awareness, and has a history of falls;</p> <p>-Fall on 12/17/22 after rolling out of bed trying to pick up Continuous Positive Airway Pressure (CPAP) mask off the floor.</p> <p>-The resident's care plan did not address bed rails.</p> <p>Review of the resident's Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 3/3/24, showed the following:</p> <p>-Intact cognition;</p> <p>-Had no upper extremity or lower extremity impairments;</p> <p>-Used a walker and a wheelchair;</p> <p>-Independent with transfers;</p> <p>-Independent with bed mobility.</p> <p>Observation on 5/19/24 at 4:32 P.M. showed the resident lay on his/her left side in his/her bed. The half bed rail on the right side of the resident's bed was in the raised position. The half bed rail on the left side of the resident's bed was lowered.</p> <p>Observation on 5/21/24 at 10:29 A.M. showed the half bed rail on the right side of the resident's bed was in the raised position. The left rail was lowered.</p> <p>During interview on 5/21/24 at 12:49 P.M., the resident said the following:</p> <p>-Someone put the right bed rail up and put the left bed rail down on his/her bed;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The right bed rail will not come down;</p> <p>-He/She did not want the right bed rail up, but would like the left bed rail raised;</p> <p>-He/She had this bed for over a year. The last bed had assist bars;</p> <p>-He/She used the bed rails for safety and comfort.</p> <p>Review of the resident's medical record showed no documentation the facility completed a bed rail entrapment assessment or received consent prior to installing bed rails on the resident's bed.</p> <p>During interview on 5/21/24 at 12:57 PM., Licensed Practical Nurse (LPN) N said the following:</p> <p>-The resident used the bed rails for safety;</p> <p>-He/She thought the therapy department completed the bedrail assessments.</p> <p>2. Review of Resident #39's face sheet showed the resident was his/her own responsible party.</p> <p>Review of the resident's care plan, revised 11/29/23, showed the following:</p> <p>-The resident is at risk for falls related to physical weakness/debility, impaired posture and decision to sometimes attempt transfers without assist;</p> <p>-U-bar (a 1/8 bed rail used for bed mobility) on left side.</p> <p>Review of the resident's significant change MDS, dated [DATE], showed the following:</p> <p>-Cognitively intact;</p> <p>-Limited range of motion on the upper and lower extremities on one side of his/her body;</p> <p>-Substantial/Maximum assistance required for rolling left and right, lying to sit on side of bed transfers, sit to stand transfers and chair/bed-to-chair transfers.</p> <p>Observation on 5/19/24 at 3:35 P.M., showed the resident sat in his/her wheelchair in his/her room. The resident had 1/8 bed rail in the raised position on the left side of the bed.</p> <p>During an interview on 5/19/24 at 3:35 P.M., the resident said he/she used the 1/8 bed rail to turn in bed and help him/her get out of bed.</p> <p>Observation on 5/21/24 at 5:33 A.M., showed the resident lay in bed sleeping. The 1/8 bed rail on the left side of the bed was in the raised position.</p> <p>Review of the resident's medical record showed no bed rail assessment, no bed rail entrapment assessment or informed consent from the resident for the use of the bed rail.</p> <p>3. Review of Resident #44's annual MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Severe cognitive impairment;</p> <p>-Wandering present one to three days;</p> <p>-Requires partial/moderate assistance to roll left and right;</p> <p>-Requires substantial/maximum assistance from staff to move from sitting to lying, lying to sitting on the side of the bed, from sitting to standing, and chair to bed or bed to chair transfers.</p> <p>Review of the resident's care plan, last reviewed/revised 5/7/24, showed the following:</p> <p>-The resident had cognitive impairment related to dementia;</p> <p>-The resident was a fall risk;</p> <p>-Fall mats to both sides of the bed;</p> <p>-Resident needs assistance with activities of daily living (ADLs) and mobility due to weakness, and cognition;</p> <p>-Resident will be as independent as safely possible and any additional needs will be met with the assistance of staff;</p> <p>-Restorative therapy three times weekly for lower extremities strength and range of motion (ROM);</p> <p>-Assist of one to two staff members with bed mobility: rolling side to side, sitting up and lying down;</p> <p>-Assist of one to two staff members toileting- toilet transfers, peri-care and clothing management;</p> <p>-Often incontinent of bowel and bladder, especially at night;</p> <p>-Wheelchair with wedge cushion for mobility;</p> <p>-Able to self-propel short distances, but needs assistance with longer-distances;</p> <p>-Unable to walk at this time;</p> <p>-The care plan did not address the use of bed rails or entrapment risk.</p> <p>Observation on 5/19/24 at 3:54 P.M., showed the resident was not in his/her room. The 1/8 bed rail on the resident's right side of the bed was in the raised position.</p> <p>Review of the resident's medical record, on 5/20/24, showed no side rail assessments, no physician order for side rails, no documentation of interventions attempted prior to installation of bed rails, no bed rail entrapment assessment or informed consent from the resident or resident's representative for bed rail use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 5/21/24 at 5:30 A.M., showed the resident in bed with the 1/8 bed rail on the resident's right side of the bed in the raised position.</p> <p>During interview on 5/21/24 at 1:30 P.M., the Certified Occupational Therapy Assistant (COTA) and Physical Therapist (PT) said the following:</p> <ul style="list-style-type: none"> <li>-The therapy department only suggested when bed rails should be used;</li> <li>-The nursing department completed the consent form and assessments.</li> </ul> <p>During an interview on 5/21/24 at 1:51 P.M. Training Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She did MDS assessments to help the facility;</li> <li>-She pulled a report and did the MDS assessments that were due;</li> <li>-The facility lost the MDS Coordinator and Director of Nursing (DON) over a year ago;</li> <li>-The current MDS Coordinator had started three weeks ago but had not had training yet.</li> </ul> <p>During interview on 5/23/24 at 6:49 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The MDS Coordinator was responsible for completing the bedrail assessments;</li> <li>-Bedrail assessments should be completed quarterly;</li> <li>-The resident should sign a consent form for bedrails.</li> </ul> <p>42592</p> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for one resident (Resident #41) in a review of 24 sampled residents and for one additional resident (Resident #61). Staff failed to provide routine showers to ensure good personal hygiene and prevent body odors for Resident #61, failed to respond timely to call lights, and failed to provide restorative therapy when the restorative aide (RA) no longer worked at the facility for Resident #28 and #41. The facility did not have a Registered Nurse (RN) eight consecutive hours a day seven days a week. The facility did not consistently have nursing staff as identified in the facility assessment, or provide the education, training, and competencies as identified in the facility assessment. The facility census was 67.</p> <p>Review of the Facility Assessment, revised 5/20/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Nursing Services, hours per day based on average census:</li> <li>-Director of Nursing (DON) eight hours a day for 40 hours per week;</li> <li>-Minimum Data Set (MDS) Coordinator eight hours a day for 40 hours per week;</li> <li>-Nurse Educator eight hours a day for 40 hours per week;</li> <li>-Medical Records eight hours per day;</li> <li>-RN eight hours per day;</li> <li>-Licensed Practical Nurse (LPN) 24 hours per day;</li> <li>-Certified Medication Technician (CMT) 16 hours per day;</li> <li>-Certified Nurse Assistant (CNA) 75 hours per day (10 CNA's between all shifts working 7.5 hr shifts).</li> </ul> <p>1. Review of minutes of a resident council meeting, on 5/21/24 at 2:26 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Resident #48 said he/she had a roommate that was not getting changed (provided incontinent care) or attention in a timely fashion. The facility still had times when there was an agency staff they were not familiar with;</li> <li>-Resident #41 and #39 said agency staff do not pass medications on time. Resident #39 said he/she didn't get his/her pain pill until late yesterday, then couldn't get his/her afternoon pain pill as a result;</li> <li>-Resident #41 said sometimes they have to wait an hour for help.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Review of Resident #61's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Uses walker and wheelchair;</li> <li>-Requires supervision or touching assistance from staff to shower/bathe, for lower body dressing and personal hygiene;</li> <li>-Requires partial or moderate assistance from staff for tub/shower transfers.</li> </ul> <p>Review of the resident's care plan, dated 3/15/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Activities of Daily Living (ADLs) Functional Status/Rehabilitation Potential:</li> <li>-Self care deficit in ADLs related to debilitation/weakness, physical discomfort from significant ascites (build up of fluid in the abdomen), episodes of shortness of breath and supervision to partial assist depending on his/her physical feeling at the time;</li> <li>-Resident will have assistance with his/her ADLs as needed during periods of weakness/fatigue;</li> <li>-Encourage the resident to allow staff to perform tasks that may require bending at the waist to reduce pressure/pain to abdomen;</li> <li>-Allow resident to make decisions about his/her care.</li> </ul> <p>Review of the resident's facility shower sheets, for the month of April 2024, showed staff documented assisting the resident with showering on the following days:</p> <ul style="list-style-type: none"> <li>-On 4/10/24 (first one documented for April);</li> <li>-On 4/16/24 (six days since last shower);</li> <li>-On 4/26/24 (10 days since last shower);</li> <li>-On 4/29/24.</li> </ul> <p>Review of the resident's facility shower sheets, for the month of May 2024, showed staff documented assisting the resident with showering on the following days:</p> <ul style="list-style-type: none"> <li>-On 5/2/24;</li> <li>-On 5/9/24 (seven days since last shower/bath).</li> </ul> <p>Observation on 5/19/24 at 4:16 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident in his/her room in his/her wheelchair;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The resident had long facial hair on his/her chin and body odor.</p> <p>During an interview on 5/19/24 at 4:16 P.M., the resident said the following:</p> <p>-The resident often goes a week without a shower/bath;</p> <p>-He/She would like at least two showers a week.</p> <p>-He/She does not want whiskers on his/her chin, but they are long because the facility only trims his/her facial hair during baths and he/she has not had on this week;</p> <p>-The facility was often short staffed;</p> <p>-He/She has asked for his/her sheets to be changed, but it has been weeks because there weren't enough staff to do those kinds of things.</p> <p>The resident did not have a documented shower or bath for 10 days prior, from the record review to the observation and interview.</p> <p>3. During an interview on 5/19/24 at 4:19 P.M., Resident # 26 said when there was not enough staff, it took 30 minutes to one hour to answer his/her light and that happened frequently.</p> <p>4. During an interview on 5/20/24 at 10:52 A.M., Resident #52's responsible party said the following:</p> <p>-He/She was at the facility four to five days a week, sometimes three times a day;</p> <p>-There are not enough activities for dementia residents;</p> <p>-No one does activities with the dementia residents;</p> <p>-There were no activities for any residents on the weekend except what the residents do themselves;</p> <p>-When he/she visits, he/she sees lights on and no one answers them sometimes.</p> <p>5. During an interview on 5/21/24 at 6:15 A.M., CNA W said the residents are expected to be assisted with showers on shower days, but sometimes there was not enough staff because staff called in or did not show up for work.</p> <p>6. Review of Resident #41's face sheet showed his/her diagnoses included chronic kidney disease, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, cellulitis (infection) of right lower limb, cellulitis of left lower limb, complete traumatic amputation (removal) of the leg at level between knee and ankle of the right lower leg and diabetes mellitus (inability to regulate blood sugar) with diabetic neuropathy (nerve disease cause numbness and or weakness).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's physician orders, dated 3/6/23, showed restorative plan of care for bilateral upper extremity and lower extremity strengthening as tolerated and sit to stand at grab bar or parallel bar to maintain modified independence for transfers.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Independent with eating and oral hygiene;</li> <li>-Requires partial/moderate assistance from staff for upper body dressing;</li> <li>-Requires substantial/maximal assistance from staff to shower/bathe, to go from sitting to lying flat and lying to sitting on the side of the bed;</li> <li>-Dependent on staff for toilet hygiene, lower body dressing and footwear, to roll left and right and to transfer;</li> <li>-Wheelchair use;</li> <li>-No impairments to range of motion;</li> <li>-No restorative nursing minutes.</li> </ul> <p>Review of the resident's Nursing-Restorative Program Referral, dated 11/14/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Goal: Maintain upper body and lower body strength;</li> <li>-Restorative Nursing two times weekly;</li> <li>-Upper body strength with approximately six pound (lbs.) resistance;</li> <li>-Lower body strength with moderate resistance;</li> <li>-Precaution: watch skin integrity on legs.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed functional limitation in range of motion to one lower extremity. No restorative nursing minutes.</p> <p>Review of the resident's medical record showed not evidence staff completed restorative nursing.</p> <p>During an interview on 5/19/24 at 4:48 P.M., the resident said there was not enough staff to give him/her a bath. He/She would like two baths a week. He/She rarely got one bath and never gets two baths.</p> <p>During an interview on 5/22/24, at 2:04 P.M., the resident said he/she would like restorative nursing but the facility did not had the staff to do restorative nursing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 05/23/24 at 1:35 P.M., the therapy director said the following:</p> <ul style="list-style-type: none"> <li>-She was the director at the facility since late February;</li> <li>-When she first started, there was a RA for the restorative program;</li> <li>-The RA quit not to long after she started at the facility (late February) and there was currently no restorative program;</li> <li>-The Director of Nursing (DON) discharged everyone from the RA program due to no current RA.</li> </ul> <p>7. Review of the facility's RN payroll and RN agency staffing sheets, dated March 2024, showed the facility did not have evidence of any RN hours on 3/4/24, 3/9/24, 3/10/24, and 3/31/24.</p> <p>Review of the facility's RN payroll and RN agency staffing sheets, dated April 2024, showed the facility did not have evidence of any RN hours on 4/19/24, and only had 6.75 hours (did not fulfill the eight hour requirement) on 4/5/24.</p> <p>Review of the facility's RN payroll and RN agency staffing sheets, dated May 2024, showed the facility did not have evidence of any RN hours on 5/18/24.</p> <p>8. During the survey entrance conference on 5/19/24, the state agency (SA) requested staffing sheets for the prior month. The facility had to research agency staff and payroll data to accurately complete the staffing sheets for review to show which staff accurately worked. The SA did not receive the staffing sheets until 5/22/23.</p> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said she took over staffing several weeks ago to help out. She did not know who or how they did staffing prior to that. She over schedules agency staff and they send home who they don't need because often agency staff do not show up to work.</p> <p>During an interview on 05/23/24 at 6:49 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The facility does not have any full time licensed nurses besides her. The facility used agency staff for the licensed nurses;</li> <li>-The facility currently did not have a restorative nursing program due to no trained restorative aide being available for the program;</li> <li>-The RA quit, and when he/she quit, all of the residents who were on the restorative nursing program, were discontinued from the program;</li> <li>-She was the only full time RN at the facility. The facility utilized agency RNs for the weekends, except for a couple of weekends that she worked. For the recent shifts that the facility had not had RN coverage, it was because the Agency RNs had not shown up</li> </ul> <p>During an interview on 6/25/24 at 8:59 A.M., the Administrator said the restorative aide was terminated on 3/19/24. He expected the facility to staff according to the facility assessment and to meet resident needs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0725  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	46506

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to provide education, test, and return demonstrations, as identified by the facility on the facility assessment, to ensure competent staff. The facility census was 67.</p> <p>Review of the Facility Assessment, updated 5/20/24, showed the following staff education and competencies will be shown with each area below:</p> <p>-Activities of daily living: Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself. All Certified Nurse Assistant (CNA), Certified Medication Technician (CMT), Licensed Practical Nurse (LPN) and Registered Nurses (RN) will do a return demonstration to observe their ability;</p> <p>-Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself. All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post traumatic stress disorder (PTSD) (mental and behavioral disorder that develops from experiencing a traumatic event), other psychiatric diagnoses, intellectual or developmental disabilities. All CNA, CMT, LPN and RNs will do in-servicing and performance reviews;</p> <p>-Medications and Pain management: Awareness of any limitations of administering medications, administration of medications that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic (eye), etc. Assessment/management of polypharmacy. Assessment of pain, pharmacological and nonpharmacological pain management. All CMT, LPN and RNs will have ability observed and LPN/RN will have performance review;</p> <p>-Infection prevention and control: Identification and containment of infections and prevention. All CNA, CMT, LPN and RNs will do education and a return demonstration to observe their ability;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Management of medical conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD) (lung disorder), gastroenteritis (intestinal infection) , infections such as urinary tract infection (UTI), pneumonia and hypothyroidism. LPN and RNs will do a performance review;</p> <p>-Therapy: physical therapy, occupational therapy, speech/language, respiratory therapy, management of braces, splints. All CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Other special care needs: Dialysis, hospice, ostomy care and tracheostomy care. All CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Nutrition: Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions. All dietary service staff, CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Provide person centered/directed care: Psycho/social/spiritual support: Build relationship with resident/get to know him/her; engage resident in conversation, find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her. ALL staff performance review and observed ability;</p> <p>-Facility conducts monthly in-service meetings with staff. Competency assessments, performance reviews and observed abilities are also completed. Training is conducted based from the assessments and observation results.</p> <p>1. Review of CNA C's employee education file showed the employee was hired 12/5/17. The employee education file did not contain any evidence of education hours or competencies in the last year. (The only training documented was new hire training, dated 12/5/17, and did not contain any competencies).</p> <p>2. Review of CNA PP's employee education file showed the employee was hired 4/17/23. The employee education file did not contain any evidence of education hours or competencies in the last year. (The only training documented was new hire training, dated 4/17/23, and did not contain any competencies).</p> <p>During an interview on 5/21/24 at 8:10 A.M., the Interim Director of Nursing said the the Social Service Director (SSD) tracks the NA and CNA training hours and competencies. She did not know if the facility had any other official training schedule at this time.</p> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said the following:</p> <p>-She no longer kept track of CNA or NA training;</p> <p>-Registered Nurse (RN) Training Coordinator/Minimum Data Set (MDS) Coordinator does all of the CNA training and competencies.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/21/24 at 1:51 P.M., the RN Training Coordinator/MDS Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She does not do any CNA education or CNA competencies;</li> <li>-She does not do annual training or competencies for staff except the uncertified nurse assistants.</li> </ul> <p>During an interview on 5/22/24 at 3:16 P.M., the Business Office Manger (BOM) confirmed the CNA's hire dates and provided a copy of their training record. She does not have any other training information.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Interim Director of Nursing said the following:</p> <ul style="list-style-type: none"> <li>-The facility was trying to implement a computer software training system but it had not been accomplished yet;</li> <li>-There was no training schedule;</li> <li>-When she was at the facility earlier in the year, she did do observations of staff using gait belts for transfers;</li> <li>-The facility was documenting when training was completed, but there have been changes to nursing administration since then and she is not sure where the documentation would be or if any of the current staff attended.</li> <li>-She does not know if there were any documented competencies, if there were she could not locate them.</li> </ul>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This had the potential to affect all residents. The facility census was 67.</p> <p>Review of the facility assessment, updated 5/20/24, showed the facility resources needed to provide competent support and care for the resident population, every day and during emergencies, included RN coverage eight hours per day.</p> <p>Review of the facility's RN payroll and RN agency staffing sheets, dated March 2024, showed the facility did not have evidence of any RN hours on 3/4/24, 3/9/24, 3/10/24, and 3/31/24.</p> <p>Review of the facility's RN payroll and RN agency staffing sheets, dated April 2024, showed the facility did not have evidence of any RN hours on 4/19/24, and only had 6.75 hours (did not fulfill the eight hour requirement) on 4/5/24.</p> <p>Review of the facility's RN payroll and RN agency staffing sheets, dated May 2024, showed the facility did not have evidence of any RN hours on 5/18/24.</p> <p>During an interview on 5/21/24 at 8:10 A.M., the interim Director of Nursing said she was the only full time RN at the facility. The facility utilized agency RNs for the weekends, except for a couple of weekends that she worked. For the recent shift that the facility had not had RN coverage, it was because the Agency RNs had not shown up.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to ensure two nurse aides (NA NN and NA OO), completed a nurse aide training program within four months of their employment as an NA in the facility. The facility census was 67.</p> <p>During an interview on 5/22/24 at 11:00 A.M., the Director of Nursing (DON) said the facility did not have a specific policy regarding certification of nurse aides. The facility followed the regulatory guidance.</p> <p>1. Review of NA NN's employee file showed his/her employment as an NA started on 11/13/23 (approximately six months and one week from the time of hire to the time of review).</p> <p>Review of the state NA registry showed no evidence the employee was certified as a nurse aide.</p> <p>2. Review of NA OO's employee file showed his/her employment as an NA started on 10/3/23 (approximately seven months and three weeks from the time of hire to the time of review).</p> <p>Review of the state NA registry showed no evidence the employee was certified as a nurse aide.</p> <p>During an interview on 5/21/24 at 8:10 A.M., the Director of Nursing said the following:</p> <ul style="list-style-type: none"> <li>-Nurse aides are sent to another facility to do their initial 16 hours of training;</li> <li>-The facility does not have any NA's at this time;</li> <li>-If the facility has NA's, they have to complete the NA certification within four months of their hire date;</li> <li>-The Social Service Director (SSD) tracks the NA and certified nurse aide (CNA) training hours.</li> </ul> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said the following:</p> <ul style="list-style-type: none"> <li>-She no longer kept track of CNA or NA training;</li> <li>-When she did, if a NA started, they had to complete 16 hours of training before they could work on the floor;</li> <li>-The NA's had to be registered for class and certified within four months;</li> <li>-If they did not complete their certification within four months, they have to move to another position;</li> <li>-The Registered Nurse (RN) Training Coordinator/MDS Coordinator did all of the CNA training.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/21/24 at 1:51 P.M., the (RN) Training Coordinator/MDS Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She does not do any CNA education;</li> <li>-She does not do annual training or competencies for CNA's</li> <li>-She only assist with NA training on Fridays at another facility (this facility sends NA's to that facility);</li> <li>-She takes the NA's to another facility to do their training;</li> <li>-There are two NA's, she was not sure of their hire dates, that have completed their classroom training but have not passed the test;</li> <li>-The NA's are required to be certified within four months.</li> </ul> <p>During an interview on 5/22/24 at 3:16 P.M., the Business Office Manger (BOM) confirmed the NA's hire dates and provided a copy of their training record.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to ensure each Certified Nurse Assistant (CNA) had no less than 12 hours of in-service education per year based on their individual performance review, calculated by hire date. The facility identified two CNAs employed by the facility for more than a year. Two of two CNAs (CNA C, and CNA PP) sampled did not have the required 12 hours of in-service education. The facility census was 67.</p> <p>Review of the Facility Assessment, updated 5/20/24, showed the following staff education and competencies will be shown with each area below:</p> <ul style="list-style-type: none"> <li>-Activities of daily living: Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself. All CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> <li>-Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself. All CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> <li>-Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. All CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> <li>-Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). All CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> <li>-Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. All CNA, CMT, LPN, RN will do in-servicing and performance reviews;</li> <li>-Infection prevention and control: Identification and containment of infections, and prevention. All CNA, CMT, LPN, RN will do education and a return demonstration to observe their ability;</li> <li>-Therapy Physical therapy, Occupational therapy, Speech/Language, Respiratory therapy, management of braces, splints. All CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> <li>-Other special care needs: Dialysis, hospice, ostomy care, and tracheostomy care. All CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> <li>-Nutrition: Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions. All Dietary services, CNA, CMT, LPN, RN will do a return demonstration to observe their ability;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Provide person centered/directed care: Psycho/social/spiritual support: Build relationship with resident/get to know him/her; engage resident in conversation Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her. ALL staff performance review and observed ability.</p> <p>The facility conducts monthly in-service meetings with staff. Competency assessments, performance reviews, and observed abilities are also completed. Training is conducted based from the assessments and observation results.</p> <p>1. Review of CNA C's employee education file showed the employee was hired 12/5/17. The employee education file did not contain any evidence of education hours or competencies in the last year. (The only training documented was new hire training 12/5/17 and did not contain any competencies).</p> <p>2. Review of CNA PP's employee education file showed the employee was hired 4/17/23. The employee education file did not contain any evidence of education hours or competencies in the last year. (The only training documented was new hire training 4/17/23 and did not contain any competencies).</p> <p>During an interview on 5/21/24, at 8:10 A.M., the Director of Nursing said the the Social Service Director (SSD) tracks the NA and CNA training hours and competencies.</p> <p>During an interview on 5/21/24, at 8:25 A.M., the SSD said the following:</p> <p>-She no longer kept track of CNA or NA training;</p> <p>-Registered Nurse (RN) Training Coordinator/MDS Coordinator does all of the CNA training and competencies.</p> <p>During an interview on 5/21/24, at 1:51 P.M., the (RN) Training Coordinator/MDS Coordinator said the following:</p> <p>-She does not do any CNA education or CNA competencies;</p> <p>-She does not do annual training or competencies for CNA's.</p> <p>During an interview on 5/22/24, at 3:16 P.M., the Business Office Manger (BOM) confirmed the NA's hire dates, and provided a copy of their training record.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Interim Director of Nursing said the following:</p> <p>-The facility was trying to implement a computer software training system;</p> <p>-It was not accomplished.</p> <p>-There has been no training schedule;</p> <p>-When she was at the facility earlier in the year she did do observations of staff using gait belts for transfers;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility was documenting when it was completed but there have been changes to nursing administration since then and she was not sure where the documentation would be or if any of the current staff attended.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>38016</p> <p>Based on observation and interview, the facility failed to post required nurse staffing information, which included the facility name, total actual hours worked by both licensed and unlicensed nursing staff to include Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nurse Assistants (CNA)s directly responsible for resident care and the resident census on a daily basis. The facility census was 67.</p> <p>Request was made for a facility policy regarding posted staffing and none was provided.</p> <p>1. Observation on 5/19/24 at 3:34 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Dry erase board at the nursing station, dated 5/18/24, with two names under nurses and one name beside Certified Medication Technician (CMT), a name at the bottom of the board and five more names without labels;</li> <li>-The dry erase board did not include the facility name, staff titles, actual hours worked or the facility census;</li> <li>-There was also a binder at the desk that was not where residents and visitors could see it;</li> <li>-The binder had staff and hours scheduled, but it did not show the facility name, the census or the titles of the staff, just first names of staff.</li> </ul> <p>Observation on 5/20/24 at 3:04 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Dry erase board at the nursing station with two names under nurses, and one name beside CMT and six more names without labels;</li> <li>-The dry erase board did not include the facility name, staff titles, actual hours worked, or the facility census;</li> <li>-There was also a binder at the desk that was not where residents and visitors could see it;</li> <li>-The binder had staff and hours scheduled, but it did not show the facility name, the census or the titles of the staff, just first names of staff.</li> </ul> <p>Observation on 5/21/24 at 10:14 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Dry erase board at the nursing station with one name with RN written beside it, two names under nurses and one name beside CMT and six more names without labels;</li> <li>-The dry erase board did not include the facility name, staff titles, actual hours worked or the facility census;</li> <li>-There was also a binder at the desk that was not where residents and visitors could see it;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>-The binder had staff and hours scheduled, but it did not show the facility name, the census or the titles of the staff, just first names of staff.</p> <p>During the survey entrance conference on 5/19/24, the state agency (SA) requested staffing sheets for the prior month. The facility had to research agency staff and payroll data to accurately complete the staffing sheets for review to show which staff accurately worked. The SA did not receive the staffing sheets until 5/22/23.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Director of Nursing said the staff posting should be posted by the front door where everyone can see it and have all the required information (facility name, census, total numbers and hours of staff working directly with residents for RN, LPN, CMT and CNA's for each shift).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</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 ensure one resident (Resident #40), who was admitted to the facility with mental illness, received appropriate person-centered and individualized treatment and services to meet his/her assessed needs. Resident #40 presented with behaviors including entering another resident's room (Resident #21) wearing no pants and only a brief, taking a cigarette from another resident and lighting it in the tea room and throwing the lit cigarette in a trash can causing trash to ignite, smoking in his/her room, and yelling and cussing at another resident (Resident #15). The resident frequently made threatening gestures (threats or attempts to choke) other residents. The facility failed to adequately implement meaningful interventions, including non-pharmacological interventions, alternate strategies, or ensure the resident received services to address the resident's behaviors. The facility census was 67.</p> <p>During interview on 6/11/24 at 9:50 A.M. the administrator said he did not have a policy regarding behavior management.</p> <p>1. Review of Resident #40's face sheet, undated, showed the following:</p> <p>-He/She had a durable power of attorney;</p> <p>-Diagnoses included schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), major depressive disorder (common and serious medical illness that negatively affects how someone feels, the way someone thinks and how someone acts), anxiety disorder (persistent and excessive worry that interferes with daily activities), and history of mood disorder (mental health condition that primarily affects your emotional state).</p> <p>Review of the resident's Pre-Admission Screening and Resident Review Level II (PASRR II) (comprehensive evaluation required as a result of a positive Level I Screening), dated 7/6/20, showed the following:</p> <p>-The resident was physically and emotionally abused by a parent all his/her life and by a second spouse that the resident divorced;</p> <p>-He/She became aggressive when staff woke the resident for breakfast and shower at previous facility;</p> <p>-Assessment and implementation of behavioral support plan included monitoring of behavioral symptoms, provision of behavioral supports, allow the resident to have as much control of his/her care as possible, and give him/her choices in care;</p> <p>-Provision of a structured environment: provide for individual personal space, establish consistent routines, and provide schedule of daily tasks/activities.</p> <p>Review of the resident's care plan, updated on 12/16/21, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Problem: Inappropriate sexual behavioral symptoms directed towards residents and staff of the opposite sex. On 12/15/21, the resident touched another resident's private area;</p> <p>-Obtain a psych consult/psychosocial therapy;</p> <p>-Avoid offering staff of the opposite sex for care;</p> <p>-Redirect the resident when appropriate sexual behaviors are present.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 12/24/23, showed the following:</p> <p>-The resident had moderately impaired cognition;</p> <p>-He/She was independent with rolling left and right in bed, sitting to lying in bed, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, walk tenfeet, and wheelchair locomotion;</p> <p>-He/She received antipsychotic, antianxiety, and antidepressant medications.</p> <p>Review of the resident's psychiatric progress note, dated 12/27/23, showed the following:</p> <p>-The physician saw the resident for a follow up visit of sleep, mood, anxiety, delusions, and medication reconciliation;</p> <p>-The resident had impaired insight and judgement as evidenced by decisions of recent past.</p> <p>Review of the resident's nurse note, dated 1/6/24 at 1:41 P.M., showed the following:</p> <p>-The resident inappropriately touched another resident of the opposite sex in the dining room during lunch;</p> <p>-The residents were separated;</p> <p>-The durable power of attorney (DPOA) was notified of the incident. The DPOA requested the resident be checked for urinary tract infection and to see if any medications had recently been changed as this was out of the resident's normal behavior.</p> <p>Review of the resident's care plan, updated on 1/6/24, showed the following:</p> <p>-Problem: the resident chose to smoke;</p> <p>-He/She was a safe smoker, however, history of elopement so the resident will smoke with supervision;</p> <p>-Designated smoking area, designated smoking times, staff assigned to assist with residents that smoke;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Cigarettes and lighters are kept at nursing station;</p> <p>-Problem: Inappropriate sexual behavioral symptoms directed towards residents and staff of opposite sex. On 12/15/21, the resident touched another resident's private area;</p> <p>-The resident and power of attorney agreed of the benefit from a device for self-gratification, new intervention identified on 1/6/24;</p> <p>-1/6/2, the resident will remain on hallway with predominately same sex residents;</p> <p>- There were no interventions to address the resident's sexually inappropriate behavior when in other common/areas of the facility.</p> <p>Review of the resident's nurse note, dated 1/26/24 a 8:57 P.M., showed the following:</p> <p>-The resident was found walking away from his/her roommate's bed (Resident #8);</p> <p>-Resident #8's face was red and purple in color. He/She said Resident #40 was choking him/her and Resident #8 couldn't breathe;</p> <p>-The nurse assisted Resident #40 out of the room and away from Resident #8;</p> <p>-Resident #40 said Resident #8 was hitting the remote on the bed, and he/she didn't want to hear it, so he/she choked Resident #8;</p> <p>-The staff called for psych evaluation. Resident #40 was discharged with the emergency medical team (EMT) via ambulance.</p> <p>Review of the resident's nurse notes, dated 2/2/24 at 12:45 P.M., showed the following:</p> <p>-The Director of Nursing and Social Services went to the hospital to evaluate the resident;</p> <p>-Per hospital staff, the resident displayed inappropriate sexual behaviors on 1/29/24 and 1/30/24;</p> <p>-Per hospital nurse notes, on 1/31/24, the resident was easily annoyed and angered;</p> <p>-Per hospital care plan, 2/1/24 at 1:30 A.M, the resident was not on sexually acting out precautions, it was then noted at 10:15 A.M., the resident was on sexually acting out precautions;</p> <p>-Per hospital care plan, 2/1/24 at 8:51 P.M., documentation showed the resident was easily annoyed or angered and unable to tolerate the presence of others;</p> <p>-The resident said he/she did not remember anything, however, the resident almost immediately said he/she had an altercation with another resident;</p> <p>-The resident said he/she shocked the roommate by choking him/her because the roommate would not stop banging the remote;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-When the staff asked the resident what he/she would do if another situation arrived, to which the resident said he/she would stay away or tell the nurse;</p> <p>-It was explained to the facility staff the resident's behaviors would need to improve before the resident could safely come back to the nursing home.</p> <p>Review of the resident's social services note, dated 2/2/24 at 3:34 P.M., showed the following:</p> <p>-The Social Services Director and DON went to evaluate the resident at the hospital before the resident returned back to the facility;</p> <p>-Based on the assessment, the staff believed it was not possible for the resident to return safely.</p> <p>Review of the resident's nurse note, dated 2/6/24 at 12:30 P.M., showed the following:</p> <p>-The DON spoke with a staff member from the hospital where the resident was located. He/She expressed concern that the resident was exhibiting behaviors on 2/2/24;</p> <p>-Per hospital staff, their physician signed off and the resident was supposed to be discharged ;</p> <p>-Per the hospital they were sending an ambulance at 12:00 because insurance was no longer paying, and they could not keep the resident there. DON expressed concern over sending resident without an assessment, to which hospital staff said it was their policy to have residents out before a certain time. The DON again expressed concern over resident having recent behaviors just four days prior;</p> <p>-Per hospital staff they were sending the resident whether or not the assessment found the resident was still having unsafe behaviors.</p> <p>Review of the resident's nurse notes, dated 2/7/24 at 5:30 P.M., showed the following:</p> <p>-The resident arrived to the facility;</p> <p>-The staff placed the resident on frequent monitoring for 72 hours.</p> <p>Review of the resident's nurse note, dated 2/8/24 at 7:04 P.M., showed the following:</p> <p>-The resident waited for the smoking session to begin and sat in the main dining room;</p> <p>-The resident stood behind another resident with his/her hands up in the choking position; no contact was made with the other resident;</p> <p>-The staff separated both residents. The nurse asked the resident what happened, and the resident said, I did not touch him/her. The resident put his/her hands like this demonstrating for the nurse;</p> <p>-The nurse explained to the resident that what he/she did could be considered a threat;</p> <p>-One-on-one care provided with the resident and will continue until ordered otherwise.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurse note, dated 2/8/24 at 8:30 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-At 7:05 P.M., staff member overheard residents yelling profanity near the smoking exit. Staff observed the resident immediately behind another resident;</li> <li>-The staff moved the resident to a more appropriate distance from the other resident to de-escalate the situation;</li> <li>-The staff placed the resident on one-on-one supervision;</li> <li>-Per witness, the resident wanted to be first in line to smoke. He/She did not ask the other resident (Resident #8), to move. Resident #40 came up behind the other resident and started to kick the other resident's wheelchair, then Resident #40 placed his/her hands bilaterally on the resident's neck with forceful gripping hands;</li> <li>-Per alleged victim, he/she was talking with another resident and Resident #40 came from behind, almost wrapping his/her hands around the alleged victim, the alleged victim asked Resident #40 what his/her hands were doing around his/her throat, and Resident #40 denied it;</li> <li>-Resident #40 said he/she was behind the alleged victim and his/her hands started cramping so he/she stretched them out, about four inches from the alleged victim's neck, and he/she was not upset at the time;</li> <li>-Resident #40 will remain on one-on-one supervision for the safety of all residents.</li> </ul> <p>Review of the resident's care plan showed no update to address the incident on 2/8/24 or any additional interventions implemented after the one on one monitoring was discontinued.</p> <p>Review of the resident's Social Services Director (SSD)'s note, dated 2/22/24 at 1:48 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The SSD spoke with the resident about room change to see if the resident enjoyed the private room and the resident said, doing ok;</li> <li>-The SSD reminded the resident if she had any issues with another resident in the facility, the resident needed to talk to the charge nurse or SSD to help the resident with any concerns or issues at the time.</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 was independent with rolling left and right in bed, sitting to lying in bed, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, walk ten feet, and wheelchair locomotion;</li> <li>-He/She received an antipsychotic, antianxiety, and antidepressant;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- The resident had no behaviors towards others.</p> <p>Review of the resident's care plan, updated on 3/27/24, and additions dated 1/6/24 showed the following:</p> <p>Problem: The resident displayed aggressive behavior toward peers;</p> <p>-The resident was sent to the emergency department for psychiatric evaluation;</p> <p>-He/She was referred to psychiatric provider for care of behaviors;</p> <p>-Standing order for urinalysis due to altered mental status;</p> <p>-The staff moved the resident to a private room (2/27/24);</p> <p>Problem: The resident continued to inappropriately touch residents of the opposite sex in a sexual manner;</p> <p>-The staff will check the resident for a urinary tract infection;</p> <p>-The staff will observe the resident closely when interacting with peers.</p> <p>Review of the resident's nurse notes, dated 3/30/24 at 1:50 P.M., showed the following:</p> <p>-The staff found Resident #40 in another resident's room of the opposite sex and on the same hall as Resident #40, but he/she was about six feet away from the other resident;</p> <p>-No inappropriate behaviors seen at the time;</p> <p>-The resident made sexual comments to the staff;</p> <p>-The staff notified the nurse practitioner, and new order received for urinalysis;</p> <p>-The staff notified the DON. Staff to closely monitor.</p> <p>Review of the resident's nurse note, dated 3/31/24 at 1:47 A.M., showed the following:</p> <p>-The staff found the resident going into Resident #21's room, a resident of the opposite sex and across the hall from Resident #40, wearing no pants, only his/her brief;</p> <p>-The staff informed Resident #40 it was inappropriate for him/her to be in there and he/she needed to go back to his/her room;</p> <p>-The resident argued with staff but went back to his/her room.</p> <p>Review of the resident's physician's orders showed a new order, dated 4/1/24, for Provera (progesterone hormone) 5 mg give one tablet orally daily.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurse note, dated 4/3/24 at 5:11 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Resident #40 approached an independent smoker in the tea room and grabbed the other resident's cigarettes out of his/her hand, stole one, and lit it;</li> <li>-Resident #40 threw the lit cigarette in the trash can causing the trash to smoke;</li> <li>-The staff and the other resident extinguished the lit cigarette. Resident #40 was taken back to his/her room. )</li> </ul> <p>Review of the resident's care plan showed no documentation of the incident of the resident taking another resident's cigarettes and lighter, throwing a lit cigarette in the trash, or interventions to address this behavior.</p> <p>Review of the resident's primary care physician's notes , dated 4/25/24, showed the following:</p> <ul style="list-style-type: none"> <li>-When the resident had urinary tract infection symptoms, he/she became very hypersexual and had a lot of irritability;</li> <li>-Urine culture on 4/4/24 showed infection with Escherichia coli (E. coli-type of bacteria that normally lives in your intestines) extended-spectrum beta-lactamases (ESBL-enzymes or chemicals produced by germs like certain bacteria that make bacterial infections harder to treat with antibiotics).</li> </ul> <p>Review of the resident's nurse practitioner note, dated 5/13/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Schizoaffective disorder, depressive type - continue aripiprazole (antipsychotic medication) 10 milligrams (mg) daily, Buspar (antianxiety medication) 5 mg twice a day, hydroxyzine (an antihistamine used to treat anxiety) as needed, Seroquel (antipsychotic medication) 25 mg at bedtime, Zoloft (antidepressant medication) 200 mg daily, and monitor mood and behavior;</li> <li>-Major depressive disorder- continue aripiprazole 10 mg daily, Buspar 5 mg twice a day, hydroxyzine as needed, Seroquel 25 mg at bedtime, Zoloft 200 mg daily, and monitor mood and behavior;</li> <li>-Inappropriate sexual behavior - continue Provera (progesterone hormone) 5 mg orally daily and monitor behaviors.</li> </ul> <p>Review of the resident's nurse notes, dated 5/18/24 at 10:24 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The staff caught Resident #40 and Resident #15 smoking in the dining room;</li> <li>-The staff took the cigarettes and lighter away from the resident, then educated the resident as to the dangers of what smoking inside can do to him/her and others in the facility;</li> <li>-Neither of the residents were independent smokers.</li> </ul> <p>Review of the resident's nurse note, dated 5/23/24 at 6:50 A.M., showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The nurse heard the resident arguing with Resident #15. Both residents were in wheelchairs at arm's length away from each other by the nurses' station;</p> <p>-Both residents were exchanging words and yelling at one another before a staff member separated them;</p> <p>-Resident #40 said Resident #15 slapped him/her on the arm;</p> <p>-The staff member witnessed Resident #15 slap Resident #40 on the arm and said to stop calling him/her a fat bitch;</p> <p>-The staff started 15 minute observation checks on both residents.</p> <p>Review of the resident's physician orders, dated May 2024, showed the following:</p> <p>-Aripiprazole 10 mg, give one tablet orally daily after lunch for treatment of major depressive disorder;</p> <p>-Buspirone (antianxiety) 5 mg, give one tablet orally twice a day (started on 2/7/24);</p> <p>-Hydroxyzine 25 mg give one tablet orally every six hours as needed for anxiety (started 2/7/24);</p> <p>-Provera 5 mg give one tablet orally daily (started 4/1/24);</p> <p>-Seroquel 25 mg give one tablet orally at bedtime;</p> <p>-Sertraline (antidepressant) 100 mg give two tablets orally daily (started 4/29/24);</p> <p>-Behavior monitoring and behavior interventions every shift (started 9/24/20).</p> <p>Observation on 5/19/24 at 5:00 P.M., showed the following:</p> <p>-Eight residents of the opposite sex lived on the same hall as the resident; (The resident's care plan showed the resident was to be living on a hall with all same sex residents.)</p> <p>-Resident #21 had the resident enter his/her room without pants;</p> <p>-Resident #21 lived across the hall from the resident.</p> <p>During an interview on 5/23/24 at 8:30 A.M., Certified Nurse Assistant (CNA) C said the following:</p> <p>-The staff put the resident on every 15-minute checks when he/she had behaviors;</p> <p>-The resident had a behavior with Resident #15 yesterday (5/22/24);</p> <p>-The resident called Resident #15 a fat bitch, then Resident #15 hit the resident on the arm and told him/her to stop calling him/her a bitch;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The staff separated the residents and put the resident on 15-minute checks;</p> <p>-The staff were supposed to be present and monitor the resident, but not required every 15-minutes, when the resident waited at the door for a smoke break;</p> <p>-The staff reminded the independent smokers not to give the resident any cigarettes or a lighter;</p> <p>-The resident stole other residents' cigarettes at times;</p> <p>-CNA C was present when the resident sexually touched Resident #57's crotch;</p> <p>-He/She said, if the resident sits or interacts with any residents of the opposite sex, then he/she will try to move Resident #40 because he/she didn't know when it will happen again.</p> <p>Observation on 5/23/24 at 12:50 P.M., showed the following:</p> <p>-The resident propelled self from dining room towards his/her room;</p> <p>-He/She stopped twice and stared at residents sitting in the common area;</p> <p>- No staff were observed monitoring the resident.</p> <p>During an interview on 5/23/24 at 12:50 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident usually did not come out of his/her room, except to smoke;</p> <p>-The staff were supposed to redirect the resident when he/she had a negative behavior, then call the physician to request a urinalysis order;</p> <p>-The resident kept to himself/herself;</p> <p>-The resident's behaviors were random without triggers.</p> <p>During an interview on 5/23/24 at 1:08 P.M., the Director of Nursing (DON) said the following:</p> <p>-The confrontation between Resident #15 and Resident #40 would not have happened if Resident #15 would have just rolled away;</p> <p>-Resident #40's behaviors were triggered by urinary tract infections, that could not be predicted;</p> <p>-Resident #40 spent most of his/her time sleeping in his/her room and only came out to smoke and sometimes ate in dining room;</p> <p>-The staff were supposed to watch the resident's behaviors when he/she came out of his/her room;</p> <p>-She was aware the resident became angry when he/she slept past the smoking times, however, the resident was usually redirected;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-She did not want staff waking up the resident while sleeping because he/she needed it, with the resident's mental health history, his/her brain benefited from sleep;</p> <p>-The staff reminded the independent smokers not to give cigarettes to other residents, however, they still gave other residents cigarettes;</p> <p>-The staff saw the resident throw a lit cigarette in a trash can on 4/3/24 and intervened immediately, nothing happened because of it;</p> <p>-She was going to talk to Resident #15's anger management counselor to request that coping skills were discussed.</p> <p>During an interview on 6/6/24 at 1:32 P.M., the Director of Nursing said the following:</p> <p>-Frequent monitoring depended on the reasoning for the initiation of the frequent monitoring;</p> <p>-The more serious the issue then the more frequently staff were to monitor a resident;</p> <p>-Resident #40 did not have any symptoms related to a urinary tract infection except having a change in behavior;</p> <p>-The intervention to prevent urinary tract infection for the resident was to encourage fluids.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on interview and record review, the facility failed to ensure residents' monthly pharmacy drug regimen recommendations were reviewed or followed up on for three residents (Resident #20, #13, #8), of 24 sampled residents. The census was 67.</p> <p>Review of the facility policy, Consultant Pharmacist Reports, dated July 2021, showed the following:</p> <ul style="list-style-type: none"> <li>-Medication Regimen Review: The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The MRR also involves thorough review of the resident records, and may include collaboration with other members of the interdisciplinary team, collaboration with the resident, family members or other resident representatives. MRR also involves reporting of findings with recommendations for improvement. All findings and recommendations are reported to the director of nursing and the attending physician, the medical director and the administrator;</li> <li>-The consultant pharmacist reviews the medication regimen of each resident at least monthly;</li> <li>-The findings are phoned, faxed, or e-mailed within (24 hours) to the director of nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the resident's active record.</li> </ul> <p>1. Review of Resident #8's Annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff and dated 1/31/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Physical behaviors 1-3 days during the look back period.</li> </ul> <p>Review of the resident's continuity of care document (CCD) (a facility used form that details resident information) showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnoses included bipolar (a mental health condition that causes extreme mood swings), depression and anxiety;</li> <li>-Divalproex tablet, delayed release (used to treat certain types of seizures) 500 milligrams (mg), two tablets at bedtime;</li> <li>-Quetiapine tablet (antipsychotic medication that treats several kinds of mental health conditions) 300 mg twice daily;</li> <li>-Haloperidol (to treat nervous, emotional, and mental conditions) 0.5 mg twice daily;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Venlafaxine (used to treat depression) 75 mg daily.</p> <p>Review of the resident's progress notes showed the the pharmacy consultant documented the following:</p> <p>-On 06/16/2023 at 4:45 P.M., see report;</p> <p>-On 07/18/2023 at 03:47 P.M., see report;</p> <p>-On 08/17/2023 at 12:05 P.M., see report;</p> <p>-On 10/20/2023 at 04:16 P.M., see report;</p> <p>-On 11/14/2023 at 01:06 P.M., see report;</p> <p>-On 12/13/2023 at 04:11 P.M., see report;</p> <p>-On 01/17/2024 at 05:04 P.M., see report;</p> <p>-On 03/04/2024 at 08:33 P.M., see report for recommendation;</p> <p>-On 04/12/2024 at 12:11 P.M., see report for recommendation;</p> <p>(Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>The state agency (SA) requested the resident's pharmacy recommendation reports, as indicated in his/her progress notes, of the Director of Nursing (DON) on 5/23/24 at 1:51 P.M. (none were provided).</p> <p>2. Review of Resident #13's undated face sheet showed the following:</p> <p>-The resident's original admitted was 7/28/23;</p> <p>-Diagnosis of bipolar disorder (a disorder associated with episodes of mood swings, ranging from depressive lows to manic highs), conversion disorder (a psychiatric condition that causes physical and sensory symptoms that can't be explained by a known medical condition) with seizures or convulsions, psychotic disorder with delusions due to known physiological condition, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (high blood pressure)</p> <p>Review of the resident's undated physician order sheets (POS) showed the following:</p> <p>-Lexapro (an antidepressant medication) 20 mg once a day, started 7/28/23;</p> <p>-Plavix (a blood thinning medication) 75 mg once a day, started 7/28/23;</p> <p>-Wellbutrin XL (an antidepressant medication) 300 mg once a day, started 7/28/23</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Hydrocodone-acetaminophen (a pain medication) 5-325 mg every 12 hours as needed, started 8/25/23;</p> <p>-Xarelto (a blood thinning medication) 20 mg, started 10/1/23.</p> <p>Review of the resident's progress note, dated 10/29/23 at 1:45 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 12/13/23 at 12:58 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 1/17/24 at 1:26 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's physician's orders showed an order dated 2/1/24 for Seoquel (an antipsychotic medication) 300 mg at bedtime.</p> <p>3. Review of Resident #20's undated face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnosis of chronic pain syndrome, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (excessive worry and feeling of fear, dread, and uneasiness), hypertension (high blood pressure), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dysarthria (slurred speech) following unspecified cerebrovascular disease (conditions that affect the blood vessels and blood supply to the brain).</p> <p>Review of the resident's undated physician order sheets (POS) showed the following:</p> <p>-Eliquis (a blood thinning medication) 5 mg twice a day, started on 10/5/23;</p> <p>-Alprazolam (an anxiety medication) 0.5 mg every six hours, started on 10/12/23.</p> <p>Review of the resident's progress note, dated 11/14/23 at 10:13 A.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's May 2024 POS showed an order, dated 12/8/23, showed an order for hydrocodone-acetaminophen (a pain medication) 10-325 mg, one tablet as needed (PRN).</p> <p>Review of the resident's care plan, dated 12/12/23, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident was at risk for adverse effects related to taking antianxiety medication;</p> <p>-Attempt a gradual dose reduction as recommended;</p> <p>-Pharmacy consultant review routinely.</p> <p>Review of the resident's progress note, dated 2/12/24 at 1:06 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 3/4/24 at 8:46 A.M., showed the pharmacy consultant wrote see report for gradual dose reduction (GDR) recommendations.</p> <p>Review of the resident's consultant pharmacist report, dated 3/4/24, showed GDR recommendation for Alprazolam, however, there was no response from the resident's physician.</p> <p>Review of the resident's consultant pharmacist report, dated 5/21/24, showed there was no response from the first GDR recommendation from 3/24.</p> <p>During interview on 5/23/24 at 6:49 P.M., the DON said the following:</p> <p>-The pharmacist came to the facility monthly to review the residents' medications;</p> <p>-He/She thought the pharmacist sent recommendations by email.</p> <p>-She was unaware the pharmacy recommendations had to be printed from the pharmacy website. She did not have access to the pharmacy reports until 5/23/24. She did not have access to the pharmacist previous reports. There was a binder where the facility kept old reports and recommendations, but a lot of the reports were missing.</p> <p>50675</p> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>50851</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident #13), in a review of 24 sampled residents, remained free from unnecessary drugs when the facility failed to have adequate indications for multiple blood thinning medications. The facility census was 67.</p> <p>The facility provided no policy for unnecessary drug use following request.</p> <p>1. Review of Resident #13's undated physician order sheets (POS) showed the following:</p> <ul style="list-style-type: none"> <li>-Plavix (a blood thinning medication) 75 milligrams (mg) once a day, started 7/28/23;</li> <li>-Xarelto (a blood thinning medication) 20 mg, started 10/1/23.</li> </ul> <p>(Review showed no diagnosis for the use of the blood thinning medications.)</p> <p>Review of the resident's progress note, dated 10/29/23 at 1:45 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 12/13/23 at 12:58 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 1/17/24 at 1:26 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 2/5/24 at 8:04 A.M., showed staff wrote the resident had orders for both Xarelto and Plavix. The Director of Nursing (DON) called to verify orders. Waiting response at this time.</p> <p>Review of the resident's records show no response regarding Xarelto and Plavix.</p> <p>During interview on 6/11/24 at 3:22 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-She had been interim DON twice at the facility;</li> <li>-She did not know why the resident was on an anticoagulant and an antiplatelet medication;</li> <li>-She did not remember if she was DON in February when a progress note was made regarding clarification on Xarelto and Plavix;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-She did not remember if a nurse reported needing clarification on Xarelto and Plavix;</p> <p>-The physician often came into the facility;</p> <p>-She did not know when the physician had last seen the resident.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41412</b></p> <p>Based on observation, interview and record review, the facility failed to ensure two residents (Resident #55 and #8) and one additionally sampled resident (Resident #6), with orders for as needed (PRN) psychotropic medications, in a review of 24 sampled residents, were limited to 14 days as required, except if an attending or prescribing physician believed that it was appropriate for the PRN order to be extended beyond 14 days. The facility failed to attempt a gradual dose reduction (GDR) on psychotropic medications or document a clinical justification to continue current dosage for three residents (Resident #54, #66 and #13). The facility census was 78.</p> <p>Review of the undated facility policy, antipsychotic medication use, showed the following:</p> <p>-Purpose: Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition;</p> <p>-Guidelines:</p> <p>-The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications;</p> <p>-Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication;</p> <p>Antipsychotic medication use:</p> <p>-For acute psychiatric situations, antipsychotic medication use shall meet the following criteria:</p> <p>-The acute treatment period is limited to seven days or less;</p> <p>-A clinician, in conjunction with the interdisciplinary team, must evaluate and document the situation within seven days, to identify and address any contributing and underlying causes of the acute psychiatric condition and verify the continuing need for antipsychotic medication;</p> <p>-Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation;</p> <p>-If antipsychotic medications are administered as PRN dosages repeatedly over several days, the physician should discuss the situation with staff and evaluate the resident as needed to determine whether the use is appropriate and the symptoms are responding to the medication;</p> <p>-The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The policy did not specifically address GDRs or 14 day stop dates.</p> <p>1. Resident #66's face sheet showed he/she had diagnoses that included major depressive disorder.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) (a federally mandated assessment instrument completed by facility staff), dated 4/16/24, showed the following:</p> <p>-Takes antipsychotics routinely;</p> <p>-Takes antidepressants;</p> <p>-No GDR attempted;</p> <p>-Has not been documented by a physician that a GDR is clinically contraindicated.</p> <p>Review of the resident's May 2024 physician order sheets (POS) showed orders for the following:</p> <p>-Trintellix (antidepressant) 30 milligrams (mg) daily; order date of 7/11/23;</p> <p>-Rexulti (antipsychotic to treat major depressive disorder) 2 mg every day; order date of 2/1/24.</p> <p>Review of the resident's medical record showed no documentation of a GDR being completed or that one had been documented as contraindicated by the physician for Trintellix or Rexulti.</p> <p>2. Review of Resident #6's face sheet showed he/she had diagnoses that included anxiety.</p> <p>Review of the resident's February 2024 POS showed an order for Ativan (antianxiety medication) 0.5 milligrams (mg) three times daily as needed (PRN) every eight hours; order date of 2/7/24; no stop date.</p> <p>Review of the resident's February 2024 MAR showed the following:</p> <p>-Ativan 0.5 mg three times daily PRN every eight hours;</p> <p>-No documentation staff administered the medication to the resident during the month.</p> <p>Review of the resident's March 2024 POS showed an order for Ativan 0.5 mg three times daily PRN every eight hours, order date of 2/7/24 with no stop date.</p> <p>Review of the resident's March 2024 MAR showed the following:</p> <p>-Ativan 0.5 mg three times daily PRN every eight hours;</p> <p>-No documentation staff administered the medication to the resident during the month.</p> <p>Review of the resident's April 2024 POS showed an order for Ativan 0.5 mg three times daily PRN every eight hours, order date of 2/7/24 with no stop date.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's April 2024 medication administration record (MAR) showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.5 mg three times daily PRN every eight hours;</li> <li>-On 4/16/24 at 1:13 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/18/24 at 7:48 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/19/24 at 8:23 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/20/24 at 7:53 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/22/24 at 9:47 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/23/24 at 7:23 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/28/24 at 7:19 P.M., staff documented administering the resident the Ativan medication;</li> <li>-On 4/29/24 at 9:19 P.M., staff documented administering the resident the Ativan medication.</li> </ul> <p>Review of the resident's May 2024 POS showed an order for Ativan 0.5 mg three times daily PRN every eight hours, order date of 2/7/24 with no stop date.</p> <p>Review of the resident's May 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.5 mg three times daily PRN every eight hours;</li> <li>-On 5/1/24 at 8:54 P.M., staff documented administering the resident the Ativan medication.</li> </ul> <p>3. Review of Resident #55's March 2024 POS showed an order for Ativan 0.25 mg for anxiety twice daily PRN, order date of 3/23/24 with no stop date and diagnoses anxiety.</p> <p>Review of the resident's March 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.25 mg for anxiety twice daily PRN, order date of 3/23/24 with no stop date;</li> <li>-No documentation staff administered the medication for any day, time or shift during the month.</li> </ul> <p>Review of the resident's April 2024 POS showed an order for Ativan 0.25 mg for anxiety twice daily PRN, order date of 3/23/24 with no stop date.</p> <p>Review of the resident's April 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.25 mg for anxiety twice daily PRN, order date of 3/23/24 with no stop date;</li> <li>-On 4/7/24 at 4:21 A.M., staff documented administering the resident his/her Ativan medication.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's May 2024 POS showed an order for Ativan 0.25 mg for anxiety twice daily PRN, order date of 3/23/24 with no stop date.</p> <p>Review of the resident's May 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.25 mg for anxiety twice daily PRN, order date of 3/23/24 with no stop date;</li> <li>-No documentation staff administered the medication 5/1/24 through 5/23/24.</li> </ul> <p>4. Review of Resident #54's face sheet, undated, showed the resident's diagnoses included depression (common and serious medical illness that negatively affects how you feel, the way you think and how you act) and generalized anxiety disorder (persistent feeling of anxiety or dread that interferes with how you live your life).</p> <p>Review of the resident's physician orders, dated May 2024, showed Zoloft (antidepressant) 50 mg, one tablet orally at bedtime for depression (started on 06/27/23).</p> <p>Review of the resident's medical record showed no documentation a gradual dose reduction of Zoloft was attempted or contraindicated.</p> <p>5. Review of Resident #8's Annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Physical behaviors one to three days during the look back period.</li> </ul> <p>Review of the resident's March 2024 POS showed an order for Ativan 0.5 mg for anxiety three times daily PRN, order date of 10/1/23 with no stop date and diagnoses of anxiety.</p> <p>Review of the resident's March 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.5 mg for anxiety three times daily PRN, order date of 10/1/23 with no stop date;</li> <li>-No documentation staff administered the medication for any day, time, or shift during the month.</li> </ul> <p>Review of the resident's April 2024 POS showed an order for Ativan 0.5 mg for anxiety three times daily PRN, order date of 10/1/23 with no stop date.</p> <p>Review of the resident's April 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Ativan 0.5 mg for anxiety three daily PRN, order date of 10/1/23 with no stop date;</li> <li>-No documentation staff administered the medication for any day, time, or shift during the month.</li> </ul> <p>Review of the resident's May 2024 POS showed an order for Ativan 0.5 mg for anxiety three times daily PRN, order date of 10/1/23 with no stop date.</p> <p>Review of the resident's May 2024 MAR showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Ativan 0.5 mg for anxiety three times daily PRN order date of 10/1/23 with no stop date;</p> <p>-No documentation staff administered the medication for any day, time, or shift during the month.</p> <p>6. Review of Resident #13's undated face sheet showed the following:</p> <p>-The resident's original admitted was 7/28/23;</p> <p>-Diagnosis of bipolar disorder (a disorder associated with episodes of mood swings, ranging from depressive lows to manic highs), conversion disorder (a psychiatric condition that causes physical and sensory symptoms that can't be explained by a known medical condition) with seizures or convulsions, psychotic disorder with delusions due to known physiological condition, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (high blood pressure)</p> <p>Review of the resident's undated physician order sheets (POS) showed the following:</p> <p>-Lexapro (an antidepressant medication) 20 mg once a day, started 7/28/23;</p> <p>-Wellbutrin XL (an antidepressant medication) 300 mg once a day, started 7/28/23.</p> <p>Review of the resident's progress note, dated 10/29/23 at 1:45 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 12/13/23 at 12:58 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 1/17/24 at 1:26 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's medical record showed no documentation a gradual dose reduction on Lexapro and Wellbutrin XL was attempted or contraindicated.</p> <p>7. Review of Resident #20's undated face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnosis of chronic pain syndrome, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (excessive worry and feeling of fear, dread, and uneasiness), hypertension (high blood pressure), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dysarthria (slurred speech) following unspecified cerebrovascular disease (conditions that affect the blood vessels and blood supply to the brain).</p> <p>Review of the resident's undated physician order sheets (POS) showed an order for alprazolam (an anti-anxiety medication) 0.5 mg every six hours, started on 10/12/23.</p> <p>Review of the resident's progress note, dated 11/14/23 at 10:13 A.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's care plan, dated 12/12/23, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was at risk for adverse effects related to taking antianxiety medication;</li> <li>-Attempt a gradual dose reduction as recommended;</li> <li>-Pharmacy consultant review routinely.</li> </ul> <p>Review of the resident's progress note, dated 2/12/24 at 1:06 P.M., showed the pharmacy consultant wrote see report. (Review of the resident's medical record showed no documentation of the pharmacy consultant's report with recommendations and no documentation to show the facility addressed any recommendations with the resident's physician.)</p> <p>Review of the resident's progress note, dated 3/4/24 at 8:46 A.M., showed the pharmacy consultant wrote see report for gradual dose reduction (GDR) recommendations.</p> <p>Review of the resident's consultant pharmacist report, dated 3/4/24, showed GDR recommendation for alprazolam, however, there was no response from the resident's physician.</p> <p>Review of the resident's consultant pharmacist report, dated 5/21/24, showed there was no response from the first GDR recommendation from 3/24.</p> <p>Review of the resident's medical record showed no documentation the physician addressed the recommended gradual dose reduction for alprazolam or documented the reason a GDR was contraindicated.</p> <p>During interview on 5/21/24 at 2:22 P.M. and 5/23/24 at 6:49 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The pharmacist came to the facility monthly to review the residents' medications; this review would include the need for GDRs;</li> <li>-He/She thought the pharmacist sent recommendations by email;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She was unaware the pharmacy recommendations had to be printed from the pharmacy website. She did not have access to the pharmacy reports until 5/23/24. She did not have access to the pharmacist previous reports. There was a binder where the facility kept old reports and recommendations, but a lot of the reports were missing;</p> <p>-Nurses obtaining orders for PRN psychotropic medications should be asking physicians for the 14 day stop date when obtaining an order;</p> <p>-She would also hope that the pharmacist doing the reviews would catch these situations and document them on their monthly reports.</p> <p>46506</p> <p>50675</p> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46506</p> <p>Based on observation, interview and record review, the facility failed to administer insulin according to manufacturers' recommendations to ensure staff administered the prescribed insulin dose for one resident (Resident #27) in a review of 24 sampled residents and two additional residents (Resident #44 and #45). The facility census was 67.</p> <p>During an interview on 05/22/24, at 11:00 A.M., the Director of Nursing (DON) said the facility did not have a specific policy for Insulin Pen administration.</p> <p>Review of the, How to use your Lantus SoloStar Pen information sheet, revised 08/2022, showed the following:</p> <ul style="list-style-type: none"> <li>-Wipe the [NAME] tip (rubber seal) with an alcohol swab;</li> <li>-Dial a test dose of 2 units;</li> <li>-Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose;</li> <li>-Press the injector button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test;</li> <li>-Make sure the window shows 0 and then select the dose.</li> </ul> <p>Review of the Novolog FlexPen instructions for use, revised 02/2023, showed the following:</p> <ul style="list-style-type: none"> <li>-Pull off the pen cap. Wipe the rubber stopper with an alcohol swab;</li> <li>-Attach the needle;</li> <li>-Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: turn the dose selector to select 2 units;</li> <li>-Hold the FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge;</li> <li>-Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip;</li> <li>-Check and make sure the dose selector is set at 0;</li> <li>-Turn the dose selector to the number of units you need to inject.</li> </ul> <p>1. Review of Resident #27's face sheet showed a diagnosis of type II diabetes mellitus (too much sugar in the blood stream).</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's May 2024 physician order sheet showed the following:</p> <ul style="list-style-type: none"> <li>-Novolog FlexPen 100 units/milliliter (u/ml), administer 1 unit per sliding scale for a blood sugar result of 201 to 250, with an order start date of 11/29/23;</li> <li>-Lantus Solostar 100u/ml, administer 21 units subcutaneously once a day between 5:00 A.M. and 10:00 A.M., with a start date of 04/25/24.</li> </ul> <p>Observation on 05/21/24, at 6:55 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Licensed Practical Nurse (LPN) R reviewed the blood sugar results for the resident with a recorded result of 201;</li> <li>-The blood sugar result required 1 unit of sliding scale Novolog as well as 4 units of scheduled Novolog;</li> <li>-LPN R attached a new needle to the Novolog pen;</li> <li>-LPN R did not dial the Novolog pen to 2 units to prime the pen;</li> <li>-LPN R attached a new needle to the Lantus pen;</li> <li>-LPN R did not dial the Lantus pen to 2 units to prime the pen;</li> <li>-LPN R dialed the Lantus pen to 21 units and administered both insulins to the resident.</li> </ul> <p>2. Review of resident #44's face sheet showed a diagnosis of type II diabetes mellitus.</p> <p>Review of the resident's May 2024 physician order sheet showed an order for Lantus Solostar insulin pen, 50 units once a day between 6:00 A.M. to 8:00 A.M., with an order start date of 09/04/23.</p> <p>Observation on 05/21/24, at 6:45 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-LPN R reviewed the blood sugar results for the resident with a recorded result of 86;</li> <li>-The blood sugar result did not require any sliding scale insulin;</li> <li>-LPN R attached a new needle to the insulin pen;</li> <li>-LPN R did not dial the pen to 2 units to prime the pen;</li> <li>-LPN R dialed the Lantus pen to 50 units and administered the insulin to the resident.</li> </ul> <p>e. Review of Resident #45's face sheet showed a diagnosis of type II diabetes mellitus.</p> <p>Review of the resident's May 2024 physician order sheet showed an order for Lantus 30 units once a day with an order start date of 09/18/23.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/21/24, at 6:50 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-LPN R reviewed the blood sugar results for the resident with a recorded result of 115;</li> <li>-LPN R attached a new needle to the Lantus insulin pen;</li> <li>-LPN R did not dial the pen to 2 units to prime the pen;</li> <li>-LPN R dialed the Lantus pen to 30 units and administered the insulin for the resident.</li> </ul> <p>During an interview on 06/07/24, at 12:15 P.M., LPN R said the following:</p> <ul style="list-style-type: none"> <li>-He/She was unaware that an insulin pen needed to be primed with 2 units of insulin prior to administration;</li> <li>-He/She did not prime the pens for resident #27, #44 or #45 during observation on annual survey.</li> </ul> <p>During an interview on 05/23/24, at 6:49 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-Insulin pens should be primed with 2 units of insulin;</li> <li>-The pen needs to be dialed to a 2, wasted and then dialed to dose to administer;</li> <li>-If the pen was not primed the resident might not get the full dose of insulin.</li> </ul>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42592</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were secured when staff left medications unattended and out of sight, on top of the medication cart, with residents in the vicinity of the medications. The facility census was 67.</p> <p>Review of the facility policy, Medication Administration Guidelines, revised [DATE], showed the policy did not address the storage of medications.</p> <p>Review of the undated facility policy, Medication Administration, showed the policy did not address the storage of medications.</p> <p>Request for a medication storage policy was requested but none received.</p> <ol style="list-style-type: none"> <li>1. Review of Resident #40's face sheet showed he/she had dementia.</li> <li>2. Observation on [DATE] at 10:53 A.M., showed the following: <ul style="list-style-type: none"> <li>-Licensed Practical Nurse (LPN) N sat inside the nursing station doing paperwork;</li> <li>-Medication Cart #2 sat outside the nursing station, in front of LPN N;</li> <li>-On top of the medication cart was an open computer with the lid in the upright position;</li> <li>-On top of the medication cart was also a box of half-full box of DuoNeb nebulizer treatment solution (breathing treatment medication), an open tube of triamcinolone cream (topical product used to treat redness, itching, swelling or other discomfort caused by skin conditions), an open tube of permethrin cream (topical product used to treat scabies (mites that attach themselves to the skin) and two open tubes of Nystatin cream (topical product used to treat fungal or yeast infections of the skin);</li> <li>-LPN N did not respond when the surveyor picked up each medications and observed the labels;</li> <li>-Resident #40 self propelled up to Medication Cart #2 and asked the surveyor who stood by the medication cart for Tums (antacid); the resident extended his/her arm to the medication cart drawer, attempting to pull it open, stating, they should be right in there;</li> <li>-LPN N did not respond to the resident's statement/request.</li> </ul> </li> </ol> <p>During an interview on [DATE], at 10:57 A.M., LPN N said the following:</p> <ul style="list-style-type: none"> <li>-He/She was responsible for Medication Cart #2;</li> <li>-Medications should not be left on top of the medication cart unsupervised or not within sight;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had completed a medication cart inspection and pulled the observed medications from the cart because they were either expired and needed to be destroyed, had been discontinued, or he/she was getting ready to use the medication to complete an ordered treatment;</p> <p>-He/She was unable to see the top of the medication cart or the medications as he/she sat at the desk because the view was obstructed by the computer;</p> <p>-He/She had not seen the surveyor pick up each of the medications nor was he/she aware there were residents sitting near the medication cart.</p> <p>During an interview on [DATE] at 6:49 P.M., the Director of Nursing said medications should not be left out, unattended. They should always be stored/kept locked up when not in use and should always be in sight if being used.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>41412</p> <p>Based on interview and record review, the facility failed to ensure the Dietary Manager (DM) had the appropriate competencies and skills set to carry out the function of the food and nutrition services. This practice effected all residents in a facility. The facility census was 67.</p> <p>Review of the facility job description, titled Dietary Manager, dated May 2006, showed the minimum qualifications and education for the position included the completion of an approved Certified Dietary Managers Course.</p> <p>Review of the employee list with job titles, showed the dining services department head was the dietary manager.</p> <p>1. Review of the dietary manager's employee file on 5/23/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Date of hire was 1/23/23;</li> <li>-No certification showing the DM was a certified dietary manager (a federal requirement for long-term care facilities);</li> <li>-No certification showing the DM was a certified food service manager;</li> <li>-No certification showing the DM had a national certification for food service management;</li> <li>-No documentation of an associate's or higher degree in food service management or in hospitality;</li> <li>-No documentation to show the DM had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting;</li> <li>-State Food Safety Food Protection Manager Certification certification, which allows food service managers to get certified to provide safe food in their establishments (this certification does not meet the dietary manager certification requirements).</li> </ul> <p>During an interview on 6/27/24 at 8:50 A.M., the Dietary Manager said the following:</p> <ul style="list-style-type: none"> <li>-She had been employed as the Dietary Manager since September 2023;</li> <li>-The facility had not provided any training related to the Dietary Manager position; she had just attended a food safe course;</li> <li>-She had not received an associate's or higher degree in food service management or in hospitality.</li> </ul> <p>During an interview on 5/23/24 at 11:59 A.M., the Registered Dietitian said the following:</p> <ul style="list-style-type: none"> <li>-She comes to the facility monthly;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The dietary manager said as far as she knew, the dietary manager was not certified.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Director of Nursing said the following:</p> <p>-The dietary manager does not have a Certified Dietary Manager (CDM) certification;</p> <p>-The administrator was responsible to ensure the staff have their certifications.</p> <p>During an interview on 5/23/24, at 2:45 P.M., the Administrator said he would expect the Dietary Manager to be certified as required. If the Dietary Manager was not supervised, he would expect a certified Dietary Manager or Dietitian to train, oversee and be a resource until she was certified. He has not been at the facility long enough to know everyone's certifications, he does not know if she is certified or not.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>38016</p> <p>Based on observation, interview, and record review, the facility failed to ensure food served to residents was palatable and served at a safe and appetizing temperature. The facility census was 67.</p> <p>Review of the facility policy, Dietary Services, dated April 2006, showed the facility will serve each resident nutritious food properly prepared and appropriately seasoned, in accordance with the physician's order and as recommended by the National Research Council.</p> <p>1. During an interview on 5/19/24 at 4:30 P.M., Resident #9 said the food was not always served warm and was cold a lot of the time.</p> <p>During interview on 5/19/24 at 4:19 P.M., Resident #26 said the food was always served cold.</p> <p>During an interview on 5/19/24 at 4:48 P.M., Resident #41 said the food was terrible and was cold. Sometimes the food was overcooked and hard.</p> <p>During an interview on 5/19/24 at 3:55 P.M., Resident #34 said he/she ate in his/her room all the time. The food was not good and was never warm.</p> <p>During interview on 5/19/24 at 3:35 P.M., Resident #39 said the food was not always served warm.</p> <p>During interview on 5/19/24 at 3:55 P.M., Resident #46 said the food could be better and was not always served warm.</p> <p>2. Observation on 5/19/24 at 5:15 P.M. showed staff served the supper meal, which consisted of sloppy joes, green beans and a hashbrown, from the steam table in the kitchen. At 5:38 P.M., staff began preparing the hall trays for residents who chose to eat in their rooms. Staff prepared the last hall tray at 5:47 P.M.</p> <p>Observation of the test tray on 5/19/24 at 5:55 P.M., received after the last resident was served from the hall cart, showed the following:</p> <ul style="list-style-type: none"> <li>-The temperature of the green beans was 114 degrees Fahrenheit. The green beans were bland in flavor;</li> <li>-The temperature of the hashbrown was 96 degrees Fahrenheit. The hashbrown was greasy and soggy;</li> <li>-The sloppy joe mixture was salty.</li> </ul> <p>During an interview on 5/19/24 at 5:35 P.M., Resident #26 said the green beans and the hashbrown were cold and did not taste good. The hashbrown was soggy.</p> <p>During an interview on 5/19/24 at 5:37 P.M., Resident #48 said the sloppy joe was salty and did not taste right.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Observation on 5/20/24 at 12:23 P.M., showed Dietary [NAME] H took holding temperatures of the lunch items located on the steam table, which included ham and beans, fried potatoes and cooked cabbage.</p> <p>Review of the holding temperature log for the lunch meal on 5/20/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Ham and beans: 165 degrees Fahrenheit;</li> <li>-Fried potatoes: 145 degrees Fahrenheit;</li> <li>-Cooked cabbage: 143 degrees Fahrenheit;</li> </ul> <p>Observation on 5/20/24 at 12:30 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Dietary [NAME] H began serving residents in the dining room from the steam table in the kitchen;</li> <li>-Staff served ham and beans, fried potatoes, and cooked cabbage from the steam table;</li> <li>-The dining room lunch service ended at 12:58 P.M.</li> </ul> <p>Observation on 5/20/24 at 1:01 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Dietary [NAME] H began preparing hall trays from the steam table in the kitchen;</li> <li>-Staff served ham and beans, fried potatoes, and cooked cabbage on hot plates from the warming cart and covered each plate with an insulated base and cover;</li> <li>-Staff finished preparing the hall trays at 1:31 P.M. and placed the test tray on the hall cart with the residents' hall trays.</li> </ul> <p>Observation of the food temperatures for the test tray (last tray served from hall cart) on 5/20/24 at 1:49 P.M. , showed the following:</p> <ul style="list-style-type: none"> <li>-The temperature of the fried potatoes was 90.3 degrees Fahrenheit;</li> <li>-The temperature of the cooked cabbage was 93.3 degrees Fahrenheit.</li> </ul> <p>During an interview on 5/22/24 at 6:50 A.M., Dietary [NAME] H said the following:</p> <ul style="list-style-type: none"> <li>-He/She expected hot foods to be served hot;</li> <li>-Staff check the final holding temperatures just before serving and recorded the temperatures in the temperature log;</li> <li>-It usually took 30 to 35 minutes for him/her and the aide to serve out the dining room trays from kitchen, and 30 to 35 minutes to serve out the hall trays from kitchen;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She was not aware of any issues with the meal temperatures. If there would be an issue, the plate of food would be warmed, or a new plate served out to the resident.</p> <p>During an interview on 5/22/24 at 8:30 A.M., the Dietary Manager said the following:</p> <p>-She expected hot foods to be served hot;</p> <p>-Staff should prepare meals by methods that conserve nutritive value, flavor, and appearance;</p> <p>-She expected food to be palatable, attractive, and at a safe and appetizing temperature.</p> <p>During an interview on 5/22/24 at 8:40 A.M., the Administrator said the following:</p> <p>-He expected staff to prepare meals by methods that conserve the nutritive value, flavor, and appearance;</p> <p>-He expected food to be palatable, attractive, and at a safe and appetizing temperature.</p> <p>During an interview on 5/24/24 at 10:35 A.M., the Registered Dietician said the following:</p> <p>-She expected hot foods to be served hot;</p> <p>-She expected meals to be prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>-She expected food to be palatable, attractive, and at safe and appetizing temperature.</p> <p>42592</p> <p>44610</p> <p>50851</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44610</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in accordance with professional standards for food service safety. Staff failed to label and date, opened food items. Staff failed to store food items off the floor. Staff failed to properly clean the ice machine and ensure an air gap was present at each ice machine drain. Staff failed to ensure food service equipment and surfaces were appropriately cleaned. Staff failed to follow proper hygienic practices when preparing and serving food to residents, including using hair restraints appropriately, and hand hygiene technique. The facility census was 67.</p> <p>1. Review of the dietary service manual dated April 2006, Food Storage Guidelines showed the following:</p> <ul style="list-style-type: none"> <li>-Dietary employees will follow safe food handling guidelines to prevent the spread of foodborne illness;</li> <li>-All food, including bulk items, should be tightly sealed with an identifying label and date.</li> </ul> <p>Observation on 5/20/24 at 4:28 P.M., in the kitchen refrigerator unit one, showed the following:</p> <ul style="list-style-type: none"> <li>-Three ham and cheese sandwiches in plastic bags were not labeled and dated;</li> <li>-Two bowls of pudding covered with plastic were not labeled and dated;</li> <li>-One chicken salad sandwich in a plastic bag was not labeled and dated.</li> </ul> <p>During an interview on 5/21/24 at 1:39 P.M., Dietary [NAME] H said the following:</p> <ul style="list-style-type: none"> <li>-Items placed in the refrigerators and freezers should be labeled and dated;</li> <li>-He/She was behind on checking items in the refrigerators and freezers for labeling and dating;</li> <li>-All kitchen staff were to check for labeling and dating of items in the refrigerators and freezers.</li> </ul> <p>2. Review of the facility policy, Ice Maker, dated April 2006, showed the following:</p> <ul style="list-style-type: none"> <li>-Run ice scoop through dish machine daily and replace in plastic container;</li> <li>-The outside of the machine will be cleaned weekly;</li> <li>-Monthly, wash inside of machine thoroughly with warm detergent solution, rinse with baking soda water and dry, wash outside with soft brush or cloth and dry, machine is to be free of extraneous material, except for properly stored ice scoop.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 5/20/24 at 9:59 A.M., in the ice machine room, showed the following:</p> <ul style="list-style-type: none"> <li>-The wall mounted ice scoop holder had a white scaly material in the bottom, and an ice scoop in the holder was in contact with the material;</li> <li>-A white scaly material was on the outside of the ice machine door and on the right hinge;</li> <li>-A yellowish slime substance was across the interior surface of the ice tray dump system;</li> <li>-The upper exterior drain tube inserted into a 1.5-inch wall mounted drain pipe had no air gap.</li> </ul> <p>During an interview on 5/21/24 at 4:20 P.M., the Maintenance Director said the following:</p> <ul style="list-style-type: none"> <li>-He expected the ice machine to have an appropriate air gap at the drain;</li> <li>-He was responsible for ensuring a proper drain air gap, and was unaware the ice machine did not contain an air gap;</li> <li>-Dietary staff was responsible for cleaning and sanitizing the ice machine, and he was responsible for checking the interior section of the ice machine for biofilm and ensuring dietary staff cleaned the machine;</li> <li>-He expected the ice machine to be cleaned monthly and have a deep cleaning performed annually.</li> </ul> <p>3. Review of the facility policy, Cleaning Schedules, dated April 2006, showed the following:</p> <ul style="list-style-type: none"> <li>-It is the responsibility of the Dietary Service Manager to enforce the cleaning schedules and to monitor the completion of assigned cleaning tasks;</li> <li>-Daily, weekly, and monthly cleaning schedules prepared by the Dietary Service Manager with all cleaning tasks listed will be posted in the Dietary Department;</li> <li>-Specify the day(s) the cleaning schedule will be done, specify who is responsible to do the cleaning by shift and position, post the schedule prior to the beginning of each week, the employee will initial in the column under the day the task is completed.</li> </ul> <p>Observation on 5/20/24 at 10:05 A.M., in the kitchen, showed the following:</p> <ul style="list-style-type: none"> <li>-Each compartment in the five-compartment steam table contained slime and debris in 1-inch of water;</li> <li>-The exterior and interior surfaces of the sneeze guard were coated with oil, debris, and dried food runs;</li> <li>-Food debris and liquid run marks were on the outside metal surface.</li> </ul> <p>Observation on 5/20/24 at 10:11 A.M., in the kitchen, showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Dust, debris, and an oily material were on the exterior of the kitchen hood and the fire suppression system control panel;</p> <p>-Dust, debris and an oily material were on the interior of the hood, fire suppression piping manifold, and four suppression nozzles;</p> <p>-Three filters/baffles had a moderate buildup of oily material.</p> <p>Observation on 5/20/24 at 10:13 A.M., in the kitchen, showed the following:</p> <p>-The burners on the six-burner stove top were covered with black carbon buildup, oily material and food/debris;</p> <p>-Oily material, food splatters and run marks were on the metal back splash behind the stove top and griddle;</p> <p>-Oily material, food and debris were on the metal splash guard on the right side of the griddle;</p> <p>-The deep fryer had a buildup of oily material, food, debris and brown stains;</p> <p>-A yellowish brown debris was on the wall behind the stovetop, griddle, and deep fryer.</p> <p>Observation on 5/20/24 at 10:20 A.M., in the kitchen, showed the following:</p> <p>-The top of the toaster oven was covered with brown/black material and there were food crumbs underneath the unit;</p> <p>-The metal electrical box and conduit mounted on the wall above the toaster oven had a buildup of oil, dust and debris;</p> <p>-Dust and debris were on the wall-mounted emergency light located above the toaster oven/microwave;</p> <p>-Oily material, dust and debris were on the wall-mounted magnetic knife holder;</p> <p>-Dried food splatters were on the interior surface of the microwave and food crumbs were underneath the unit;</p> <p>-Food splatters were on the wall behind the toaster oven and microwave from the right side of kitchen hood to the corner of the unit one refrigerator;</p> <p>-The stainless-steel countertop and the lower shelf had a buildup of food debris;</p> <p>-The stainless-steel countertop with the food processor had oily material, dust, and debris on the lower shelf.</p> <p>Observation on 5/20/24 at 10:25 A.M., in the kitchen, showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A moderate covering of dust and debris was on the square ceiling vent located in the corner between the two-compartment sink and the unit one refrigerator;</p> <p>-A black material, dust and debris were on three round ceiling vents located above the food preparation table, steam table, and serving table;</p> <p>-A black material, dust, and debris were on four round ceiling vents in the Dietary Manager's office area and the dishwasher area.</p> <p>Observation on 5/20/24 at 10:35 A.M., in the kitchen, showed the following:</p> <p>-An oil/grease material and spill stains were on the exterior surfaces of the flour and sugar bins;</p> <p>-An oil/grease material and spill stains were on the exterior surface of the oatmeal bin.</p> <p>Observation on 5/20/24 at 10:45 A.M., in the kitchen and dishwasher areas, showed the following:</p> <p>-The ceilings had a yellow discoloration, dust/debris, and peeling paint;</p> <p>-The walls had a yellow discoloration, dust/debris, and food splattering;</p> <p>-The floor was dirty and sticky. Dirt and debris were located under the equipment, tables, and shelving.</p> <p>Observation on 5/20/24 at 10:52 A.M., in the kitchen dry storage room, showed a cardboard box of potatoes sat directly on the floor next to a water softener salt solution storage tank.</p> <p>Observation on 5/20/24 at 10:57 A.M., in the kitchen, showed the following:</p> <p>-Food splatters, oily material, dust and debris on the windows and frames to the Dietary Manager's office (located within the kitchen preparation area);</p> <p>-The walls, located on the kitchen side of the Dietary Manager's office, had food splatters and debris.</p> <p>Observation on 5/20/24 at 11:03 A.M., in the kitchen, showed food splatters, crumbs, and debris on the exterior surface and bottom rubber corner guards of the plate warmer.</p> <p>Observation on 5/20/24 at 2:42 P.M., in the kitchen, showed the industrial mixer was not in use. A buildup of dried food splatter was on the food surface of the mixing bowl, and the mixing bowl was not covered.</p> <p>Observation on 5/20/24 at 2:44 P.M., in the kitchen, showed the following:</p> <p>-The unit one refrigerator had stains and dirt/debris on the exterior surface and food and debris on the bottom/floor inside the unit;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The unit three refrigerator had stains and dirt/debris on the exterior surface and dirt and debris on the bottom/floor inside the unit;</p> <p>-The unit four freezer had stains and dirt/debris on the exterior surface and dirt and debris on the bottom/floor inside the unit;</p> <p>-The unit five freezer had stains and dirt/debris on the exterior surface and dirt and debris on the bottom/floor inside the unit;</p> <p>Observation on 5/20/24 at 2:51 P.M., in the kitchen dishwashing room, showed the following:</p> <p>-The top of the dishwasher was covered with dirt and debris;</p> <p>-Four 1-foot by 1-foot floor tiles were missing under the garbage disposal;</p> <p>-The floor tile next to the floor drain was cracked/broken.</p> <p>Observation on 5/20/24 at 3:59 P.M., in the ice machine room, showed dirt and debris on the exterior surface of the lid to the red and white ice chest.</p> <p>During an interview on 5/20/24 at 4:05 P.M., Dietary Aide J said the following:</p> <p>-He/She was responsible for cleaning the dishwasher area, three-compartment sink, the exterior surfaces of the refrigerator and freezer units daily;</p> <p>-He/She did not always clean these items daily due to not having enough time to finish before clocking out;</p> <p>-He/She did not use the daily, weekly, and monthly cleaning log sheets on the refrigerator units, because he/she forgot about them.</p> <p>During an interview on 5/20/24 at 4:45 P.M., Dietary [NAME] K said the following:</p> <p>-The cooks were responsible for daily cleaning of all the cooking equipment after use, and the evening cook was responsible for cleaning the kitchen floor;</p> <p>-Cleaning was not always completed due to running out of time.</p> <p>During an interview on 5/21/24 at 5:55 A.M., Dietary [NAME] H said the following:</p> <p>-He/She would like to see the kitchen in a cleaner condition when he/she arrived to work at 5:30 A.M.;</p> <p>-Staff should clean the dietary equipment used to prepare meals after each use. The evening staff should clean the steamtable water compartments at end of that shift.</p> <p>4. Review of the Handwashing/Glove Use Guidelines, dated April 2006, showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Hands should be washed: Before beginning each shift; After breaks; After using the restroom; After smoking or eating; After blowing nose; After disposing of trash or food; After handling dirty dishes; After handling raw meat, poultry or eggs; After picking up anything from the floor; When changing tasks; Any other time deemed necessary;</p> <p>-To ensure safe and proper food handling during food preparation and service, the food code states that food items should not be handled with bare hands;</p> <p>-Utensils or tongs should be used to serve or handle foods, both raw and cooked, whenever possible;</p> <p>-Do not use gloves unless only one task is being performed;</p> <p>-When preparing or handling food items such as meatloaf or raw chicken, gloves should be worn;</p> <p>-Handwashing per guidelines should occur between each task;</p> <p>-Gloves should be worn if handling food if necessary;</p> <p>-Gloves should be removed when changing or walking away from specific tasks and hands should then be washed per guidelines.</p> <p>Observations on 5/20/24 at 12:10 P.M., 12:14 P.M., and 12:31 P.M., showed Certified Nurse Aide (CNA E entered the kitchen area without a hairnet. He/She did not wash his/her hands and filled water pitchers, then left the kitchen and returned to the dining room area during the meal service.</p> <p>Observation on 5/20/24 at 1:05 P.M., showed the following:</p> <p>-Dietary [NAME] K entered the kitchen and put on gloves without washing his/her hands;</p> <p>-He/She picked up a clean baking sheet and placed it on the food preparation counter;</p> <p>-He/She went to the kitchen back hall area and returned with a plastic bag of frozen dinner rolls, opened the plastic bag, reached in with the same gloved hands, picked up frozen dinner rolls from inside the bag, and placed them on the baking sheet.</p> <p>During an interview on 5/20/24 at 4:45 P.M., Dietary [NAME] K said the following:</p> <p>-He/She did not remember entering the kitchen and not washing hands before putting on gloves;</p> <p>-Staff should wash their hands at the hand wash sink before putting on gloves and washing hands.</p> <p>Observation on 5/20/24 at 1:21 P.M., showed Dietary [NAME] H dropped a meal tray ticket on the floor, picked up the ticket with his/her gloved hand and placed it back on the resident's meal tray before handing the tray to dining room staff through the kitchen serving window. The cook did not discard his/her gloves, wash his/her hands, and continued to serve meal trays at the steam table.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/21/24 at 5:55 A.M., Dietary [NAME] H said when picking the lunch meal tray ticket up off the floor on 5/20/24, he/she should not have placed it back on the meal tray. He/She should have removed his/her gloves, washed his/her hands and put on new gloves on before returning to serving meal trays from the steamtable.</p> <p>Observation on 5/21/24 at 12:09 P.M., in the kitchen, showed the following:</p> <ul style="list-style-type: none"> <li>-The housekeeping manager wore gloves and picked up a container of peanut butter and placed it on the preparation table;</li> <li>-She went to the refrigerator, opened the door, picked up a container of jelly from inside the refrigerator, closed the door and placed the container on the preparation table with the peanut butter;</li> <li>-Without changing his/her gloves, she reached into a loaf of white bread, pulled out pieces of bread with his/her gloved hands, placed the bread on a cutting board, and prepared peanut butter sandwiches;</li> <li>-After she made each peanut butter sandwich, she picked up each sandwich with his/her gloved hands and placed them into a sandwich bag.</li> <li>-While wearing the same gloves, she opened the refrigerator and placed the bagged sandwiches inside the unit.</li> </ul> <p>Observation on 5/21/24 at 1:21 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Dietary [NAME] H wore gloves as he/she served the lunch meal trays from the steamtable;</li> <li>-He/She went to the preparation area, opened a bag of potato chips, reached inside with his/her gloved hands, and obtained a hand full of chips. He/She placed the chips in his/her hand into a bowl and placed the bowl on a resident's meal tray.</li> </ul> <p>During an interview on 5/21/24 at 1:39 P.M., Dietary [NAME] H said the following:</p> <ul style="list-style-type: none"> <li>-He/She did not realize he/she reached into the bag of chips with the same gloves he/she used to serve at the steam table. The noon meal was running behind and he/she was rushed;</li> <li>-He/She should have washed his/her hands and put on new gloves before reaching into the chip bag or used clean tongs to reach into the chip bag.</li> </ul> <p>During an interview on 5/22/24 at 6:50 A.M., Dietary [NAME] H said the following:</p> <ul style="list-style-type: none"> <li>-Facility staff/nursing staff should wear hair nets when entering the kitchen;</li> <li>-Staff have been educated on hair net use in the kitchen;</li> <li>-Staff should wash their hands when entering the kitchen, and should wash their hands and change gloves between tasks in the kitchen.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/22/24 at 7:20 A.M., the housekeeping supervisor said the following:</p> <ul style="list-style-type: none"> <li>-She did not normally work in the kitchen, and was helping out on 5/22/24 because only the cook and a dishwasher were on duty;</li> <li>-She did not realize she used the same gloved hands for all the tasks in preparing the peanut butter sandwiches;</li> <li>-She probably should have washed his/her hands and changed his/her gloves between tasks when preparing the sandwiches.</li> </ul> <p>During an interview on 5/22/24 at 8:30 A.M., the Dietary Manager said the following:</p> <ul style="list-style-type: none"> <li>-In general, she was aware of the identified items not being clean and in a sanitized condition. She had been absent from work for approximately one week, and this is her first day back;</li> <li>-She was not aware of cleaning issues with the ice machine, and was not aware of the required air gap at the ice machine drains;</li> <li>-She was not aware of food items in the refrigerators/freezers that were not properly labeled and dated. She expected all items to be labeled and dated;</li> <li>-She expected facility staff to wear hairnets in the kitchen area;</li> <li>-She expected staff to use proper handwashing and gloving practices in the kitchen;</li> <li>-She expected staff to store, prepare and serve food in a safe and sanitary manner.</li> </ul> <p>During an interview on 5/22/24 at 8:40 A.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-He was not aware the ice machine did not have the required air gap, and was not in a clean and sanitized condition;</li> <li>-He expected facility staff to wear hairnets in the kitchen;</li> <li>-He expected staff to use proper hand washing and gloving practices in the kitchen;</li> <li>-He expected dietary staff to store, prepare and serve food in a safe and sanitary manner.</li> </ul> <p>During an interview on 5/24/24 at 10:35 A.M., the Registered Dietician said she expected dietary staff to store, prepare and serve food in a safe and sanitary manner.</p> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>42592</p> <p>Based on observation, interview, and record review, the administration of the facility failed to use resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility census was 67.</p> <p>1. Observations during survey from 05/19/24 through 05/23/24 showed the following:</p> <ul style="list-style-type: none"> <li>-No record of infection control logs;</li> <li>-No yearly staff education regarding care of residents with dementia;</li> <li>-No yearly staff education on abuse and neglect;</li> <li>-Yearly required training hours for certified nursing assistants not provided;</li> <li>-No organized Quality Assurance and Performance Program (QAPI);</li> <li>-No facility hired licensed nursing staff; utilizing all agency staff as licensed nursing staff;</li> <li>-Cardiopulmonary resuscitation status not consistent throughout a resident's medical record for numerous residents;</li> <li>-Dietary services not provided in a sanitary environment and not provided to meet residents individual needs/requests on an ongoing basis;</li> <li>-Medication administration not provided consistently according to professional standards and without errors;</li> <li>-Quality of care issues regarding management of foot care and services to prevent decline in mobility and range of motion not consistently provided;</li> <li>-Protective oversight and safety measures with prevention of injuries not provided consistently;</li> <li>-Supplies, like linens for bathing and bed changes, not available to provide resident cares;</li> <li>-Assistance with activities of daily living not provided to meet the needs of individual residents consistently;</li> <li>-Staff not following infection control measures consistently;</li> <li>-Activities program not provided that met the needs and interests of all residents, including dementia residents and weekend/evening activities;</li> <li>-Proper certification for activities director, infection preventionist and dietary manager;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Resident rights of dignity and reasonable accommodation of needs, preferences and choices were not ensured;</p> <p>-Grievances were not being followed up on;</p> <p>-No oversight to ensure proper Advance Beneficiary Notices (ABN) were completed had not been provided;</p> <p>-No oversight to ensure proper resident and/or resident representative notification when a resident's trust account reached \$200 less the Supplemental Security Income (SSI) resource for a resident who received Medicaid benefits;</p> <p>-No oversight to ensure residents fully understood what a binding arbitration agreement was;</p> <p>-The facility failed to keep the floors and walls in good repair and failed to maintain a homelike environment in the facility;</p> <p>-Professional standards of care not consistently followed while providing care and increased the risks of infections and contaminations;</p> <p>-Sufficient staffing to ensure residents needs were met was not provided;</p> <p>-The facility failed to complete a thorough investigation of an allegation of abuse per the facility policy;</p> <p>-No oversight to ensure a notice of transfer to the hospital or bed hold policy was being provided to a resident and/or the resident representative;</p> <p>-The facility did not have dedicated staff to complete required assessments timely and accurately;</p> <p>-The facility failed to ensure pharmacy reviews were being received and followed up on.</p> <p>During an interview on 5/22/24 at 6:07 P.M., the Interim Director of Nursing (DON) said the following:</p> <p>-She had been at the facility off and on since November 2023 serving as the Interim DON;</p> <p>-She had not had a DON or assistant DON for the last couple of months;</p> <p>-All licensed nursing staff currently utilized at the facility were agency staff;</p> <p>-The facility had not had full time permanent administration, so some systems were not in place.</p> <p>During an interview on 5/23/24 at 3:54 P.M., the Interim Administrator said the following:</p> <p>-He started at the facility 5/7/24;</p> <p>-He was told the facility had a lot of turn over and was relying heavily on agency staffing;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He was working with the DON to get systems in place but has not been at the facility very long.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0847</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>42592</p> <p>Based on interview and record review, the facility failed to ensure two additional sampled resident s (Resident #34 and #48), fully understood the binding arbitration agreement (a private process where disputing parties agree that one or several individuals can make decisions about the dispute after receiving evidence and hearing arguments) prior to signing the agreement. Additionally the facility failed to ensure required elements for the binding arbitration agreement were part of the facility policy. The facility census was 67.</p> <p>Review of the undated facility admission packet showed the following:</p> <p>-Alternative Dispute Resolution Addendum: All claims, disputes, and controversies arising out of or in any manner relating, directly or indirectly, to the resident's care of stay that the facility (in each case, a dispute) shall be subject to certain alternative dispute resolution procedures that must be exhausted prior to pursuing any other remedy that may be available. Those required alternative dispute resolution procedures are: (a) mandatory non-binding mediation; and (B) mandatory non-binding appeal arbitration;</p> <p>-Each party agrees that compliance with the requirements of the addendum shall be a condition precedent to its right to assert any claims with respect to a dispute in any other form;</p> <p>-Mandatory Non-Binding Mediation: If there is a dispute, the party claiming the existence of a dispute must make written demand for mediation prior to instituting a lawsuit, action or arbitration proceeding. Mediation of any dispute must be attempted in good faith;</p> <p>-The mediation shall be conducted in the county where the facility is located, unless another location is mutually agreed upon by the parties. The cost and expenses of mediation, with the exception of the costs and expenses relating to investigation, representation and case presentation on behalf of the resident, shall be borne by the facility;</p> <p>-The mediator shall be chosen by joint agreement of the resident and the facility. In the even an agreement cannot be reached with respect to a mediator, either party may request that Judicial Arbitration and Mediation Services, Inc. or it successor appoint a mediator. Selection of the mediator by its successor shall be binding on the resident and the facility;</p> <p>-Mandatory Non-Binding Appealable Arbitration: Should mandatory non-binding mediation of the dispute be unsuccessful, it is agreed that the dispute shall be submitted to non-binding appealable arbitration in accordance with the Health Care Clams Settlement Procedures, as promulgated, amended and administered by the American Arbitration Association;</p> <p>-All arbitration hearings conducted hereunder shall take place in the county where the facility is located. The hearing before the arbitrator(s) of the matter to be arbitrated shall be at the time and place within said county as selected by the arbitrator(s);</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0847</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>-The decision of the arbitrator(s) with respect to a dispute shall be non-binding and appealable to a court having jurisdiction;</p> <p>-This contract contains an arbitration provision. This may be enforced by the parties.</p> <p>Review of the facility provided admission agreement showed the arbitration agreement did not include:</p> <p>-The resident or his/her representative is not required to enter into the agreement as a condition of admission to the facility or as a requirement to continue to receive care;</p> <p>-Did not include language which prohibited or discouraged the resident or representative from communicating with federal, state, or local officials;</p> <p>-The resident or his/her representative has the right to rescind the agreement within 30 calendar days of signing the agreement.</p> <p>During an interview on 05/23/24, at 3:31 P.M., Resident #34 said the following:</p> <p>-He/She was his/her own responsible party;</p> <p>-He/She knew what arbitration meant but was unsure if he/she signed any agreement and the facility had not specifically explained anything to him/her about arbitration.</p> <p>During an interview on 05/23/24, at 3:20 P.M., Resident #48 said the following:</p> <p>-He/She has been at the facility for eight or nine months;</p> <p>-He/She was his/her own responsible party;</p> <p>-He/She understood what arbitration was, but was unsure if she specifically signed an agreement;</p> <p>-He/She signed a lot of papers and did not recall a staff member specifically discussing the arbitration agreement with him/her.</p> <p>During an interview on 05/23/24, at 3:48 P.M., the Social Service Designee said the following:</p> <p>-She has been doing social services and admission packets since September 2023;</p> <p>-She was responsible for completing the admission packet that included the arbitration agreement;</p> <p>-Arbitration meant if there was an outstanding bill or something like that, that it will go to court;</p> <p>-She tells the residents if they don't understand something that she will explain it in more detail;</p> <p>-She explains the process during the admission process;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0847</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>-She uses the form the company provides for the arbitration agreement signatures;</p> <p>-She was unaware of any specific components that are required to be listed on the arbitration agreement.</p> <p>The SSD did not provide requested documentation from Resident #34 and #48's admission packet to show what the residents may or may not have signed.</p> <p>During an interview on 05/23/24, at 4:20 P.M., the Administrator said the following:</p> <p>-He is not aware of what the arbitration agreement is, he just learned that term during the facility's annual survey;</p> <p>-Social services would be responsible for getting the arbitration agreement signed;</p> <p>-He is unaware of what components exactly needs to be listed on the agreement.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to identify, develop and implement a Quality Assurance and Performance Improvement Plan (QAPI) to monitor and evaluate system problems. The facility census was 67.</p> <p>Request for a Quality Assurance (QA)/QAPI policy was made of the facility and none provided.</p> <p>Review of a binder, provided by the administrator, on 5/23/24 at 3:54 P.M., labeled QAPI, showed the last meeting minute notes were dated January 2023. No current, facility specific, QAPI plan was included in the binder for review.</p> <p>During an interview on 5/23/24, at 3:54 P.M., the Interim Administrator said the following:</p> <ul style="list-style-type: none"> <li>-He started at the facility 5/7/24;</li> <li>-The QAPI policy/program/plan as requested on entrance was not provided to the state agency (SA) because the facility does not have a policy or recent minutes or completed QAPI information that he could find;</li> <li>-The last QAPI minutes he found were dated 1/23/23;</li> <li>-He interviewed current staff and no staff remember having a QAPI committee or meeting recently;</li> <li>-He found an outline of what to do but was not sure if it was a current outline;</li> <li>-He would expect the facility to have a QAPI program with process improvement activities that meets quarterly with the appropriate team members.</li> </ul>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>38016</p> <p>Based on interview and record review, the facility staff failed to implement an effective quality assessment and assurance (QAA) committee to develop and track any identified concerns for resolution. The facility census was 67.</p> <p>Request for a Quality Assurance (QA)/QAPI policy was made of the facility and none provided.</p> <p>Review of a binder, provided by the administrator, on 5/23/24 at 3:54 P.M., labeled QAPI, showed the last meeting minute notes were dated January 2023.</p> <p>During an interview on 5/23/24, at 3:54 P.M., the Interim Administrator said the following:</p> <ul style="list-style-type: none"> <li>-He started at the facility 5/7/24;</li> <li>-The QAPI policy and QAPI members were not given to the state agency (SA) team as requested on entrance because the facility did not have a policy or recent minutes that he/she can find;</li> <li>-The last QAPI minutes he found were dated 1/23/23;</li> <li>-He interviewed current staff and no staff remember having a meeting recently;</li> <li>-The current staff could not give him any Process Improvement Plans that are currently being worked on;</li> <li>-He would expect the facility to have a QA/QAPI program with process improvement activities that meets quarterly with the appropriate team members.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>38016</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, the facility failed to provide documentation of a Quality Assurance and Process Improvement (QAPI) committee that included the appropriate attendees. The facility census was 67.</p> <p>Request for a Quality Assurance (QA)/QAPI policy was made of the facility and none provided.</p> <p>Review of a binder, provided by the administrator, on 5/23/24 at 3:54 P.M., labeled QAPI, showed the last meeting minute notes were dated 1/23/23.</p> <p>During an interview on 5/23/24 at 3:54 P.M., the Interim Administrator said the following:</p> <ul style="list-style-type: none"> <li>-He started at the facility 5/7/24;</li> <li>-The QAPI policy and QAPI members were not given to the state agency (SA) team as requested on entrance because the facility does not have a policy or recent minutes that he can find;</li> <li>-The last QAPI minutes he found were dated 1/23/23;</li> <li>-He interviewed current staff and no staff report being on a QA/QAPI committe;</li> <li>-He would expect the facility to have a QAPI program with process improvement activities that meets quarterly with the appropriate team members;</li> <li>-He expects the Administrator, Director of Nursing, a few floor staff, most of the department heads, medical director, pharmacist, and the dietitian to participate in the QAPI program and attend at least the qarterly meetings;</li> <li>-He had not attended or been part of a QA/QAPI meeting since he began working at the facility.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34003</p> <p>Based on observation, interview, and record review, the facility failed to follow current infection control for six residents (Resident #20, #46, #13, #4, #39 and #68), in a review of 24 sampled resident and six additional residents (Resident #34, #14, #49, #38, #6 and #28). Staff failed to follow Enhanced Barrier Precautions (EBH) for one resident (Resident #20) who had an indwelling catheter. The facility failed to follow infection control practices while performing blood glucose monitoring (a procedure where a drop of blood is obtained to test the amount of sugar in the blood) for five residents (Resident #46, #34, #14, #49 and #13) when staff failed to appropriately sanitize the glucometer (a machine that tests a drop of blood for the amount of sugar it contains) after use, and failed to place the glucometer on a clean surface after use and cleaning. The facility failed to store oxygen tubing and nebulizer equipment (equipment used to give aerosol breathing treatments) when not in use in a way to prevent potential contamination from unclean surfaces, failed to change oxygen tubing as ordered and failed to clean the nebulizer treatment cup reservoirs per facility policy for four residents (Resident #4, #38, #39 and #68). The facility failed to maintain the prevention of communicable disease in regards to Tuberculosis (TB) (a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) when the facility failed to ensure Tuberculin Skin Tests (TST) for three residents (Resident #6, #13 and #38) and for two new employees (Certified Nursing Assistant CNA DD and the Administrator), in a review of 12 new employees, were completed in accordance with the general requirements for TB testing for long-term care residents and staff. The facility staff failed to clean feces from Resident #49's toilet and from under the resident's bed after he/she had been incontinent. Staff failed to wash their hands with soap and water when necessary and failed to change gloves, when staff used soiled gloves to provide care to Resident #28 and touched clean linen and other items with soiled gloves. The facility failed to have a water management plan, water flow map/diagram, acceptable water parameters to monitor for Legionella (a bacteria that can cause a severe type of pneumonia and mild flu-like illness) did not follow up on water temperatures that were out of range and did not have a water management team or screen suspected residents for Legionella. The facility census was 67.</p> <p>Review of the facility undated facility policy, Catheter, Emptying A Urinary Drainage Bag, showed the drainage bag and tubing should be kept off the floor at all times to prevent contamination and damage.</p> <p>Review of the facility policy for Enhanced Barrier Precautions (EBP) to Infection Control Guidance dated 3/2024 showed the following:</p> <p>-Purpose: To prevent broader transmission of MDRO (multidrug-resistance organism) and to help protect residents with chronic wounds and indwelling devices. EBP (Enhanced barrier precautions) should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed.;</p> <p>-Residents to be included: Residents known to be infected or colonized with a MDRO; residents with an indwelling medical device including the following: Central venous catheter, urinary catheter, feeding tube (PEG tube, G-tube), tracheostomy/ventilator regardless of their MDRO status; residents with a wound, regardless of their MRDO status;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-When to use EBP: Use EBP when providing high-contact resident care activities such as: bathing/showering, transferring residents from one position to another, providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device, performing wound care;</p> <p>-Guidelines: Conduct proper hand hygiene before starting care; gloves and donning and doffing of gown are required when conducting high-contact resident care activities that are listed. Gloves and gown should be removed and discarded after each resident care encounter. Attempts to arrange cares to be grouped together to assist in reducing consumption of supplies where practical; EBP's do not require placement of resident in a private room and they can continue to participate in group activities;</p> <p>-Residents with a wound or indwelling medical device and excretions or secretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO should be placed on contact precautions unless or until a specific organism is identified;</p> <p>-EBP should be followed when performing transfers or assisting during bathing in a shared/common shower and when working with residents in the therapy gym. (Specifically, when anticipating close physical contact while assisting with transfers and mobility);</p> <p>-Residents that are placed on EBP should have PPE in close proximity outside the door and trash can in resident's room for disposal prior to leaving the room;</p> <p>-Multi-resident medical equipment must be sanitized between resident uses.</p> <p>Review of the facility's undated policy, Blood Glucometer Disinfecting, showed the following:</p> <p>-Purpose: to prevent the spread of infection;</p> <p>-Equipment: Approved wipes with 10% bleach or comparable product;</p> <p>-Guidelines:</p> <ol style="list-style-type: none"> <li>1. Wash hands;</li> <li>2. Put on gloves;</li> <li>3. Provide a clean field in which to place the glucose meter (a paper towel works well for this);</li> <li>4. Clean the blood glucose meter prior to using with approved wipes with 10% bleach or comparable product, place on clean field and let air dry according to manufacturer's directions. Do not touch the clean field with gloves, including the test port. Glucometer may be wrapped in another wipe and stored;</li> <li>5. Remove gloves;</li> <li>6. Wash hands.</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The policy did not instruct how long to keep the glucometer wet while/after cleaning;</p> <p>-The policy did not include the manufacturer's instructions.</p> <p>Review of the undated facility policy, Oxygen Administration, showed the following:</p> <p>-Purpose: To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues;</p> <p>-At regular intervals, check and clean oxygen equipment, masks, tubing and cannulas;</p> <p>-Place cannula tubing in plastic bag attached to concentrator when tubing is not in use;</p> <p>-Care and Use of Prefilled Disposable Humidifiers:</p> <p>9. Label humidifier with date and time opened.</p> <p>Review of the undated facility policy, Cleaning Guidelines - Oxygen Equipment, showed the following:</p> <p>-Purpose: Oxygen equipment will be cleaned to ensure safety in handling and administering oxygen;</p> <p>3. Prefilled humidifier bottles will be discarded when empty;</p> <p>6. Tubing, masks, and cannulas used with oxygen therapy should be replaced monthly and PRN, and marked with date and initials.</p> <p>Review of the undated facility policy, Cleaning Guidelines - Medication Nebulizers/Continuous Aerosol, showed the following:</p> <p>-After completion of therapy:</p> <p>a. Remove nebulizer container;</p> <p>b. Rinse container with fresh tap water;</p> <p>c. Dry with clean paper towel or gauze sponge (Use caution not to contaminate internal nebulizer tubes);</p> <p>-Store circuit in plastic bag marked with date and resident name between uses.</p> <p>Review of the undated facility policy, Gloves, showed the following:</p> <p>-Wear gloves when it can be reasonably anticipated that hands will be in contact with mucous membranes, non intact skin, any moist body substances (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, or items/surfaces soiled with these substances) and/or persons with a rash;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Gloves must be changed between residents and between contacts with different body sites of the same resident;</p> <p>-If the glove is torn or a needle stick or other injury occurs, the glove should be removed, discarded in the trash and a new glove used promptly as resident safely permits;</p> <p>-Dirty gloves are worse than dirty hands because microorganisms adhere to the surface of a glove easier than to the skin on your hands;</p> <p>-Change gloves between contacts (as defined above) with different residents or with different body sites of the same resident.</p> <p>Review of the undated facility policy, Handwashing showed the following:</p> <p>-Turn on water and adjust temperature;</p> <p>-Soap hands well;</p> <p>-Rub hands briskly, paying special attention to area between fingers;</p> <p>-Use brush to clean under nails as necessary;</p> <p>-Rinse with hands lowered to allow soiled water to drain directly into sink;</p> <p>-Do not splash water onto clothing;</p> <p>-Do not allow hands to touch sink;</p> <p>-Use disposable hand towel to turn off faucet and dry hands well, especially between fingers.</p> <p>Review of the undated facility policy titled, Tuberculosis Policy, showed the following:</p> <p>-It is important for each facility to have a tuberculosis control program in place. This must include the documentation of the tuberculosis status of each resident, staff member, and volunteer of each long term care facility. This can best be accomplished by screening residents on admission, and pre-employment and annual testing of employees and volunteers as outlined below;</p> <p>-RECOMMENDATIONS FOR RESIDENTS:</p> <p>-All residents new to long-term care who do not have documentation of a previous skin test reaction &gt; 10 mm or a history of adequate treatment of tuberculosis infection or disease, shall have the initial test of a Mantoux PPD two- step skin test to rule out tuberculosis within one month prior to or one week after admission as required by Department of Health Rule 19 CSR 20-20.100. If the initial result is 0-9 mm, the second test, which can be given after admission, should be given at least one week and no more than three weeks after the first test. The result of the second test is used as the baseline. Documentation of a chest x-ray ruling out pulmonary tuberculosis within one month prior to admission, along with an evaluation to rule out signs and symptoms of tuberculosis, may be acceptable by the facility on an interim basis until the Mantoux PPD two-step test is completed;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Skin test results of &gt; 10 mm, whether documented in the resident's medical history, obtained by the first test, or obtained by the second of the two-step test applied by the facility require a chest x-ray to rule out current tuberculosis disease. It is important to also perform an evaluation to determine if signs or symptoms of tuberculosis (unexplained weight loss, fever, and persistent cough) are present. Once tuberculosis disease is ruled out, it is important to record the results of the skin test in millimeters (mm), in a prominent place on the resident's medical record. Including the skin test result at the same place and in the same manner as the resident's allergies is appropriate;</p> <p>-The policy did not address what to do if a resident refused testing;</p> <p>-RECOMMENDATIONS FOR EMPLOYEES:</p> <p>-The results of annual tuberculin testing of employees in a long-term care facility are a good indicator of the extent of transmission of tuberculosis within that facility. The following occupationally-exposed persons should be tested at least annually: all employees, attending physicians and dentists, volunteers who spend &gt; 10 hours weekly in the facility, nursing and allied health personnel, students, instructors and other individuals in regular attendance within long-term facilities. Every facility should have a tuberculosis surveillance program that includes the following procedures:</p> <p>-Initial Examination: Provide a tuberculin skin test (Mantoux, five tuberculin units (TU) of purified protein derivative (PPD) to all employees during pre-employment procedures, unless a previous reaction &gt; 10 mm is documented. If the initial skin test result is 0-9 mm, a second test should be given at least one week and no more than three weeks after the first test. The results of the second test should be used as the baseline in determining treatment and follow-up of these employees. A history of BCG (bacilli Calmette-Guerin) does not preclude an initial screening test, and a reaction of 10 mm or more should be managed as a tuberculosis infection. A chest x-ray examination should be provided for employees who have a skin test reaction &gt; 10 mm or who have symptoms compatible with pulmonary tuberculosis in order to determine the presence of current disease;</p> <p>Review of the Centers for 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:</p> <p>-The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains;</p> <p>-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (<a href="https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html">https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html</a>). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit;</p> <p>-Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities:</p> <p>-Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system;</p> <p>-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens;</p> <p>-Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained.</p> <p>Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F.</p> <p>Review of the facility Weekly Water Temperature Log form SWO26, undated, showed the following directions to staff completing the form:</p> <p>-Check two random rooms per wing for proper water temperature;</p> <p>-Resident rooms should reach temperatures of 105-120 degrees F, maximum;</p> <p>-If a resident's water temperature is below 105 degrees: look for a cold water mix at a fixture such as a whirlpool, shower faucet, or chemical additive machine, turn cold side off. If too low of temperature still occurs, call for service;</p> <p>-If a resident's room's water temperature is above 120 degrees: adjust the water heater, look for a hot water leak, or check mixing valves. If too high of temperature still occurs, call for service;</p> <p>-Kitchen and laundry room temperatures should reach 140 degrees unless low temperature chemicals are being used;</p> <p>-When it is necessary to replace a faucet, ensure it is replaced with a double lever faucet.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Review Resident #20's care plan, dated 11/24/23, showed the resident required an indwelling urinary catheter (a tube inserted into the bladder to empty urine from the bladder) related to urine retention.</p> <p>Review of resident's progress note dated 12/22/23 at 10:43 P.M. showed the following:</p> <ul style="list-style-type: none"> <li>-The resident returned from the hospital;</li> <li>-The resident received a new order for antibiotic for a urinary tract infection (UTI).</li> </ul> <p>Review of resident's progress note, dated 2/4/24 at 12:38 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident returned from hospital by ambulance;</li> <li>-The resident received a new order for Omnicef (an antibiotic) for a UTI.</li> </ul> <p>Review of resident's progress note, dated 2/27/24 at 6:54 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident received intravenous (IV) fluids and IV antibiotics;</li> <li>-The resident returned back to the facility;</li> <li>-The resident returned with a prescription for oral antibiotics.</li> </ul> <p>Review of the resident's May 2024 physician order sheet (POS) showed the resident had an indwelling urinary catheter for urinary retention.</p> <p>During interview on 05/21/24 at 9:35 A.M., Certified Nurse Aide (CNA) C and CNA E said the following:</p> <ul style="list-style-type: none"> <li>-They did not know what Enhanced Barrier Precautions (EBP) were;</li> <li>-No residents were on precautions.</li> <li>-There were no gowns available, only gloves.</li> </ul> <p>Observation on 05/21/24 at 10:29 A.M. showed the following:</p> <ul style="list-style-type: none"> <li>-The resident lay in bed and had a urinary catheter;</li> <li>-The urine in the catheter drainage bag was brown and cloudy;</li> <li>-The urine in the catheter tubing was red and filled with sediment (a substance that settles at the bottom of urine) (normal urine does not have sediment);</li> <li>-CNA E and CNA C put on gloves and changed the resident's incontinence brief;</li> <li>-CNA E wiped discharge from the catheter insertion site and the resident's inner thighs.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Neither CNA E or CNA C wore a gown when providing care for the resident.</p> <p>During interview on 5/22/24 at 11:30 A.M., Licensed Practical Nurse (LPN) R said he/she did not know what enhanced barrier precautions were.</p> <p>2. Review of Resident #49's face sheet showed his/her diagnoses included diabetes.</p> <p>Review of the resident's POS, dated 5/1/24, showed an order for glucose monitoring twice a day (BID) before breakfast and dinner.</p> <p>Observation on 5/21/24 at 5:31 A.M. showed the following:</p> <p>-LPN D placed a multi use glucometer on top of the medication cart;</p> <p>-LPN D sanitized his/her hands with hand sanitizer, applied gloves and took a glucose test strip out of the bottle and placed it in the glucometer; he/she then took the machine in the resident's room, wiped one of the resident's fingers with an alcohol wipe, used a lancet to prick the resident's finger, and with the first drop of blood, placed the test strip to the drop;</p> <p>-LPN D then brought the machine back to the cart and placed the machine on top of the cart, (not on a barrier), removed a wipe from a container of Micro kill bleach wipes and wiped the glucometer with the wipe a couple of times, sat the machine back on top of the medication cart (without a barrier) and moved to the next room.</p> <p>3. Review of Resident #14's face sheet showed his/her diagnoses included diabetes.</p> <p>Review of the resident's POS, dated 5/1/24, showed an order for glucose monitoring daily.</p> <p>Observation on 5/21/24 at 5:45 A.M. showed:</p> <p>-LPN D placed a multi use glucometer on top of the medication cart;</p> <p>-LPN D sanitized his/her hands with hand sanitizer, applied gloves and took an glucose test strip out of the bottle and placed it in the glucometer; he/she then took the machine in the resident's room, wiped one of the resident's fingers with an alcohol wipe, used a lancet to prick the resident's finger, and with the first drop of blood, placed the test strip to the drop;</p> <p>-LPN D then brought the machine back to the cart and placed the machine on top of the cart, (not on a barrier), removed a wipe from a container of Micro kill bleach wipes and wiped the glucometer with the wipe a couple of times, sat the machine back on top of the medication cart (without a barrier) and moved to the next room.</p> <p>4. Review of Resident #13's face sheet showed his/her diagnosis included diabetes.</p> <p>Review of the resident's POS, dated 5/1/24, showed an order for blood glucose monitoring three times daily.</p> <p>Observation on 5/21/24 at 5:50 A.M. showed the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-LPN D placed a multi use glucometer on top of the medication cart;</p> <p>-LPN D sanitized his/her hands with hand sanitizer, applied gloves and took a glucose monitoring strip out of the bottle and placed it in the glucometer; he/she then took the machine in the resident's room, wiped one of the resident's finger with an alcohol wipe, used a lancet to prick the finger, and with the first drop of blood, placed the test strip to the drop;</p> <p>-LPN D then brought the machine back to the cart and placed the machine on top of the cart, (not on a barrier), removed a wipe from a container of Micro kill bleach wipes and wiped the glucometer with the wipe a couple of times, sat the machine back on top of the medication cart (without a barrier) and moved to the next room.</p> <p>5. Review of Resident #34's face sheets showed his/her diagnoses included diabetes.</p> <p>Review of the resident's POS, dated 5/1/24, showed an order for blood glucose monitoring twice daily.</p> <p>Observation on 5/21/24 at 5:55 A.M. showed the following:</p> <p>-LPN D placed a multi use glucometer on top of the medication cart;</p> <p>-LPN D sanitized his/her hands with hand sanitizer, applied gloves, took a glucose strip out of the bottle and placed it in the glucometer; he/she then took the machine in the resident's room, wiped one of the resident's finger with an alcohol wipe, used a lancet to prick the finger, and with the first drop of blood, placed the test strip to the drop;</p> <p>-LPN D then brought the machine back to the cart and placed the machine on top of the cart, (not on a barrier), removed a wipe from a container of Micro kill bleach wipes and wiped the glucometer with the wipe a couple of times, sat the machine back on top of the medication cart (without a barrier) and moved to the next room.</p> <p>6. Review of Resident #46's face sheet showed his/her diagnoses included diabetes.</p> <p>Review of the resident's POS, dated 5/1/24, showed an order for Aspart Insulin (a short acting insulin) per sliding scale (an amount to be determined based off an glucose test result), before meals.</p> <p>Observation on 5/21/24 at 5:00 A.M. showed the following:</p> <p>-LPN D placed a multi use glucometer on top of the medication cart;</p> <p>-LPN D sanitized his/her hands with hand sanitizer, applied gloves, took a glucose test strip out of the bottle and placed it in the glucometer; he/she then took the machine in the resident's room, wiped one of the resident's fingers with an alcohol wipe, used a lancet to prick the finger, and with the first drop of blood, placed the test strip to the drop;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-LPN D then brought the machine back to the cart and placed the machine on top of the cart, (not on a barrier), removed a wipe from a container of Micro kill bleach wipes and wiped the glucometer with the wipe a couple of times, sat the machine back on top of the medication cart (without a barrier) and moved to the next room.</p> <p>During an interview on 5/21/24 at 6:45 A.M., LPN D said the following:</p> <p>-The glucometer is sanitized after each use by using a wipe from the Micro Kill bleach container, wiping front and back, then placing the glucometer on the cart to let dry before use on another resident;</p> <p>-He/She should have cleaned the top of the medication cart each time he/she used the glucometer to ensure a clean field. He/She had not done this.</p> <p>During an interview on 5/23/24 at 5:00 P.M. the Director of Nursing (DON) said the following:</p> <p>-The glucometer should be cleaned between each resident use.</p> <p>-The facility uses a bleach wipe, the machine should be wiped off after each use and left wet to dry a few minutes then air dry;</p> <p>-A clean field should be used when sitting the machine on the medication cart, staff can use a paper towel as a barrier, not the top of the medication cart.</p> <p>7. Review of CNA DD's employee file showed the following:</p> <p>-Hire date 10/1/23;</p> <p>-No documentation of a prior TB test;</p> <p>-First step TB test administered on 3/4/24 (176 days from the date of hire and since first contact with residents) and read 3/7/24;</p> <p>-No documentation of a two step test.</p> <p>8. Review of the administrator's employee file showed the following:</p> <p>-Hire date 5/1/24;</p> <p>-No documentation of a prior TB test;</p> <p>-First step TB test administered on 5/14/24 (13 days from the date of hire and since first contact with residents) and read 5/16/24;</p> <p>-No documentation of a two step test.</p> <p>9. Review of Resident #6's face sheet showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-admitted [DATE] and re-admit 3/30/23;</p> <p>-Diagnoses that included chronic cough.</p> <p>Review of the resident's immunization record showed the following:</p> <p>-No documentation the resident received a first or second step TB test at admission on 12/9/23;</p> <p>-On 3/12/24 at 11:32 A.M., the resident received a TB test; test to be read on 3/14/24; the test was read on 3/15/24 (more than 48 hours after the test was administered) at 8:00 A.M. with negative (zero mm) result documented; next scheduled administration was for 3/22/24;</p> <p>-No documentation the resident received a second step TB test on 3/22/24.</p> <p>-The resident had not received a proper TB testing and the medical record showed no documentation of a chest x-ray to rule out TB.</p> <p>10. Review of Resident #38's face sheet showed his/her admitted was 10/03/23.</p> <p>Review of the resident's immunization record showed the following:</p> <p>-On 11/24/23 at 9:45 A.M., the resident received a TB test. The test was read on 11/27/23 at 8:31 A.M. with negative result documented (not documented in mm of induration); next scheduled administration was for 12/4/23;</p> <p>-No documentation a second step TB test was administered on 12/4/23.</p> <p>Review of the resident's progress notes showed on 12/04/2023 at 10:26 A.M., resident refused TB test.</p> <p>Review of the resident's immunization record showed the following:</p> <p>-On 3/12/24 at 11:46 A.M., the resident received a TB (1st step) test; the test was read on 3/15/24 at 8:00 A.M. with negative result documented (not in mm); next scheduled administration was for 3/22/24;</p> <p>-On 3/22/24 at 2:15 P.M., the resident received a TB (2nd step) test;</p> <p>-No documentation the 2nd step TB test was read or results documented.</p> <p>11. Review of Resident #13's undated face sheet showed the resident's original admitted was 7/28/23.</p> <p>Review of the resident's undated immunization record showed the following:</p> <p>-No record of first or second TB test was administered on admission;</p> <p>-First-step TB test administered on 3/12/24 to right forearm;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-First-step TB test read on 3/15/23 and was negative, 0 mm;</p> <p>-Second-step TB test administered 3/22/24 to left forearm;</p> <p>-No documentation to show staff read the results of the second-step TB test.</p> <p>During interview on 5/22/24 at 11:30 A.M., LPN R said the nurses administer the TB tests on admission.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the DON said nurses were responsible for resident and staff TB tests. If a resident refused a TB test, then they educate the resident and get a consent. Staff get the first step TB test upon hire and then the second step fourteen days later.</p> <p>12. Review of Resident #38's face sheet showed his/her diagnoses included chronic obstructive pulmonary disease (COPD) (lung/breathing disorder), pneumonia, acute respiratory distress, seasonal allergic rhinitis, acute and chronic respiratory failure (serious condition that makes it difficult to breathe), shortness of breath and lung cancer.</p> <p>Review of the resident's progress notes showed on 11/21/23 at 2:17 P.M., discontinue as needed oxygen orders per provider due to standing orders.</p> <p>Review of the resident's May 2024 POS showed orders for the following:</p> <p>-No order for oxygen use;</p> <p>-An order to change oxygen tubing weekly on Tuesdays.</p> <p>Review of the resident's May 2024 medication administration record (MAR) showed the following:</p> <p>-Change oxygen tubing weekly on Tuesdays at 8:00 P.M.;</p> <p>-The 5/7/24 administration box for 8:00 P.M., showed LPN X documented changing the oxygen tubing as ordered;</p> <p>-The 5/14/24 administration box for 8:00 P.M., showed LPN A documented changing the oxygen tubing as ordered.</p> <p>Observation on 5/19/24 at 4:21 P.M. of the resident and the resident's room showed the following:</p> <p>-The resident sat in his/her recliner with oxygen on via nasal cannula (prongs in his/her nose delivering oxygen);</p> <p>-The oxygen tubing was connected to an oxygen concentrator and the tubing labeled with a date of 5/2/24 (the tubing had not been changed on 5/7/24 or 5/14/24 as documented);</p> <p>- The concentrator was set at 3 liters per minute.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 5/20/24 at 9:15 A.M. of the resident and the resident's room showed the resident sat in his/her wheelchair in his/her doorway with oxygen on via nasal cannula. The oxygen tubing was connected to an oxygen tank and the tubing was labeled with a date of 5/2/24. The oxygen tank was set at 4 liters per minute.</p> <p>Observation on 5/21/24 at 5:58 A.M. of the resident and the resident's room showed the resident sat in his/her recliner with oxygen on via nasal cannula. The oxygen tubing was connected to a concentrator and the tubing was labeled with a date of 5/2/24. The concentrator was set at 3 liters per minute.</p> <p>Review of the resident's May 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-Change oxygen tubing weekly on Tuesdays at 8:00 P.M.;</li> <li>-The 5/21/24 administration box for 8:00 P.M., showed LPN N documented changing the oxygen tubing as ordered.</li> </ul> <p>Observation on 5/22/24 at 3:22 P.M. of the resident and the resident's room showed the resident sat in his/her recliner with oxygen on via nasal cannula. The oxygen tubing was connected to a concentrator and the tubing was labeled with a date of 5/2/24. (the oxygen tubing was not changed on 5/21/24 as the documentation showed). The concentrator was set at 3 liters per minute of concentration.</p> <p>Observation on 5/23/24 at 8:50 A.M. of the resident and the resident's room showed the resident sat in his/her recliner with oxygen on via nasal cannula. The oxygen tubing was connected to a concentrator and the tubing was labeled with a date of 5/2/24. The concentrator was set at 3 liters per minute of concentration.</p> <p>Observation and interview on 5/23/24 at 8:55 A.M., showed LPN N said the following:</p> <ul style="list-style-type: none"> <li>-He/She was responsible for changing the resident's oxygen tubing on 5/21/24;</li> <li>-When tubing is changed, staff should initial, date and time, the tubing was changed on the tubing label;</li> <li>-LPN N confirmed the date on the tubing to be 5/2/24;</li> <li>-He/She thought he/she had changed the tubing;</li> <li>-If he/she had not changed the tubing, he/she should not have documented changing the tubing.</li> </ul> <p>13. Review of Resident #4's face sheet showed his/her diagnoses include congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) (a federally mandated assessment instrument completed by facility staff), dated 2/25/24, showed no use of oxygen therapy indicated.</p> <p>Review of the resident's care plan, revised on 02/28/24, showed no indication of oxygen usage.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's May 2024 POS showed the following:</p> <ul style="list-style-type: none"> <li>-Administer two liters of oxygen as needed for pulse oxygen saturation (the amount of oxygen in the blood stream measured by percentage of 100 or less) rate less than 92 percent;</li> <li>-Change oxygen tubing weekly on Sunday on the night shift.</li> </ul> <p>Review of the resident's May 2024 treatment administration record (TAR) showed the following:</p> <ul style="list-style-type: none"> <li>-No indication of use of as needed [TRUNCATED]</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to follow an antibiotic stewardship program as part of their infection prevention and control program that included antibiotic use protocols and a system to monitor antibiotic use. The facility census was 67.</p> <p>Review of the facility's undated policy, Antibiotic Stewardship Program, showed the following:</p> <ul style="list-style-type: none"> <li>-The infection preventionist(IP)/designee will be responsible to audit the clinical assessment documentation at the time of antibiotic prescription;</li> <li>-The IP/designee will be responsible for auditing of completeness of antibiotic prescribing documentation to include dose, route, start date, end date, days of therapy and indication;</li> <li>-The IP/designee will monitor antibiotic imitation. This is done by taking the number of new antibiotic starts for a single infection,dividing by total number of resident days, and multiplying by 1000;</li> <li>-The IP/designee will track C. difficile (inflammation of the colon caused by the bacteria Clostridium difficile) and antibiotic resistant infections;</li> <li>-The monthly infection/antibiotic control log contains: resident room number, resident name, type of infection, symptoms, date of symptoms, date physician notified, date antibiotic started, culture yes/no, pathogen identified, date antibiotic completed, reculture yes/no, resolved yes/no;</li> <li>-The monthly infection control line listing contains: resident name, age, sex, room number, infection site, date lab pathogen, date symptoms, date treatment, appropriate yes/no, resolved yes/no.</li> </ul> <p>Review of the facility's undated policy, Antibiotic Stewardship Champion Program, showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose: to reduce unnecessary antibiotic usage and led to fewer antibiotic failures and/or adverse events;</li> <li>-Goal: to monitor infection and antibiotic usage by having champions list the infections and antibiotics on a monthly infection control log, trending the infections and determine if the correct antibiotic was used for the correct length of time;</li> <li>-Champion program: The community will select an antibiotic stewardship champion (ASC) who will be responsible for implementing and maintaining the antibiotic stewardship champion program. The ASC will obtain certification through the Center for Disease Control and Prevention (CDC) for nursing home infection preventionist;</li> <li>-The ASC will also keep track of the location of infections throughout the facility on a monthly basis by highlighting the location of infections on a map of the facility.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During annual survey medical record review showed the following:</p> <ul style="list-style-type: none"> <li>-Resident #27 was being treated with Bactrim DS 800-160mg (antibiotic therapy), one tablet twice a day, for a diagnosis of ESBL (extended spectrum beta-lactamase, an enzyme found in some strains of bacteria that cannot be killed by many types of antibiotics) in the urine from 05/18/24 to 05/25/24;</li> <li>-Resident #54 was recently treated with azithromycin 250 milligrams (antibiotic therapy) once a day from 05/07/24 through 05/10/24 for a diagnosis of pneumonia;</li> <li>-Additional sampled Resident #10 was recently treated with azithromycin 250 milligrams once a day from 05/06/24 through 05/12/24 for a diagnosis of pneumonia.</li> </ul> <p>During an interview on 05/22/24, at 6:07 P.M., the interim Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-She had been at the facility since off and on since November 2023 serving as the interim DON;</li> <li>-When she started the facility had an IP that was in charge of the antibiotic stewardship program;</li> <li>-She has been serving as the IPCP for the last two months with staffing turnover;</li> <li>-She has not done anything specific with the antibiotic stewardship program since she took over as the IP;</li> <li>-She had not done any antibiotic surveillance logs or tracking of antibiotic use since she took over as the IP;</li> <li>-She has not had the time to complete the surveillance.</li> </ul> <p>42592</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to ensure the infection preventionist (IP) completed specialized training in infection prevention and control that worked at least part time at the facility. This practice effected all residents in a facility. The facility census was 67.</p> <p>Review of the facility's undated policy, Antibiotic Stewardship Champion Program, showed the following:</p> <ul style="list-style-type: none"> <li>-The community will select an antibiotic stewardship champion (ASC) who will be responsible for implementing and maintaining the antibiotic stewardship champion program;</li> <li>-The ASC will obtain certification through the Center for Disease Control and Prevention (CDC) for nursing home infection preventionist.</li> </ul> <p>Review of the Center for Disease Control website, Nursing Home Infection Preventionist Training, showed a required program of completion of 23 modules and sub-modules to obtain certification.</p> <p>During an interview on 5/22/24 at 6:07 P.M., the interim Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-She had been serving as the IP since the DON and assistant director of nursing (ADON) left the facility a couple of months ago;</li> <li>-She completed the IPCP, program but her certificate was at home on her computer a few hours from the facility.</li> </ul> <p>Review of an email communication from the administrator, on 6/03/24 at 12:44 P.M., the facility provided completed module certifications for module 1 through module 15, but did not provide a course completion certificate for the interim DON, who was serving as the facility's IP. Review of the provided documentation did not show a completed IPCP program certification for the interim DON.</p> <p>Review of an email communication from the administrator on 6/07/24 at 2:55 P.M., showed a certificate of completion for the Infection Prevention Control Program (IPCP) for the Minimum Data Set (MDS) coordinator.</p> <p>During an interview on 6/10/24 at 12:43 P.M., the MDS coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She was employed part-time at the facility to do MDS assessments;</li> <li>-She had not done anything at the facility directly related to the IPCP program;</li> <li>-She only reviewed the residents' records for antibiotic use for completion of the MDS assessment;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-She provided a copy of her certificate to the facility in case she needed to assist in that capacity in the future.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38016</p> <p>Based on observation, interview and record review, the facility failed to complete inspections of bed frames, mattresses and bed rails, as part of a regular maintenance program, to identify areas of possible entrapment for one resident (Resident #39 ), in a review of 24 sampled resident and two additional residents (Resident #15 and #44), who used bed rails/assist bars. The facility census was 67.</p> <p>Review of the undated facility policy, Bed Rails, showed the following:</p> <ul style="list-style-type: none"> <li>-The objective of the bed rail use policy is to determine if resident use is safe and appropriate;</li> <li>-Overview of Food and Drug Administration (FDA) potential zones of entrapment with FDA dimension recommendations: <ul style="list-style-type: none"> <li>-Zone 1: within the rail: any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space: less than 4 3/4;</li> <li>-Zone 2: under the rail, between the rail supports or next to a single rail support: the gap under the rail between the mattress, may allow for dangerous head entrapment. FDA recommended space: less than 4 3/4;</li> <li>-Zone 3: between the rail and the mattress: this area is the space between the inside surface of the bed rail and the mattress, and if too big it can cause a risk of head entrapment. FDA recommended space: less than 4 3/4;</li> <li>-Zone 4: under the rail at the ends of the rail, a gap between the mattress and the lowermost portion of the rail poses a risk of neck entrapment. FDA recommended space is less than 2 MI;</li> <li>-The FDA has not provided dimension recommendations for Zones 5-7. These zones should be assessed for entrapment risk. The facility should refer to manufacturer guidelines for the bed rails, mattresses, and beds;</li> <li>-Zone 5: between split bed rails: when partial length head and split rails are used on the same side of the bed, the space between the rails may present a risk of either neck or chest entrapment;</li> <li>-Zone 6: between the end of the rail and the side edge of the head or foot board: a gap between the end of the bed rail and the side edge of the headboard or footboard can present the risk of resident entrapment;</li> <li>-Zone 7: between the head or foot board and the end of the mattress: when there is too large of a space between the inside surface of the headboard or footboard and the end of the mattress, the risk of head entrapment increases;</li> </ul> </li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-When installing or maintaining bedrails, staff should follow manufacturer's recommendations and specifications for applicable bed rails, mattresses and bedframes;</p> <p>-Staff will conduct regular inspections of all bedframes, mattresses, and bed rails, to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will select equipment such as bed rails, mattresses and bedframes that are compatible.</p> <p>1. Review of Resident #15's care plan, dated 12/23/23, showed the following:</p> <p>-At risk for falls related to poor balance/gait, impulsive, poor safety awareness, and has a history of falls;</p> <p>-Fall on 12/17/22 after rolling out of bed trying to pick up Continuous Positive Airway Pressure (CPAP) mask off the floor.</p> <p>Review of the resident's Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 3/3/24, showed the following:</p> <p>-Intact cognition;</p> <p>-Independent with transfers and bed mobility.</p> <p>Observation on 5/19/24 at 4:32 P.M. showed the resident lay on his/her left side in his/her bed. The half bed rail on the right side of the resident's bed was in the raised position. The half bed rail on the left side of the resident's bed was lowered.</p> <p>Observation on 5/21/24 at 10:29 A.M. showed the half bed rail on the right side of the resident's bed was in the raised position. The left rail was lowered.</p> <p>During interview on 5/21/24 at 12:49 P.M., the resident said the following:</p> <p>-Someone put the right bed rail up and put the left bed rail down on his/her bed;</p> <p>-The right bed rail will not come down;</p> <p>-He/She did not want the right bed rail up, but would like the left bed rail raised.</p> <p>Review of the resident's medical record showed no documentation the facility conducted a regular inspection of the resident's bed frame, mattress and bed rails to identify any possible areas for entrapment.</p> <p>2. Review of Resident #39's care plan, revised 11/29/23, showed the following:</p> <p>-The resident is at risk for falls related to physical weakness/debility, impaired posture and decision to sometimes attempt transfers without assist;</p> <p>-U-bar (a 1/8 bed rail used for bed mobility) on left side.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's significant change MDS, dated [DATE] showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Limited range of motion upper and lower one side only;</li> <li>-Substantial/Maximum assist from staff for rolling left and right, lying to sit on side of bed transfers, sit to stand transfers and chair/bed-to-chair transfers.</li> </ul> <p>Observation on 05/19/24, at 3:35 P.M., showed the resident sat in his/her wheelchair in his/her room. The resident had a 1/8 bed rail in the raised position on the upper left side of the bed.</p> <p>Observation on 05/21/24, at 5:33 A.M., showed the resident lay in bed sleeping. The 1/8 bed rail on the left side of the resident's bed was in the raised position.</p> <p>Review of the resident's medical record showed no documentation the facility conducted a regular inspection of the resident's bed frame, mattress and bed rails to identify any possible areas for entrapment.</p> <p>3. Review of Resident #44's annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Requires partial/moderate assistance to roll left and right;</li> <li>-Requires substantial/maximum assistance from staff to move from sitting to lying, lying to sitting on the side of the bed, from sitting to standing and chair to bed or bed to chair transfers.</li> </ul> <p>Review of the resident's care plan, last reviewed/revised 5/7/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident has cognitive impairment related to dementia;</li> <li>-The resident is a fall risk;</li> <li>-Assist of 1-2 staff members with bed mobility: rolling side to side, sitting up and lying down;</li> <li>-Assist of 1-2 staff members toileting- toilet transfers, peri-care, and clothing management;</li> <li>-Often incontinent of bowel and bladder, especially at night.</li> <li>-Wheelchair with wedge cushion for mobility;</li> <li>-Unable to walk at this time.</li> <li>-Apply positioning bar;</li> <li>-The care plan does not address the use of bed rails or entrapment risk.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 5/19/24 at 3:54 P.M., showed the resident was not in his/her room. The 1/8 bed rail on the resident's right side of the bed was in the raised position.</p> <p>Observation on 5/21/24 at 5:30 A.M., showed the resident in bed with the 1/8 bed rail on the resident's right side of the bed was in the raised position.</p> <p>Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress or assist bars to identify areas of possible entrapment.</p> <p>During interview on 5/21/24 at 1:03 P.M., the Certified Occupational Therapy Assistant (COTA) and Physical Therapist (PT) said the following:</p> <ul style="list-style-type: none"> <li>-The therapy department only suggested when bedrails should be used;</li> <li>-The nursing department completed the consent form and assessments;</li> <li>-The maintenance department would do any measurements of the entrapment zones.</li> </ul> <p>During interview on 5/22/24 at 3:31 P.M., the Maintenance Supervisor said the following:</p> <ul style="list-style-type: none"> <li>-He only installed the bedrails;</li> <li>-He did not measure for entrapment zones;</li> <li>-The nurses do the measurements.</li> </ul> <p>During interview on 5/23/24 at 6:49 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-Maintenance should measure the entrapment zones monthly;</li> <li>-The Maintenance Supervisor did not know he was responsible for measuring entrapment zones;</li> <li>-Staff have not measured the entrapment zones monthly.</li> </ul> <p>42592</p> <p>50851</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to provide mandatory training for all staff on the facility's quality assurance and performance improvement (QAPI) program that included goals and various elements of the program. This included how the facility intends to implement the program, the staff's role in the facility's QAPI program and how to communicate concerns, problems or opportunities for improvement to the facility's Quality Assessment and Assurance (QAA) Committee. The facility census was 67.</p> <p>Review of the Facility Assessment, updated 5/20/24, showed the following staff education and competencies will be shown with each area below:</p> <p>-Activities of daily living: Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself. All Certified Nurse Assistant (CNA), Certified Medication Technician (CMT), Licensed Practical Nurse (LPN) and Registered Nurses (RN) will do a return demonstration to observe their ability;</p> <p>-Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself. All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post traumatic stress disorder (PTSD) (mental and behavioral disorder that develops from experiencing a traumatic event), other psychiatric diagnoses, intellectual or developmental disabilities. All CNA, CMT, LPN and RNs will do in-servicing and performance reviews;</p> <p>-Medications and Pain management: Awareness of any limitations of administering medications, administration of medications that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic (eye), etc. Assessment/management of polypharmacy. Assessment of pain, pharmacological and nonpharmacological pain management. All CMT, LPN and RNs will have ability observed and LPN/RN will have performance review;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Infection prevention and control: Identification and containment of infections and prevention. All CNA, CMT, LPN and RNs will do education and a return demonstration to observe their ability;</p> <p>-Management of medical conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD) (lung disorder), gastroenteritis (intestinal infection) , infections such as urinary tract infection (UTI), pneumonia and hypothyroidism. LPN and RNs will do a performance review;</p> <p>-Therapy: physical therapy, occupational therapy, speech/language, respiratory therapy, management of braces, splints. All CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Other special care needs: Dialysis, hospice, ostomy care and tracheostomy care. All CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Nutrition: Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions. All dietary service staff, CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Provide person centered/directed care: Psycho/social/spiritual support: Build relationship with resident/get to know him/her; engage resident in conversation, find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her. ALL staff performance review and observed ability;</p> <p>-Facility conducts monthly in-service meetings with staff. Competency assessments, performance reviews and observed abilities are also completed. Training is conducted based from the assessments and observation results.</p> <p>-The facility assessment did not identify QAPI training for all staff.</p> <p>Review of the undated facility, new employee training, showed the following:</p> <p>-Resident Rights information and signature of acknowledgement;</p> <p>-Abuse and Neglect prevention and reporting review, short test and signature of acknowledgement;</p> <p>-Social Media Policy and signature of acknowledgement;</p> <p>-Company Ethics policy review and signature of acknowledgement;</p> <p>-Protected Health information agreement;</p> <p>The new employee training did not include training identified QAPI training for all staff.</p> <p>1. Review of CNA C's employee education file showed the employee was hired 12/5/17. The employee education file did not contain any evidence of QAPI training.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Review of CNA PP's employee education file showed the employee was hired 4/17/23. The employee education file did not contain any evidence of QAPI training.</p> <p>During an interview on 5/21/24 at 8:10 A.M., the Director of Nursing said the the Social Service Director (SSD) tracked the NA and CNA training. She did not know if anyone kept track of facility wide training other than new hire training.</p> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said the following:</p> <ul style="list-style-type: none"> <li>-She no longer kept track of CNA or NA training;</li> <li>-Registered Nurse (RN) Training Coordinator/Minimum Data Set (MDS) Coordinator does all of the CNA training.</li> <li>-She does not train staff or track facility wide training.</li> </ul> <p>During an interview on 5/21/24 at 1:51 P.M., the RN Training Coordinator/MDS Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She does not do any CNA education or CNA competencies;</li> <li>-She does not do annual training or competencies for CNAs or for all employees.</li> </ul> <p>During an interview on 5/22/24, at 3:16 P.M., the Business Office Manger (BOM) confirmed the CNA's hire dates, and provided a copy of their training record. She did not have any other training information.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Interim Director of Nursing said the facility was trying to implement a computer software training system but that had not been accomplished yet. The facility had no training schedule.</p> <p>42592</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to maintain an effective training program for all staff, which included training on the standards, policies and procedures for the infection prevention and control program, that was appropriate and effective, and as determined by staff need. The facility census was 67.</p> <p>Review of the Facility Assessment, updated 5/20/24, showed the following staff education and competencies will be shown with each area below:</p> <ul style="list-style-type: none"> <li>-Infection prevention and control: Identification and containment of infections, and prevention. All Certified Nurse Assistant (CNA), Certified Medication Technician (CMT), Licensed Practical Nurse (LPN) and Registered Nurses (RN) will do education and a return demonstration to observe their ability;</li> <li>-Facility conducts monthly in-service meetings with staff. Competency assessments, performance reviews and observed abilities are also completed. Training is conducted based from the assessments and observation results.</li> </ul> <p>Review of the facility new employee training, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident Rights information and signature of acknowledgement;</li> <li>-Abuse and Neglect prevention and reporting review, short test and signature of acknowledgement;</li> <li>-Social Media Policy and signature of acknowledgement;</li> <li>-Company Ethics policy review and signature of acknowledgement;</li> <li>-Protected Health information agreement;</li> <li>-The new employee training did not include infection control training identified in the facility assessment.</li> </ul> <p>1. Review of CNA C's employee education file showed the employee was hired 12/5/17. The employee education file did not contain any evidence of infection control training or competencies.</p> <p>2. Review of CNA PP's employee education file showed the employee was hired 4/17/23. The employee education file did not contain any evidence of infection control training or competencies.</p> <p>During an interview on 5/21/24 at 8:10 A.M., the Director of Nursing said the the Social Service Director (SSD) tracks the NA and CNA training. She does not know if anyone keeps track of facility wide training other than new hire training.</p> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-She no longer kept track of CNA or NA training;</p> <p>-Registered Nurse (RN) Training Coordinator/Minimum Data Set (MDS) Coordinator does all of the CNA training.</p> <p>-She does not complete or track facility wide training.</p> <p>During an interview on 5/21/24 at 1:51 P.M., the RN Training Coordinator/MDS Coordinator said the following:</p> <p>-She does not do any CNA education or CNA competencies;</p> <p>-She does not do annual training or competencies for CNAs or for all employees.</p> <p>During an interview on 5/22/24 at 3:16 P.M., the Business Office Manger (BOM) confirmed the CNA's hire dates and provided a copy of their training record. She does not have any other training information.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Interim Director of Nursing said the following:</p> <p>-The facility was trying to implement a computer software training system but that had not been accomplished yet;</p> <p>-There was no training schedule.</p> <p>42592</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to ensure nurse aides received the required 12 hours of in-service education annually. The facility also did not provide or identify dementia training on the facility assessment. The facility did not provide annual abuse and neglect training. Two of two Certified Nurse Assistants (CNA)s (CNA C, and CNA PP) sampled did not have the required 12 hours of in-service education. The facility census was 67.</p> <p>Review of the Facility Assessment, updated 5/20/24, showed the following staff education and competencies will be shown with each area below:</p> <p>-Activities of daily living: Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself. All Certified Nurse Assistant (CNA), Certified Medication Technician (CMT), Licensed Practical Nurse (LPN) and Registered Nurses (RN) will do a return demonstration to observe their ability;</p> <p>-Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself. All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). All CNA, CMT, LPN and RN's will do a return demonstration to observe their ability;</p> <p>-Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post traumatic stress disorder (PTSD) (mental and behavioral disorder that develops from experiencing a traumatic event), other psychiatric diagnoses, intellectual or developmental disabilities. All CNA, CMT, LPN and RNs will do in-servicing and performance reviews;</p> <p>-Medications and Pain management: Awareness of any limitations of administering medications, administration of medications that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic (eye), etc. Assessment/management of polypharmacy. Assessment of pain, pharmacological and nonpharmacological pain management. All CMT, LPN and RNs will have ability observed and LPN/RN will have performance review;</p> <p>-Infection prevention and control: Identification and containment of infections and prevention. All CNA, CMT, LPN and RNs will do education and a return demonstration to observe their ability;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Management of medical conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD) (lung disorder), gastroenteritis (intestinal infection) , infections such as urinary tract infection (UTI), pneumonia and hypothyroidism. LPN and RNs will do a performance review;</p> <p>-Therapy: physical therapy, occupational therapy, speech/language, respiratory therapy, management of braces, splints. All CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Other special care needs: Dialysis, hospice, ostomy care and tracheostomy care. All CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Nutrition: Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions. All dietary service staff, CNA, CMT, LPN and RNs will do a return demonstration to observe their ability;</p> <p>-Provide person centered/directed care: Psycho/social/spiritual support: Build relationship with resident/get to know him/her; engage resident in conversation, find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her. ALL staff performance review and observed ability;</p> <p>-Facility conducts monthly in-service meetings with staff. Competency assessments, performance reviews and observed abilities are also completed. Training is conducted based from the assessments and observation results.Training is conducted based from the assessments and observation results;</p> <p>-The facility assessment did not address dementia or annual resident abuse and neglect prevention training.</p> <p>1. Review of CNA C's employee education file showed the employee was hired 12/5/17. The employee education file did not contain any evidence of education hours or competencies in the last year. (The only training documented was new hire training 12/5/17 and did not contain any competencies.)</p> <p>2. Review of CNA PP's employee education file showed the employee was hired 4/17/23. The employee education file did not contain any evidence of education hours or competencies in the last year. (The only training documented was new hire training 4/17/23 and did not contain any competencies.)</p> <p>3. During an interview on 5/21/24 at 8:10 A.M., the Director of Nursing said the the Social Service Director (SSD) tracked the NA and CNA training hours and competencies.</p> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said the following:</p> <p>-She no longer kept track of CNA or NA training;</p> <p>-Registered Nurse (RN) Training Coordinator/Minimum Data Set (MDS) Coordinator did all of the CNA training and competencies.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/21/24 at 1:51 P.M., the RN Training Coordinator/MDS Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She did not do any CNA education or CNA competencies;</li> <li>-She did not do annual training or competencies for CNAs.</li> </ul> <p>During an interview on 5/22/24 at 3:16 P.M., the Business Office Manger (BOM) confirmed the CNA's hire dates and provided a copy of their training records.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Interim Director of Nursing said the following:</p> <ul style="list-style-type: none"> <li>-The facility was trying to implement a computer software training system but they had not accomplished that yet;</li> <li>-There was no training schedule;</li> <li>-When she was at the facility earlier in the year, she did do observations of staff using gait belts for transfers;</li> <li>-The facility was documenting when training was completed, but there had been changes to nursing administration since then and she was not sure where the documentation would be or if any of the current staff attended.</li> </ul> <p>42592</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>38016</p> <p>Based on interview and record review, the facility failed to maintain a training program for all staff, which includes at a minimum, training on behavioral health care and services that was appropriate and effective, as determined by staff need and the facility assessment. The facility census was 67.</p> <p>Review of the Facility Assessment, updated 5/20/24, showed the following staff education and competencies will be shown with each area below:</p> <ul style="list-style-type: none"> <li>-Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post traumatic stress disorder (PTSD) (mental and behavioral disorder that develops from experiencing a traumatic event), other psychiatric diagnoses, intellectual or developmental disabilities. All Certified Nurse Assistant (CNA), Certified Medication Technician (CMT), Licensed Practical Nurse (LPN) and Registered Nurse (RN) will do in-servicing and performance reviews;</li> <li>-Provide person centered/directed care: Psycho/social/spiritual support: Build relationship with resident/get to know him/her; engage resident in conversation, find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her. ALL staff performance review and observed ability;</li> <li>-Facility conducts monthly in-service meetings with staff. Competency assessments, performance reviews and observed abilities are also completed. Training is conducted based from the assessments and observation results.</li> </ul> <p>All facility staff were not included on the Mental health and behavior training identified on the facility assessment, the facility assessment only identified nursing staff.</p> <p>Review of the undated facility, new employee training, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident Rights information and signature of acknowledgement;</li> <li>-Abuse and Neglect prevention and reporting review, short test and signature of acknowledgement;</li> <li>-Social Media Policy and signature of acknowledgement;</li> <li>-Company Ethics policy review and signature of acknowledgement;</li> <li>-Protected Health information agreement;</li> </ul> <p>-The new employee training did not include behavioral health training for all staff or for staff identified in the facility assessment.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Lincoln County Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 East Cherry Street Troy, MO 63379	
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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Review of CNA C's employee education file showed the employee was hired 12/5/17. The employee education file did not contain any evidence of education on behavioral health care and services.</p> <p>2. Review of CNA PP's employee education file showed the employee was hired 4/17/23. The employee education file did not contain any evidence of education on behavioral health care and services.</p> <p>During an interview on 5/21/24 at 8:10 A.M., the Director of Nursing said the the Social Service Director (SSD) tracked the NA and CNA training. She did not know if anyone kept track of facility wide training other than new hire training.</p> <p>During an interview on 5/21/24 at 8:25 A.M., the SSD said the following:</p> <ul style="list-style-type: none"> <li>-She no longer kept track of CNA or NA training;</li> <li>-Registered Nurse (RN) Training Coordinator/Minimum Data Set (MDS) Coordinator did all of the CNA training.</li> <li>-She does not do or track facility wide training.</li> </ul> <p>During an interview on 5/21/24 at 1:51 P.M., the RN Training Coordinator/MDS Coordinator said the following:</p> <ul style="list-style-type: none"> <li>-She does not do any CNA education or CNA competencies;</li> <li>-She does not do annual training or competencies for CNAs or for all employees.</li> </ul> <p>During an interview on 5/22/24 at 3:16 P.M., the Business Office Manger (BOM) confirmed the CNA's hire dates and provided a copy of their training record. She does not have any other training information.</p> <p>During an interview on 5/23/24 at 6:49 P.M., the Interim Director of Nursing said the following:</p> <ul style="list-style-type: none"> <li>-The facility was trying to implement a computer software training system but they had not accomplished that yet;</li> <li>-There was no training schedule.</li> </ul> <p>42592</p>		