STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265438	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Manor	710 Broadridge Jackson, MO 63755

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the bed hold rate and reason for transfer for four residents (Residents #14, #16, #53, and #85) out of six sampled residents. The facility's census was 66.Review of the facility's policy titled, Discharge/Transfer – Involuntary, dated 10/07/21, showed: - The facility must provide a written notice to the resident, and if known, a family member or legal representative of the resident prior to the resident being transferred or discharged ; - The written discharge notice must contain the reason for transfer or discharge, the date of transfer, and the location to which the resident is transferred or discharged . Review of the facility's policy titled, Resident Bed Hold, dated 11/15/22, showed: - The facility will have a process in place to ensure residents and/or their representatives are made aware of the facility's bed hold and reserve bed payment policy in advance of being transferred to the hospital or when taking therapeutic leave of absence from the facility; - The facility will provide written information about these policies to the resident and/or representative prior to and upon transfer for such absences. 1. Review of Resident #14's medical record showed: - Transferred to the hospital on [DATE], and readmitted to the facility on [DATE]; - No documentation the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of the transfer; - No documentation of the bed hold rate; - No documentation of the reason for the transfer. 2. Review of Resident #16's medical record showed: - Transferred and admitted to the hospital on [DATE], and readmitted to the facility on [DATE]; - No documentation the resident's representative was informed in writing of the transfer/discharge to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a hospital at the time of transfer; - No documentation of the bed hold rate; - No documentation of the reason for transfer. 3. Review of Resident #53's medical record showed: - Transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer; - No documentation of the bed hold rate; - No documentation of the reason for transfer. 4. Review of Resident #85's medical record showed: - Transferred to the hospital on [DATE], and returned to the facility on [DATE]; - Transferred to the hospital on [DATE], and returned to the facility on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - Transferred to the hospital on [DATE] and returned to the facility on [DATE]; - No documentation the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer on 06/17/25, 06/30/25, 07/05/25, and 07/09/25; - No documentation of the bed hold rate on 06/17/25, 06/30/25, 07/05/25, and 07/09/25; - No documentation of the reason for transfer on 06/17/25, 06/30/25, 07/05/25, and 07/09/25. - No documentation the resident's representative was informed in writing of the transfer/discharge to a hospital at the time of transfer; During an interview on 08/22/25 at 9:24 A.M., the Social Services Designee (SSD) said nursing was responsible for filling out the transfer/bed hold form at the time of transfer. During an interview on 08/22/25 at 9:28 A.M., the Business Office Manager (BOM) said he/she had sheets that told the bed hold amount but did not see the listed amount on the bed hold document filled out at transfer. During an interview on 08/22/25 at 9:30 A.M., Licensed Practical Nurse (LPN) D said he/she filled out the transfer/bed hold form but did not fill in the bed hold amount. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/25 at 9:30 A.M., Registered Nurse (RN) C said he/she did not have access to the bed hold rates. Nursing was not privy to the financial information. During an interview on 08/22/25 at 12:20 P.M., the BOM said he/she used to send out the transfer/bed hold notices to the resident's responsible party, but now nursing did them since the facility had hired two Assistant Directors of Nursing (ADON). During an interview on 08/22/25 at 12:23 P.M., ADON I said nursing informed the resident representative in person or over the phone. The transfer/bed hold notices were mailed to the resident representative by the BOM. During an interview on 08/22/25 at 3:50 P.M., the Administrator said she would expect residents or resident representative to be notified in writing of a transfer, a reason for the transfer, and the bed hold rate at the time of transfer in a language they could understand.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to obtain and follow physician's orders for four residents (Residents #1, #5, #49, and #56) out of 17 sampled residents. The facility census was 66.Review of the facility policy titled, Physician Orders, last reviewed 09/28/22, showed: - Physician orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners and Physician's Assistants) authorized to prescribe orders; - Orders must be recorded in the medical record by the Licensed Nurse authorized to transcribe such orders; - Physician orders must be documented clearly in the Medical Record. The required components of a complete order are date and time of order, name of practitioner providing order, name and strength of medication/treatment, quantity/duration, dosage/frequency, route of administration, indication/diagnosis, and stop date, if indicated; - Physician orders that are missing required components, are illegible or unclear must be clarified prior to implementation; - Physician Order Sheet (POS) will be maintained with current physician orders as new orders are received. Discontinued orders will be marked as discontinued with the date, and all new orders will be written in the appropriate area on the physician order with the date the order was received; - Physician orders will be transcribed to the appropriate administration record: medication administration record (MAR) or treatment administration record (TAR); - Physicians and Physician Extenders will review and sign their physician orders at least every 30 days, or as required by state regulations; - Pharmacy monthly review of the physician orders will be completed to assure appropriateness, accuracy, and completeness. 1. Review of Resident #1's medical record showed: - admission date of 05/04/25; - Diagnosis of end stage renal disease (kidneys do not filter or remove fluid as it should); - An order for Zosyn (an antibiotic) intravenous (IV - administered through the vein) solution 3-0.375 grams/50 milliliters (ml) four times a day for nine days for urinary tract infections (UTI - infection in the urinary tract), dated 08/17/25; - No order for an IV catheter. Review of the resident's MAR and TAR, dated August 2025, showed Zosyn not administered on 08/20/25 at 6 A.M., and 6 P.M., and 08/21/25 at 6 A.M., with three doses missed out of 15 doses. Observation on 08/21/25 at 8:35 A.M., of the resident showed the resident with 22 gauge IV to right (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forearm with undated clear dressing. During an interview on 08/21/25 at 8:35 A.M., the resident said he/she had the IV put in a couple days ago by someone in the facility and had not had any issues with it so far. Observation on 08/21/25 at 12:35 P.M., showed Registered Nurse (RN) F flushed the resident's IV with normal saline with difficulty and connected to the Zosyn medication. The Zosyn medication leaked from the IV site and RN stopped the Zosyn infusion. 2. Review of Resident #5's medical record showed: - admission date of 02/17/25; - Diagnoses of severe hypoxic ischemic encephalopathy (brain damage caused by a lack of oxygen), acute and chronic respiratory failure (a condition in which the blood doesn't have enough oxygen or has too much carbon dioxide), major depressive disorder (long-term loss of pleasure or interest in life), anxiety disorder (persistent worry and fear about everyday situations), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), and tracheostomy (a breathing tube surgically placed into the wind pipe to get oxygen to the lungs); - An order for weekly weights every Wednesday, dated 04/18/25. Review of the resident's weight summary showed: - No weight recorded for 04/30/25, 05/07/25, 05/21/25, 05/28/25, 06/04/25, 07/09/25, and 07/16/25, for a total of seven missed opportunities out of 17 opportunities. 3. Review of Resident #49's medical record showed: - admission date of 12/13/24; - Diagnoses of microcephaly (small head due to abnormal brain development, dysphagia (difficulty eating and swallowing), and reduced mobility; - An order for weekly weights one time a day every Wednesday for tube feeding/monitor, order dated 03/17/25. Review of weekly weights, dated July through August 2025, showed no weight recorded on 07/0725, 07/14/25, or 07/21/25, with three missed opportunities out of 12 opportunities. During an interview on 08/22/25 at 10:20 A.M., Registered Nurse (RN) C said the restorative aide did the weights, but Certified Nurse Assistants (CNAs) and nurses could do them too. During an interview on 08/22/25 at 10:31 A.M., Restorative Aide E said he/she was mostly responsible for the weights. He/She weighed the resident usually on Mondays and residents with tube feedings were weighed weekly unless he/she was told otherwise if a resident was supposed to get weighed daily by the nursing staff and the dietitian. Once he/she weighed the resident, then he/she (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gave the information to the nurses to document in the computer. 4. Review of Resident #56's medical record showed: - admission date 12/27/23; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), encephalopathy (acute inflammation of the brain), hyperlipidemia (high blood level of cholesterol), hypertension (high blood pressure), anxiety (persistent worry and fear about everyday situations), and Alzheimer's disease (progressive mental deterioration); - An order to monitor resident's pulse oximetry every day, dated 06/17/25; - From 06/17/25 through 07/14/25, the resident's pulse oximetry was not documented; - On 07/17/25 - 08/01/25, 08/04/25 - 08/12/25, 08/14, 08/15/25 - 08/17/25, and 08/19/25 - 08/22/25, the resident's pulse oximetry was not documented with 56 missed opportunities out of 66 opportunities. During an interview on 08/22/25 at 3:50 P.M., the Director of Nursing (DON) and the Administrator said they would expect staff to follow physician's orders as ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide necessary services to maintain grooming, and personal hygiene for two residents (Residents #53 and #85) out of eight sampled residents. The facility census was 66.Review of the facility's policy titled, Activities of Daily Living (ADL) Care Bathing, dated 07/21/22, showed:- Nursing staff will assist in bathing residents to promote cleanliness and dignity;- The policy did not address how often showers will be given. Review of Resident Shower Schedule, undated, showed:- Resident #53 scheduled for showers two times weekly on Tuesday and Friday;- Resident #85 scheduled for showers two times weekly on Wednesday and Saturday. 1. Review of Resident #53's medical record showed:- An admission date of 06/17/25;- Diagnoses of type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), need for assistance with personal care, hypertension (high blood pressure), anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, or panic that interfere with daily life), depression (a serious mood disorder that affects daily life, including sleep, eating, and work, and requires treatment for symptoms like a persistent sad mood, loss of interest, fatigue, and suicidal thoughts), unspecified dementia (when cognitive and functional decline consistent with dementia is present, but the specific underlying cause cannot be determined or the condition is complicated by other co-existing conditions), and cerebral infarction (stroke). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment to be completed by the facility), dated 07/09/25, showed:- Severely impaired cognition;- Maximal assistance with dressing and personal hygiene;- Dependent with toileting;- Dependent for bathing/showering. Review of the resident's Shower Sheets, dated 07/01/25 - 08/22/25, showed in July, the resident scheduled for showers on 07/08/25, 07/11/25, 07/22/25 and 07/25/25 but did not receive them. The resident noted to have refused a shower on 07/18/25 and 07/26/25 with no evidence of reattempts made. Resident #53 missed six of nine opportunities for a shower, receiving a total of three showers total for the month of July 2025. Observation on 08/21/25 at 10:19 A.M., of the resident showed the resident lay in bed with unkempt and dirty hair. 2. Review of Resident #85's Medical Record showed:- An admission date of 04/16/25;- Diagnoses of congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), unspecified dementia, type II diabetes, and depression. Review of the resident's admission MDS, dated [DATE], showed:- Cognitive status intact;- Independent with dressing, toileting, and personal hygiene;- Resident refused bathing/showering assessment. Review of the resident's Shower Sheets, dated 05/13/25 - 08/22/25, showed:- In May, resident did not receive a shower as scheduled on 05/14/25, 05/21/25, and 05/28/25; Resident refused showers on 05/13/25, 05/20/25, and 05/23/25 with no documentation of reattempt, and 05/28/25 with two attempts documented. Resident #85 received two of nine scheduled showers in May 2025; - In June, the resident did not receive a shower as scheduled on 06/04/25, 06/14/25, and 06/28/25; - In August, the resident did not receive a shower as scheduled on 08/09/25 and 08/13/25; Observations of Resident #85 showed:- On 08/19/25 at 11:30 A.M., the resident sleeping in wheelchair. Hair was long and unkempt;- On 08/20/25 at 9:43 A.M., of the resident sitting up in wheelchair. Hair was long and unkempt;- On 08/21/25 at 8:46 A.M., the resident sat in a wheelchair with hair appears [NAME] and glossy, with strands clumping together from excess oil. Noticeable musty odor present upon close proximity. During an interview on 08/22/25 at 3:50 P.M., the Administrator and Director of Nursing (DON) said they would expect residents to be offered and/or assisted with showers at least two times a week.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to change and date the oxygen tubing (a flexible tube that connects to the oxygen concentrator and delivers supplemental oxygen through the nostrils) and the humidifier bottle per physician orders. This practice affected one resident (Resident #14) out of two sampled residents. The facility census was 66.Facility did not provide a policy regarding oxygen tubing and humidification. 1. Review of Resident #14's medical record showed: - admission date of 04/16/24; - Diagnoses of chronic respiratory failure with hypoxia, dependence on supplemental oxygen; - An order to change oxygen tubing and storage bag weekly one time a day every Sunday, dated 11/24/24; - An order for oxygen at three liters continuous via nasal cannula, dated 11/01/24; - An order for changing the humidifier bottle on oxygen concentrator humidifier tubing, tubing, and water in oxygen humidifier one time a day every Tuesday, dated 11/05/24. Review of the resident's August 2025 Registered Nurse (RN)/Licensed Practical Nurse (LPN) Medication Administration Record (MAR) showed: - The oxygen tubing and the oxygen storage bag changed by staff on 08/03/25, 08/10/25, and 08/17/25; - The humidifier bottle and tubing changed by staff on 08/05/25, 08/12/25, and 08/19/25. Observations on 08/19/25 at 10:26 A.M., 08/20/25 at 8:45 A.M., 08/21/25 at 9:50 A.M., and 08/22/25 at 3:00 P.M., of the resident showed: - The resident wore three liters per minute oxygen by nasal cannula with oxygen tubing labeled 08/04/25, and oxygen humidifier canister empty and labeled 08/04/25; During an interview on 08/19/25 at 12:48 P.M., the resident said he/she wore oxygen all the time and staff changed the tubing but did not know how often, and staff were supposed to fill the humidifier canister, but it ran out of water sometimes. During an interview on 08/22/25 at 3:00 P.M., the resident said he/she had not seen anyone change his/her oxygen tubing or fill the humidifier canister yet. During an interview on 08/22/25 at 10:20 A.M., RN C said the night nurse was responsible for changing oxygen tubing and filling up humidifier canisters. It should be documented on the medication administration record (MAR) and oxygen tubing was usually changed on Sunday nights and humidifier canisters were filled when they needed it. A label should be placed on new tubing or the canister with the date, time, and initials of who changed it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/25 at 3:50 A.M., the Director of Nursing (DON) said she expected oxygen tubing to be changed weekly, and the humidifier canisters filled as needed. She said it should be documented on the MAR and the tubing should be labeled with date when it was changed. It should not be documented as changed if it wasn't done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain proper infection control practices when providing gastrostomy tube (g-tube - a feeding tube inserted into the stomach to provide nutrition, fluids, and medication) care for one resident (Resident #49) out of three sampled residents, when providing blood sugar checks for one resident (Resident #14) out of three sampled residents, when providing insulin to two residents (Residents #14 and #69) out of three sampled residents, and for catheter (a tube inserted into the bladder to drain urine) drainage bag care for one resident (Resident #1) out of one sampled resident. The facility census was 66.Review of the facility policy titled, Hand Hygiene, reviewed 04/28/22, showed:- Employees will be trained and receive ongoing education on the importance of hand hygiene in preventing the transmission of Healthcare-Associated Infections (HAI);- Hand hygiene should be performed following before/after providing care, contact with blood, body fluids, or contaminated surfaces, before/after applying/removing gloves/personal protective equipment (PPE), and after handling soiled items potentially contaminated with blood, bodily fluids, or secretions. Review of the facility policy titled, Enhanced Barrier Precautions (EBP), last reviewed 05/15/24, showed:- The use of gown & gloves for high-contact resident care activities is indicated. when contact precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of multidrug-resistant organisms (MDRO) colonization as well as for residents with MDRO infection/colonization;- Examples of high-contact resident care activities requiring gown & glove use for enhanced barrier precautions (EBP) include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or toileting, device care like central line, urinary catheter, enteral tube, tracheostomy/ventilator, and wound care where skin opening requiring a dressing;- Incorporate periodic monitoring/evaluation of adherence to infection prevention practices to determine the need for additional training/education. Provide education to residents/visitors.Review of the facility policy titled, Standard Precautions, dated 10/25/22, showed:- Wear gloves when touching blood, body fluids, secretions, contaminated items with mucus membranes and nonintact skin. Review of the facility policy titled, Catheter Care, dated 07/13/22, showed:- Did not address the care of the catheter tubing and/or the catheter drainage bag. 1. Observation on 08/19/25 at 11:19 A.M., of Resident #49's g-tube care showed: - Signage for EBP;- Licensed Practical Nurse (LPN) D entered the room, did not put on a gown, performed hand hygiene, and put on gloves;- LPN D performed the g-tube care. During an interview on 08/22/25 at 10:20 A.M., Registered Nurse (RN) C said a gown and gloves should be worn when doing care on someone with EBP. 2. Observations of Resident #1's catheter drainage bag showed:- On 08/19/25 at 11:55 A.M., and 08/21/25 at 8:35 A.M., the resident sat in a wheelchair in his/her room, the urinary catheter bag hung on the wheelchair, and the bag touched the wheelchair wheel; - On 08/22/25 at 7:55 A.M., staff propelled the resident in his/her wheelchair through the facility and outside to the transportation vehicle. The resident's catheter drainage bag hung on the wheelchair and rubbed against the wheel. 3. Observation on 08/20/25 at 8:12 A.M., of Resident #14's blood sugar check and insulin administration showed:- Certified Medication Technician (CMT) A performed hand hygiene, did not put on gloves, and checked the resident's blood sugar and administered the insulin.During an interview on 08/21/25 at 3:58 P.M., CMT A said he/she should get all supplies, wash hands, and wear gloves when checking blood sugars and administering insulin. He/She should rewash hands and reapply gloves between tasks.4. Observation on 08/20/25 at 9:40 A.M., of Resident #69's insulin administration showed:- CMT A did not perform hand hygiene, did not put on gloves, and administered the resident's insulin. During an interview on 08/22/25 at 3:50 P.M., the Director of Nursing (DON) and the Administrator said they would expect staff to wash hands and wear gloves when checking blood sugars and administering insulin. They would expect staff to wear appropriate PPE when doing care on residents with EBP. During an interview on 08/28/25 at 10:30 A.M., the Administrator said she would expect urinary catheter bags to not touch or rub the wheels of the wheelchair.