STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265447	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McDonald County Living Center	1000 Patterson Street Anderson, MO 64831

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52063 Based on observations, interviews, and record review, the facility failed provide pressure ulcer prevention care per standards of practice when staff failed to ensure all staff were aware of a new order for placement of protective heel boots, that the intervention was consistently implemented, and that the new intervention was care planned for one of one sampled residents (Resident #23). Review of the facility's policy, Pressure Ulcer, Care and Prevention Of, undated, showed the purpose of the policy was to prevent and treat further breakdown of pressure sores. Treatment of pressure ulcers varies depending on the orders of the attending physician. The nurse was responsible for carrying out the treatment as ordered by the attending physician and for implementing measure to prevent pressure ulcers. Heel protectors was one of the listed interventions. Review of the facility's policy, Positioning the Resident, undated, showed the purpose of the policy was to relieve pressure and prevent skin breakdown, to relieve pain, and to promote proper body alignment. Staff to use protective devices as indicated. 1. Review of Resident #23's Face Sheet, in the Electronic Medical Record (EMR), showed the following: -admitted [DATE]; -Diagnoses included unspecified dementia without behavioral disorder and need for assistance with personal care. Review of the resident's Significant Change Minimum Data Set (MDS - an federally mandated assessment tool complete by facility staff) assessment, dated 11/15/24, showed the following: -Resident was severely cognitively impaired; -Resident at risk for developing pressure ulcers; -Resident had no unhealed pressure ulcers at the time of the assessment. Review of the resident's Comprehensive Care Plan, revised 11/15/24, showed the following: (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident at risk for pressure ulcer/injury related to limited mobility and a history of urinary incontinence; -Staff to report any signs of skin breakdown (sore, tender, red, or broken areas). Review of the resident's nursing progress note dated 12/06/24, at 1:31 A.M., showed heels red, dry area to back of right heel, skin prep applied, and heels elevated on pillow at this time. Review of the resident's Active Orders, showed an order, dated 12/06/24, for heel boots while in bed. Review of the resident's Treatment Administration Record (TAR) showed an order, dated 12/06/24, for Booties to heels while in bed. Review of the resident's Comprehensive Care Plan, revised 11/15/24, showed staff did not update the care plan to reflect the new order for heel boots. Observation on 12/09/24, at 9:30 A.M., showed the resident in bed with his/her eyes closed. One padded cloth heel boot was lying on the bed near the resident's left foot. The boot was not on his/her foot. Observation on 12/09/24, at 2:50 PM, showed the resident was not in his room. Two padded heel boots were visible in the partially open bedside dresser drawer. Observation on 12/10/24, at 8:39 AM, showed the resident was lying in bed and covered with a blanket. Both of his/her feet were exposed. The resident was not wearing heel boots. Observation on 12/10/24, at 10:08 AM, showed the resident was in bed and positioned on his right side. The resident was not wearing heel boots. The top drawer of the resident's bedside chest of drawers was partially open and the heel boots were resting in the drawer. During an interview on 12/10/24, at 3:40 P.M., Certified Nursing Assistant (CNA) 1 said at about 9:00 A.M. yesterday, he/she assisted the resident's hospice nurse with putting him/her back to bed. When asked to open the top drawer of the resident's bedside chest, the CNA confirmed he/she saw the boots in the drawer and he/she thought they were for protection of the resident's heels. He/she said the hospice nurse or one of the nurse managers may have put the heel boots in the resident's drawer, but he/she was unsure. The CNA said he/she had not been directed to place the heel boots on the resident while he/she was in bed. The heel boots were for the prevention of skin breakdown. During an interview on 12/11/24, at 7:38 AM, CNA 2 said he/she saw the resident's heel boots on his/her dresser this morning, so he/she placed them on his heels. Concurrent observation during the interview confirmed the resident was wearing heel boots. CNA 2 said he/she did not have difficulty getting the resident to wear protective heel boots. During an interview on 12/10/24, at 2:30 P.M., Licensed Practical Nurse (LPN) 2 confirmed the resident had an order for protective heel boots, but the resident would kick off the boots when staff tried to place them. During shift change report staff should have learned the resident was supposed to wear heel boots when lying in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24, at 8:11 AM, the Director of Nursing (DON) said the resident was supposed to wear heel boots in bed because he/she did not self-adjust in bed, and he/she had some softness to his/her heels. The boots were for the prevention of skin breakdown. The nurse who added the order to the TAR should have also added the intervention to the Point of Care (PoC) tracking system, under miscellaneous tasks, which would have then been viewable by the CNAs who provided resident care. Facility managers should ensure necessary resident care interventions were in place while conducting daily rounds on their assigned hallways. The resident's comprehensive care plan should have included the heel boots intervention for pressure ulcer prevention. Staff should have ensured the resident's heel boots were on while he was in bed, as directed by the physician's order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30347 Based on observation, interview, and record review, the facility failed to ensure food was protected from possible contamination at all times when kitchen staff failed to air-dried bowls and pans prior to storage for use. This failure had the potential to increase the risk of food borne illness and had the potential to affect all 54 residents who resided in the facility and who received dietary services. Review of the facility's policy titled, Dishwashing and Storage, undated, showed the following: -Air-dry all items. Never use a towel to dry items. Make sure items are completely dry before stacking or storing them. Store them in a way that will protect them from contamination. 1. Observation and interview on 12/09/24, at 9:45 A.M., showed the following: -Five soup bowls stacked together that were still wet from washing and had not been allowed to fully air dry; -Cook (C) 1 said the bowls should be dry before they are stacked to help prevent contamination. Observation and interview on 12/09/24, at 9:54 A.M., showed the following: -Four pans, 6 inches by 10 inches by 6 inches deep, had been cleaned and stacked for use and were found to be still wet when they were unstacked. The pans were not allowed to fully air dry. -The pans were wet and staff didn't let them fully air dry before they stacked them.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on interview and record review, the facility failed to have a system to ensure consistent communication and collaboration of care occurred between the facility and hospice staff for one resident (Resident #39) of one resident reviewed for hospice services. Review showed the facility did not provide a policy related to coordination of hospice services. 1. Review of Resident #39's Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included heart failure, lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), and palliative (comfort) care. Review of the resident's Minimum Date Set (MDS - a federally mandated assessment completed by facility staff), with a Assessment Reference Date (ARD) of 09/11/24, located under the MDS tab of the EMR, showed the resident was severely cognitively impaired. Review of the resident's current Care Plan, located in the EMR under the Care Plan tab, showed staff care planned the resident receiving hospice services. Staff noted hospice will work with the facility to ensure goals and approach are appropriate and will work as a team to meet needs, and that I have a peaceful/comfortable end of life. Review of the resident's EMR showed no documentation of hospice evaluation(s), or hospice visits notes. Review of the hospice communication book, from current hospice provider, showed no documentation of hospice evaluation, or hospice visit notes. During an interview on 12/11/24, at 3:15 P.M., the Medical Records (MR) Staff said the current hospice provider began service as of 10/25/24. After reviewing the resident's EMR and hospice communication book, there was no record of an evaluation being completed and no written notes available for review of the care being provided by hospice staff. The only records listed in the communication book was the visit tracking log of when they visited. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24, at 3:40 P.M., the MR said the hospice staff were supposed to check out with the Administrator when they completed their visits. The Administrator had access to the hospice EMR and could look up their information. The hospice nurses talk with the facility nurses and they will then document the information if needed. The facility staff do not have access to the hospice EMR, and hospice does not document in the facility EMR. The notes that hospice makes are not in the facility EMR. During an interview on 12/11/24, at 4:10 P.M., the Administrator said the Hospice nurse was supposed to check out with the nurse and the nurse manager. The facility staff responded to the information provided. The hospice certified nursing assistant (CNA) are supposed to check out with the nurse and the nurse manager and Administrator. We have a Journey meeting (a meeting to discuss the resident's care) with hospice and hospice documents the minutes from these meetings. The facility does not have them. The hospice book for the resident was reviewed and there was no information available to review. The hospice communication book did not have any notes in it.