STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Vernon Nursing	1425 South Landrum Mount Vernon, MO 65712

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 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41787

Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of a transfer to the hospital for three residents (Residents #20, #40 and #36) of three sampled residents. The facility census was 43.

Review of the facility form titled Resident Transfer Form to ER (emergency room), dated December 2015, showed the following to be completed by facility staff:

-Date of transfer to the ER;

-Resident name, date of birth;

-Next of kin or health care power of attorney name and telephone number and whether notified;

-Resident's diagnosis, functional status;

-Reason for transfer to ER.

Review of the facility form titled Notice of Transfer/Discharge Missouri, undated, showed the following to be completed by facility staff:

-Resident name, facility name, Administrator, and phone number;

-Date of transfer,

-Reason for transfer

-Right to appeal with phone numbers and addresses to appeal.

1. Review of Resident #20's face sheet (brief information sheet about the resident) showed the following:

-admitted [DATE];

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 South Landrum Mount Vernon, MO 65712	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included quadriplegia (partial or complete paralysis (loss of the ability to move) of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), heart failure (condition in which the heart doesn't pump blood as well as it should), schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), and neuromuscular dysfunction of bladder (loss of bladder control, inability to empty bladder). Review of the resident's progress notes showed staff documented the following: -On 09/12/24, at 10:02 A.M., the resident complained of feeling very weak. The certified nurse aide (CNA) reported the resident was leaning to left side while up in wheelchair. Vital signs taken showed blood pressure 152/92 (normal 120/80), pulse 90 (normal 60 to 100, pulse oximeter 61% (normal above 92%), respirations were even and unlabored. Staff reported that the resident had been very difficult to transfer due to weakness and the resident was unable to hold legs up while propelled in wheelchair. Physician notified and resident transferred to emergency room for evaluation. Review of the resident's medical record showed facility staff did not provide a written transfer notification letter to the resident or the resident's representative. Review of the resident's progress notes showed staff documented the following: -On 09/25/24, at 1:01 P.M., therapy staff reported to the nurse the resident's heart rate was reading at 237 on the pulse oximeter monitor. The nurse was unable to obtain a manual heart rate due to very fast and irregular heart rate. Heart rate now ranging from 160s to 230s. Oxygen level reading ranging from 76 to 86% on 3 liters of oxygen. Resident stated not in pain, just felt light-headed. Physician notified and EMS contacted. Face sheet, medication list, and transfer to ER paperwork sent with resident and EMS. Resident's responsible party notified by phone. Review of the resident's medical record showed facility staff did not provide a written transfer notification letter to the resident or the resident's representative. 2. Review of Resident #40's face sheet showed the following: -admitted [DATE]; -Diagnosis included pulmonary embolism (one or more arteries in the lungs become blocked by a blood clot), atrial fibrillation (fast and irregular and often very rapid heart rate that can lead to blood clots in the heart), heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and iron deficiency anemia (too few healthy red blood cells due to too little iron in the body). Review of the resident's progress notes showed staff documented the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Vernon Nursing	1425 South Landrum Mount Vernon, MO 65712

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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 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-On 10/04/24, at 12:05 A.M., the CNA found the resident on the floor. The CNA notified the nurse. The resident was noted to be laying on the floor on his/her right side with pillow under his/her head. The resident stated he/she was going to the bathroom. Redness noted to the cheek, shoulder, ear, and hip. Resident also had a 3 by 1 centimeter (cm) abrasion to right lateral back and denied pain. Neuro checks (series of tests and questions that evaluate a person's nervous system) and range of motion was within normal limits. Two staff transferred with gait belt (device used to help people with mobility issues move safely) from floor to bed. Resident tolerated well. Oxygen saturation noted to be at 88%. Staff initiated oxygen and notified physician and administrator;

-On 10/04/24, at 12:30 A.M., staff notified the physician by phone the resident's oxygen saturation went from 88% on room air to 75% with oxygen on at 3 L by nasal cannula (NC - device used to give additional oxygen through the nose) after fall and now resident complained of severe pain when breathing deep and coughing. New order was provided to send the resident to the emergency room to evaluate and treat. Notified resident's representative of fall, condition, and order to send to the hospital. Administrator was notified of hospital transfer;

-On 10/04/24, at 1:00 A.M., emergency medical services (EMS) left with resident at 12:50 A.M.

Review of the resident's medical record showed facility staff did not provide a written transfer notification letter to the resident or the resident's representative.

3. Review of Resident # 36's face sheet showed the following information:

-admitted [DATE];

-Diagnoses included diabetes, viral hepatitis (an infection that causes liver inflammation and damage), pneumonia, depression, and obesity.

Review of the resident's progress notes showed staff documented the following:

-On 10/08/24, at 8:20 A.M., the nurse documented that the resident was displaying severe confusion and anxiety, continuously yelling out for help instead of using his/her call light and stating he/she can't breathe, doesn't know where he/she is, thought his/her leg had been stabbed and thought he/she was gushing blood. These behaviors were not normal for the resident. Vital signs taken showed all within normal limits. The resident was her own person and the resident requested that the nurse speak with the resident's daughter. The daughter was notified and requested that the resident be sent to the hospital for evaluation. The physician was notified. Emergency Medical Services were notified and arrived to transport the resident.

Review of the resident's medical record showed facility staff did not provide a written transfer notification letter to the resident or the resident's representative.

4. During an interview on 10/10/24, at 1:20 P.M., Licensed Practical Nurse (LPN) E said the nursing staff have transfer packets that included a transfer form that was completed and given to the EMTs, along with copy sent to medical records office. The nurse contacted the family by phone for transfer notice. He/she did not send any information in writing to the resident or resident's representative.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 South Landrum Mount Vernon, MO 65712	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 10/10/24, at 1:30 P.M., the Infection Preventionist said that when a resident was sent to the hospital the nursing staff complete the transfer form and send with EMS. The nurse notified family by phone. He/she did not mail any information to family. He/she did ensure a copy of the transfer form was given to medical records. 6. During an interview on 10/10/24, at 1:40 P.M., the Director of Nursing (DON) said when a resident was sent to the hospital the nursing staff completed a transfer form and sent with EMS. This information included all resident pertinent medical history. The nurses contact the family/guardian by phone. 7. During an interview on 10/10/24, at 1:55 P.M., with the Administrator and Medical Records. The Administrator said the nursing staff complete a transfer form that was sent with EMS when transferring a resident. The form included all pertinent medical history. The nursing staff contact family and guardians by phone. 48187

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265452	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Vernon Nursing	1425 South Landrum Mount Vernon, MO 65712

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of the bed hold policy for a transfer to the hospital for three residents (Residents #20, #40 and #36) of three sampled residents. The facility census was 43. Review of the facility policy titled, Bed Hold Policy and Agreement Form, dated February 2014, showed the following: -Purpose to establish policy and procedure for facility to notify the resident/responsible party of the bed hold policy and agreement to pay charges for bed hold; -The bed hold agreement is to be obtained for each occurrence, hospital or therapeutic home leave; -When hospital or therapeutic home leave is reported on the midnight census, the business office will notify the resident/responsible party to sign the bed hold agreement; -The business office will address weekend or holiday transfers on the next business day; -A telephone call may be documented as notification of bed hold agreement. 1. Review of Resident #20's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included quadriplegia (partial or complete paralysis (loss of the ability to move) of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), heart failure (condition in which the heart doesn't pump blood as well as it should), schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), and neuromuscular dysfunction of bladder (loss of bladder control, inability to empty bladder). Review of the resident's progress notes showed staff documented the following: -On 09/12/24, at 10:02 A.M., the resident complained of feeling very weak. The certified nurse aide (CNA) reported the resident was leaning to left side while up in wheelchair. Vital signs taken showed blood pressure 152/92 (normal 120/80), pulse 90 (normal 60 to 100, pulse oximeter 61% (normal above 92%), respirations were even and unlabored. Staff reported that the resident had been very difficult to transfer due to weakness and the resident was unable to hold legs up while propelled in wheelchair. Physician notified and resident transferred to emergency room for evaluation. Review of the resident's medical record showed facility staff did not provide a written transfer notification letter to the resident or the resident's representative. Review of the resident's progress notes showed staff documented the following: (continued on next page)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 09/25/24, at 1:01 P.M., therapy staff reported to the nurse the resident's heart rate was reading at 237 on the pulse oximeter monitor. The nurse was unable to obtain a manual heart rate due to very fast and irregular heart rate. Heart rate now ranging from 160s to 230s. Oxygen level reading ranging from 76 to 86% on 3 liters of oxygen. Resident stated not in pain, just felt light-headed. Physician notified and EMS contacted. Face sheet, medication list, and transfer to ER paperwork sent with resident and EMS. Resident's responsible party notified by phone. Review of the resident's medical record showed facility staff did not provide a written bed hold notification to the resident or the resident's representative. 2. Review of Resident #40's face sheet showed the following: -admitted [DATE]; -Diagnosis included pulmonary embolism (one or more arteries in the lungs become blocked by a blood clot), atrial fibrillation (fast and irregular and often very rapid heart rate that can lead to blood clots in the heart), heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and iron deficiency anemia (too few healthy red blood cells due to too little iron in the body). Review of the resident's progress notes showed staff documented the following: -On 10/04/24, at 12:05 A.M., the CNA found the resident on the floor. The CNA notified the nurse. The resident was noted to be laying on the floor on his/her right side with pillow under his/her head. The resident stated he/she was going to the bathroom. Redness noted to the cheek, shoulder, ear, and hip. Resident also had a 3 by 1 centimeter (cm) abrasion to right lateral back and denied pain. Neuro checks (series of tests and questions that evaluate a person's nervous system) and range of motion was within normal limits. Two staff transferred with gait belt (device used to help people with mobility issues move safely) from floor to bed. Resident tolerated well. Oxygen saturation noted to be at 88%. Staff initiated oxygen and notified physician and administrator; -On 10/04/24, at 12:30 A.M., staff notified the physician by phone the resident's oxygen saturation went from 88% on room air to 75% with oxygen on at 3 L by nasal cannula (NC - device used to give additional oxygen through the nose) after fall and now resident complained of severe pain when breathing deep and coughing. New order was provided to send the resident to the emergency room to evaluate and treat. Notified resident's representative of fall, condition, and order to send to the hospital. Administrator was notified of hospital transfer; -On 10/04/24, at 1:00 A.M., emergency medical services (EMS) left with resident at 12:50 A.M. Review of the resident's medical record showed facility staff did not provide a written bed hold notification to the resident or the resident's representative. 3. Review of Resident # 36's face sheet showed the following information: -admitted [DATE]; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 South Landrum Mount Vernon, MO 65712	

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included diabetes, viral hepatitis (an infection that causes liver inflammation and damage), pneumonia, depression, and obesity. Review of the resident's progress notes showed staff documented the following: -On 10/08/24, at 8:20 A.M., the nurse documented that the resident was displaying severe confusion and anxiety, continuously yelling out for help instead of using his/her call light and stating he/she can't breathe, doesn't know where he/she is, thought his/her leg had been stabbed and thought he/she was gushing blood. These behaviors were not normal for the resident. Vital signs taken showed all within normal limits. The resident was her own person and the resident requested that the nurse speak with the resident's daughter. The daughter was notified and requested that the resident be sent to the hospital for evaluation. The physician was notified. Emergency Medical Services were notified and arrived to transport the resident. Review of the resident's medical record showed facility staff did not provide a written bed hold notification to the resident or the resident's representative. 4. During an interview on 10/10/24, at 1:20 P.M., Licensed Practical Nurse (LPN) E said the nursing staff have transfer packets that included a transfer form that was completed and given to the EMTs, along with copy send to medical records office. The nurse contacted the family by phone for bed hold. He/she did not send any information in writing to the resident or resident's representative. 5. During an interview on 10/10/24, at 1:30 P.M., the Infection Preventionist said that when a resident was sent to the hospital the nursing staff complete the transfer form and send with the EMTs. The nurse notified family by phone. She did not mail any information to family. She did ensure a copy of the bed hold was given to medical records. The bed hold consent was most of the time provided verbally by phone. 6. During an interview on 10/10/24, at 1:40 P.M., the Director of Nursing (DON) said when a resident was sent to the hospital the nursing staff completed a transfer form and send with EMS. This information included all resident pertinent medical history. The nurses contact the family/guardian by phone. The bed hold was filled out at the time of transfer and sent with the resident or they notified the family by phone. 7. During an interview on 10/10/24, at 1:55 P.M., with the Administrator and Medical Records. The Administrator said the nursing staff complete a bed hold form that was sent with EMS when transferring a resident. The nursing staff contact family and guardians by phone. 48187

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER: MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 1425 South Landrum Mount Vernon, MO 65712	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, record review, and interview, the facility failed to provide care per standards of practice when staff failed complete blood glucose monitoring by finger stick without a physician order to do so for one resident (Resident #25) when the Freestyle glucose monitor (continuous glucose monitoring device) was not available. The facility census was 43. Review showed the facility did not provide a policy related to physician orders. Review of the FreeStyle Libre Sensor prescribing information, dated 2021, showed the following information: -The FreeStyle Libre 14 day Flash Glucose Monitoring System is a continuous glucose monitoring (CGM) device indicated for the management of diabetes in persons age 18 and older; -It is designed to replace blood glucose testing for diabetes treatment decisions; -The System detects trends and tracks patterns aiding in the detection of episodes of hyperglycemia (high blood glucose levels) and hypoglycemia (low blood glucose levels); -Interpretation of the System readings should be based on the glucose trends and several sequential readings over time; -Check Sensor glucose readings by conducting a finger stick test with a blood glucose meter under the following conditions, when Sensor glucose readings may not be accurate and should not be used to make a diabetes treatment decision; if you suspect that your reading may be inaccurate for any reason; when you are experiencing symptoms that may be due to low or high blood glucose; when you are experiencing symptoms that do not match the Sensor glucose readings; during the first 12 hours of wearing a FreeStyle Libre 14 day Sensor; during times of rapidly changing glucose; when the Sensor glucose reading does not include a Current Glucose number or Glucose Trend Arrow; and in order to confirm hypoglycemia or impending hypoglycemia as reported by the Sensor. 1. Review of Resident #25's face sheet (a brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included severe dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) with hyperglycemia (high blood sugar levels), and heart failure (chronic condition in which the heart doesn't pump blood as well as it should). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 10/01/24, showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 South Landrum Mount Vernon, MO 65712	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Severe cognitive impairment; -Use of wheelchair; -Dependent on staff for toileting hygiene, showering, dressing, personal hygiene, transfers, and mobility. Review of the resident's physician orders, current as of 10/10/24, showed the following: -An order, dated 08/02/24, for blood glucose monitoring with Freestyle monitor (measures glucose (sugar) levels through a small sensor - the size of two stacked quarters - applied to the back of your upper arm), four times a day; -No order for blood glucose monitoring by finger stick. Review of the resident's September 2024 and October 2024 Medication Administration Record (MAR) showed staff documented the freestyle glucose sensor as changed on 09/30/24 and scheduled to be changed on 10/14/24. Review of the resident's MAR showed staff documented blood glucose monitoring with freestyle glucose monitor four times day for the month of September 2024 and October 2024 to date. Observation on 10/09/24, at 11:32 A.M., showed the following: -Licensed Practical Nurse (LPN) G prepared supplies at the nurse treatment cart and applied gloves. The nurse entered the resident's room. The resident was seated in his/her wheelchair. The nurse wiped the resident's left index finger with an alcohol wipe and allowed to air dry. The nurse then poked the resident's finger with a lancet (small needle to prick the skin) and obtained a blood sample on the test strip (small, disposable plastic strips used to measure blood sugar levels). The nurse wiped the resident's finger with a cotton ball. The resident's blood glucose level was 87. -The nurse returned to the treatment cart disposed of the lancet and test strip, and wiped the glucometer with a disinfecting wet wipe. He/she then removed his/her gloves and used hand sanitizer. He/she charted the blood glucose reading and noted the resident required no insulin. During observation and interview on 10/10/24, at 1:15 P.M., the resident was in a wheelchair in the dining room. The resident did not respond to questions. Certified Medication Tech (CMT) H entered the room and said that the resident's Freestyle glucose monitor had fallen off the resident's arm and had not been on for two days. He/she said the nurse had been checking the glucose by finger stick. The CMT felt both arms of the resident had there was not glucose monitor on the right or left arm. During an interview on 10/10/24, at 1:20 P.M., LPN E said there were two residents in the facility with the Freestyle glucose monitoring sensor. He/she said that if the glucose sensor reading did not seem accurate or had fallen off the nurses should check the glucose reading by finger stick. He/she said there should be an order for glucose monitoring by finger stick. (continued on next page)

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	265452	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Vernon Nursing	1425 South Landrum Mount Vernon, MO 65712

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24, at 1:30 P.M., the Infection Preventionist said staff should obtain an order for finger stick blood glucose testing in case the Freestyle sensor was not working accurately or had fallen off. There should be a physician order for the test. During an interview on 10/10/24, at 1:40 P.M., the Director of Nursing (DON) said staff should obtain a physician's order for a finger stick glucose test for residents with Freestyle glucose monitors in the event glucose monitor was not working or had fallen off before the next time due to be changed. The insurance companies only allowed one glucose monitor every two weeks, so when if it had fallen off it cannot be replaced until the time period allowed. During an interview on 10/10/24, at 1:55 P.M., the Administrator said staff should follow physician orders for blood glucose monitoring and should contact the physician for finger stick orders if a glucose monitor did not work or had fallen off.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 36974 Based on observation, interview, and record review, the facility failed to ensure each resident was provided access to drinks at palatable temperature when staff stored drinks on the Special Care Unit at room temperatures. The facility census was 43. Review showed the facility did not provide a policy related to drink storage/temperatures. 1. Observations on 10/07/24, starting at 12:03 P.M., showed the following: -Open (about half-full), 46 ounce (oz.) bottle of orange juice sitting on counter in the secure care unit (SCU) dining room. The exterior of the bottle felt the same as room temperature (approximately 72 degrees Fahrenheit (F)); -Open (about half-full), 46 oz. bottle of apple juice; -Large serving pitcher labeled as Kool-aid. Observation on 10/08/24, at 9:44 A.M., showed the Kool-aid, apple juice, and orange juice out on the counter of the SCU. All exteriors of the bottles felt approximately room temperature. Observation on 10/08/24, at 12:02 P.M., showed Certified Nurse Aide (CNA) D poured room temperature Kool-aid from the pitcher for a resident. Observation on 10/09/24, at 11:27 A.M., showed apple juice and orange juice containers out on the counter of the SCU and at about room temperature. Observations on 10/10/24, at 2:22 P.M., showed the following temperatures of drinks sitting on the counter in the dining area of the SCU: -Kool-aid that measured 70.1 degrees F; -Tea that measured 64.6 degrees F; -Orange juice that measured 72.8 degrees F; -Apple juice that measured 71.9 degrees F. During an interview on 10/10/24, at 1:47 P.M., the Registered Dietician (RD) said Kool-aid, juices, and teas can be left out for several days at room temperature without significant concern of bacterial growth. However, most people would prefer the drinks with ice, or cooled down. During an interview on 10/10/24, at 2:05 P.M., CNA C, said the following: -He/she used the drinks for the residents for any time they wished for something to drink; (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The orange juice is normally used for those with blood sugar concerns; -He/she does not take temps of the juices; -He/she is unsure how long the juices and drinks are kept on counter; -There is no refrigerator in the unit. During an interview on 10/10/24, at 2:15 P.M., the Dietary Manager said she takes fresh drinks to the unit almost daily; -She has not done so today because she has not had a chance. The temperatures taken by the surveyor were not acceptable temperatures. During an interview on 10/10/24, at 2:45 P.M., the Administrator said the following: -Drinks should be kept cool or changed out frequently; -He/she did not realize the drinks were getting so warm and that was not okay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Vernon Nursing	1425 South Landrum Mount Vernon, MO 65712

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 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.

37358

Based on observation, interview, and record review, the facility failed to keep food safe from potential contamination at all times when staff failed to ensure glasses were fully air dried before stored/used. The facility census was 43.

Review of the facility policy, Dish and Utensil Handling, revised January, 2016, showed the following:

-All silverware, dishes, and glasses shall be handled to ensure sanitary conditions and infection control;

-Dishes, cups, and glasses will be air-dried prior to storing;

-Flatware is to be washed twice and air-dried.

Review of the 1999 Food Code, issued by the Food and Drug Administration, showed the following information:

-After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food.

-Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.

1. Observation on 10/07/24, at 10:27 A.M., showed the following items were found to be wet, following being washed, and sitting upside down with no air flow to allow the dishes to completely dry:

-Fifty-eight coffee cups;

-Forty-four plastic bowls;

-Thirty-eight glass plates;

-Twelve glass bowls;

-Ten glass saucers;

-Four metal steam table pans

Observation on 10/09/24, at 9:07 A.M., showed the following items were found to be wet, following being washed, and sitting upside down with no air flow to allow the dishes to completely dry:

-Fifty-six small, clear, juice cups;

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 South Landrum Mount Vernon, MO 65712	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Fifty-seven medium, clear, tea/milk cups; -Thirty-two plastic bowls During an interview on 10/10/24, at 12:20 P.M., Dietary Aide (DA) A said he/she did not know that dishes could not be turned upside down and placed on the trays (prevent air flow) before being completely dry. During an interview on 10/10/24, at 12:20 P.M., DA B said he/she was not aware that dishes could be stacked in a manner to prevent air flow before being completely dry. During an interview on 10/10/24, at 12:20 P.M., the Dietary Manager, said he/she had not even realized this was how the dishes were being dried. The dishes should not be stored in a way to prevent air flow/drying. During an interview on 10/10/24, at 12:20 P.M., the Director of Nursing (DON) said the following: -He/she knew dishes could not be left wet, and placed in a position that airflow is not permitted; -He/she said the dishes should always be air dried before being put away. During an interview on 10/10/24, at 12:20 P.M., the Administrator said the following: -He/she was not aware that the dishes were not being air dried before being put away until the next use; -He/she did expect staff to completely dry the dishes, and once dry, they can be places elsewhere or stacked, but not when wet. 36974

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 36974 Based on interview and record review, facility staff failed to maintain a complete infection control program when staff failed to ensure the required two step tuberculosis (TB-a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) screening test was administered timely and correctly documented for three staff members (Business Office Manager (BOM), Certified Medication Technician (CMT) I, and Activity Director) of ten sampled staff. The facility census was 43. Review of the facility policy tilted, Infection Prevention and Control Manual, Employee Health, dated 2019, showed the following information: -Employee was defined as employees, consultants, contractors, volunteers, caregivers who provide care to the residents on behalf of the facility, and nurse or nurse aide students working in the facility; -Each new employee will undergo a two-step Tuberculin Skin Test (TST) or a TB blood test for detection of latent tuberculosis infection or disease or testing in accordance with State requirements; -Documentation of the results of the TST must be made available to the facility; -If a new employee has previously tested positive, they are exempt from repeat TST, but appropriate documentation is necessary to support freedom from infectious disease; -New employees who present a written report of a negative two-step TST within the previous 12 months require a one-step TST, and an employee screening tool will be completed; -New employees with a known, documented positive skin test will not receive a repeat TST but will undergo a chest x-ray (CXR) if they do not have a documented negative CXR after a positive skin test; -New employees will not be allowed to work until the Tuberculin Skin Test or CXR results are known; -Employees who will be receiving the two-step Tuberculin Skin Test may begin work after the first step results are negative; -Skin test results will be documented in the employee's medical record; -Skin test results will be documented in millimeters of induration rather than stating results is positive or negative; -The tuberculin manufacturer and lot number will be recorded; -The test is read between 48 and 82 hours after administration by someone trained in Mantoux reading and interpretation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Vernon Nursing	1425 South Landrum Mount Vernon, MO 65712

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Infection Prevention and Control Manual - Employee TB Screening Tool, dated 2019, showed the following: -Employee name, date of hire, department, date of birth; -Medical questions including: have you been told you have tuberculosis; -Test #1, date, manufacturer, lot #, right arm or left arm, given by, date read, time read, results, read by; -Test #2, date, manufacturer, lot #, right arm or left arm, given by, date read, time read, results, read by. General requirements for Tuberculosis testing for employees in Long Term Care Facilities, 19 CSR 20-20. 100, reads as follows: -Long-term care facilities shall screen their employees for tuberculosis using the Mantoux method purified protein derivative (PPD - a skin test to determine if you have tuberculosis) two-step tuberculin test within one month prior to starting employment; -If the initial test is negative, the second test should be given as soon as possible within three weeks after employment begins unless documentation is provided indicating a Mantoux PPD test in the past and at least one subsequent annual test within the past two years; -It is the responsibility of the facility to maintain documentation of each employee's tuberculin status. 1. Review of the BOM personnel record showed the following: -Date of hire 01/02/24; -First-step tuberculosis skin test date administered 12/31/23 and read on 01/02/24; -The second-step tuberculosis skin test did not have a document administration date. It was read on 01/19/24. 2. Review of CMT I personnel record showed the following: -Date of hire 05/24/23; -First-step tuberculosis skin test date administered 06/08/23, with date read on read 06/10/23. (The first step was administered fifteen days after date of hire); -Second-step tuberculosis skin test with date administered on 10/16/23, with date read on 10/18/23. (The second-step administered four months after the first step.) 3. Review of the Activity Director personnel record showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER MT Vernon Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 South Landrum Mount Vernon, MO 65712	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Date of hire 06/28/23; -First-step tuberculosis skin test date administered on 06/26/23, with date read 06/28/23; -The second-step tuberculosis skin test did not have a document administration date. The date read was 07/15/23. 4. During interview on 10/10/24, at 1:30 P.M., Infection Preventionist said that TB skin testing should be started before the new hire starts working. Generally, the TB skin test if given two days before orientation and then the new hire comes in for orientation and the skin test is read at that time. The second test should be done about 2 weeks later. Staff should document the date given and the date read. The first-step should not be done several weeks after the date of hire. 5. During interview on 10/10/24, at 1:40 P.M., the Director of Nursing DON said that TB testing for new hires should be done two days before orientation so that it can be read at the date of orientation. The second-step is done a couple weeks later. The nursing staff should document the date given and the date read and the first-step test should be given before hire not after hire. 6. During interview on 10/10/24, at 1:55 P.M., the Administrator said she expected staff to correctly complete and correctly document new hire TB testing. The first-step TB testing should be done two days before orientation and read at orientation. The second-step should then be done 7 to 14 days and up to 21 days after hire date. 41787