

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/01/2024
NAME OF PROVIDER OR SUPPLIER  Cassville Health Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 County Farm Road Cassville, MO 65625	

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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28865</p> <p>Based on observation, interview, and record review, the facility failed the protect each resident's right to have and use personal possessions when the facility failed move the personal possessions of two residents (Resident #3 and #27) when the staff moved the residents to different rooms. The facility census was 41.</p> <p>Review of the facility's policy titled, Quality of Life - Homelike Environment, dated May 2017, showed the following:</p> <ul style="list-style-type: none"> <li>-Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible;</li> <li>-Staff shall provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences;</li> <li>-The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include inviting colors and decor, personalized furniture and room arrangements, plants and flowers, where appropriate, and comfortable noise levels.</li> </ul> <p>Review of the facility's policy titled, Personal Property, dated September 2012, showed the following:</p> <ul style="list-style-type: none"> <li>-Residents are permitted to retain and use personal possessions and appropriate clothing, as space permits;</li> <li>-Each resident's room is equipped with a private closet space that includes clothes racks and shelving and that permits easy access to the resident's clothing;</li> <li>-The resident is encouraged to maintain his/her room in a home-like environment by bringing personal items (i.e., photographs, knickknacks, etc.) to place on nightstands, televisions, etc.</li> </ul> <p>1. Review of Resident #3's face sheet (a brief summary of a resident's medical record) showed the following: (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
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-admitted [DATE];</p> <p>-Diagnoses included heart disease, depression, anxiety, diabetes, muscle weakness, right ankle and right foot contracted (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become stiff preventing normal movement), hand contracted, and kidney disease.</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) dated 08/07/24, showed the following:</p> <p>-Cognitively intact;</p> <p>-Ambulated with a motorized wheel chair.</p> <p>During an interview on 09/25/24, at 10:49 A.M., the resident said the following:</p> <p>-In July his/her room had water on the floor and nobody was sure of where it was coming from, the floors or the bathroom;</p> <p>-The staff moved him/her out of this room to another hall;</p> <p>-The staff moved most of his/her belongings to include plastic tubs of personal items, furniture, and small refrigerator to the end of the hall in an open unsecured area;</p> <p>-It had been almost two months since his/her belongings were moved out of his/her room;</p> <p>-He/she asked several time when could he/she go back to his/her room;</p> <p>-He/she asked several times when the room was going to be repaired and completed so he/she could move back to his/her home;</p> <p>-The resident said it has upset him/her being away from his/her home and his/her things.</p> <p>During an interview on 10/01/24, at 3:10 P.M., Certified Medication Tech (CMT) D said the following:</p> <p>-The resident's belongings were moved to the end of the hall and put in the library area;</p> <p>-The resident's belongings were not secured and were visible/accessible to anyone;</p> <p>-The resident was frustrated that his/her belongings were in a different area of the facility and not in his/her room.</p> <p>During an interview on 10/01/24, at 3:10 P.M., Certified Nurse Aide (CNA) H said the following:</p> <p>-The resident was frustrated that he/she had to go back and forth from his/her temporary room to the facility library area to access his/her belongings.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24, at 3:36 P.M., the Social Services Director (SSD) said the resident's belongings were put in the library area of the facility while work was being done on the resident's room.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-The issue in the resident's room began in July 2024;</li> <li>-Most of the resident's items he/she needed were moved to his/her new room;</li> <li>-Some of the resident's items were moved to the end of the hallway/library while the resident's room was being worked on;</li> <li>-The resident's belongings were in the hallway for two months.</li> </ul> <p>2. Review of Resident #27's face sheet (resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included chronic obstructive pulmonary disease (COPD - lung disease that makes it difficult to breathe), chronic kidney disease (damaged kidneys that can no longer filter blood the way they should), and nicotine dependence.</li> </ul> <p>Observation on 09/23/24, at 10:53 A.M., of a room with the resident's name on it showed the following:</p> <ul style="list-style-type: none"> <li>-Pictures, artwork, crafts, and calendar hanging on west wall of room;</li> <li>-Bird seed, shoes, and craft projects in closet in room;</li> <li>-No resident bed in the room.</li> </ul> <p>During interviews on 09/24/24, at 4:12 P.M., and 09/26/24, at 11:38 A.M., the resident said the following:</p> <ul style="list-style-type: none"> <li>-He/she moved out of his/her room two months ago so the air conditioner could be replaced;</li> <li>-He/she thought he/she was moving back to his/her room, so his/her belongings were left hanging on the wall;</li> <li>-Staff have not told him/her when he/she would move back to his/her original room.</li> <li>-Maintenance started using his/her original room for storage while the resident's belongings were still on the wall;</li> <li>-Staff had not offered to assist the resident with getting his/her stuff off the walls;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she was upset about moving out of his/her original room. He/she had been in that room for a long time, and it was like home to him/her.</p> <p>During an interview on 10/01/24, at 11:40 A.M., Housekeeper (HK) I said the following:</p> <p>-The resident moved out of his/her old room three weeks ago to have the air conditioner replaced;</p> <p>-The resident left some belongings in the room along with pictures and art hanging on the walls;</p> <p>-The housekeeping supervisor was responsible for moving residents belonging when they move rooms;</p> <p>-The resident was supposed to go back to his/her old room after the air conditioner was replaced.</p> <p>During an interview on 10/01/24, at 3:10 P.M., CMT D said the resident was moved out of his/her room three months ago to have the air conditioner replaced and not all of the resident's belongings were moved with him/her. The resident was not sure if or when he/she would be going back to his/her room</p> <p>During an interview on 10/01/24, at 3:36 P.M., the SSD said the The resident moved rooms due to needing the air conditioner replaced. The resident was going to move back to the room once the repairs were completed so some of the resident's belongings were left on the walls.</p> <p>During an interview on 10/01/24, at 4:52 P.M., the Housekeeping Supervisor said the resident was moved from his/her room in August 2024 so the air conditioner could be replaced. The resident left his/her belongings hanging on the wall as the resident was to return to the room.</p> <p>3. During an interview on 10/01/24, at 3:10 P.M., CMT D said housekeeping was responsible for moving resident's belongings when a room change is made.</p> <p>During an interview on 10/01/24, at 4:52 P.M., the Housekeeping Supervisor said the housekeeping staff were responsible for moving a resident's items when there is a room change. All residents' belongings should be moved with the resident.</p> <p>During an interview on 10/01/24, at 3:36 P.M., the SSD said she was responsible for arranging room changes and notification of room changes. Housekeeping was responsible for moving all of the resident's belongings when a room change is made. All of the resident's belongings should be moved with the resident.</p> <p>During an interview on 10/01/24, at 2:32 P.M., the Maintenance Supervisor said housekeeping was responsible for moving all of the resident's belongings when a resident has a room change. Resident's belongings can be left in the resident's rooms as long as they do not interfere with the repairs being done.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said housekeeping was responsible for moving resident's belongings if there was a room change. Residents should not have to move their belongings on their own.</p>		

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<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>28865</p> <p>Based on interview and record review, the facility failed provide a fully functioning Resident Council Group when the facility staff failed to address and provide feedback regarding concerns expressed residents attending resident council meetings. The facility census was 41.</p> <p>Review of the facility's policy titled, Resident Council, dated April 2017, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility supports residents' rights to organize and participate in the Resident Council;</li> <li>-The purpose of the Resident Council is to provide a forum for residents, families and resident representative to have input in the operation of the facility. discussion of concerns and suggestions for improvement, consensus building and communication between residents and facility staff, and disseminating information and gathering feedback from interested residents;</li> <li>-A Resident Council Response Form will be utilized to track issues and their resolutions. The facility department related to any issues will be responsible for addressing the item(s) of concern;</li> <li>-The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI Committee, if applicable.</li> </ul> <p>1. Review of the Resident Council Meeting Minutes, dated 07/08/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Residents wanted more activities;</li> <li>-One resident voiced missing shorts and blanket;</li> <li>-Residents stated bed pans were not being put in bag after use;</li> <li>-One resident's bed still does not lock and his/her toilet was broken;</li> <li>-Residents still fighting over the TV remote in the dining room;</li> <li>-Residents upset about the facility not providing baked potatoes;</li> <li>-Residents complained about the fire/smoke doors being closed and not working;</li> <li>-Resident had concerns related to the cleanliness of the building had spider webs in the windows.</li> </ul> <p>(The staff did not document any old business from the previous month or any follow-up/resolution to prior concerns.)</p> <p>Review of the Resident Council Meeting Minutes, dated 08/12/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The residents asked when the staff were going to clean out the flower garden due to the weeds getting tall;</p> <p>-Residents voiced not getting enough fried chicken, only baked chicken that has been too dry;</p> <p>-Residents voiced the cook does not know how to make a salad. He/she was not cutting up the lettuce;</p> <p>-Residents voiced concern of curtains not being pulled during cares;</p> <p>-Residents asked again when are the doors were getting fixed,</p> <p>-Residents voiced concerns of spider webs in the windows;</p> <p>-Residents voiced concern of not getting showers;</p> <p>-Residents voiced the front door needed washed and the entryway columns look bad.</p> <p>(The staff did not document any old business from the previous month or any follow-up/resolution to prior concerns.)</p> <p>Review of the Resident Council Meeting Minutes, dated 09/09/24, showed the following:</p> <p>-Residents voiced meals were not visually appealing;</p> <p>-Residents voiced concerns regarding the cleanliness of the building since it had cob webs;</p> <p>-Residents voiced concerns related to curtains not being pulled during cares, a resident's room not ready, a resident's room door scraping tile, and two residents bed brakes not working.</p> <p>(The staff did not document any old business from the previous month or any follow-up/resolution to prior concerns.)</p> <p>During the Resident Council interview on 09/24/24, at 11:00 A.M., the ten attending residents said the following:</p> <p>-The concerns they bring to resident council are never addressed;</p> <p>-They have complained about the doors not being fixed for several months and nothing has been done;</p> <p>-They have complained about the spider webs for months and the spider webs are still on the windows and exit doors;</p> <p>-Staff do not address the concerns brought to council and there is never any follow-up.</p> <p>During an interview on 09/26/24, at 2:00 P.M., the Activity Director said the following:</p> <p>-She take notes during the monthly council meetings;</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She takes the complaints to morning meetings and tells the appropriate department;</p> <p>-There really is no additional follow-up;</p> <p>-The issues brought to council are not resolved and they don't go over the previous months issues in the meeting;</p> <p>-She did not report to anyone the resident council concerns about the spider webs.</p> <p>During interviews on 09/24/24, at 10:08 A.M., and on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-In September 2024, he directed the Activity Director to attach a follow-up on the old business from the resident council meeting;</p> <p>-The previous months did not have any follow-up;</p> <p>-The Activity Director does bring issues from the resident council to the morning meetings and he expects each department to follow-up on any concerns from resident council;</p> <p>-The resident council's purpose was for residents to have their concerns addressed;</p> <p>-Staff should return to resident council and let them know how their complaints/concerns were addressed.</p> <p>48534</p>

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<p>F 0584</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 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> 28865</p> <p>Based on observation, interview, and record review,</p> <p>failed to provide the maintenance services need maintain the fire doors to the facility resulting in residents have difficulty moving about the the facility</p> <p>#3, #18, #8, #5, #27</p> <p>Review of the facility's policy titled, Quality of Life - Homelike Environment, dated May 2017, showed the following:</p> <p>-The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized and homelike setting. These characterizes include clean, sanitary and orderly environment;</p> <p>-Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.</p> <p>1. Observation throughout the the survey, 09/23/24 to 10/01/24, showed the following:</p> <p>-The smoke barrier doors closed and the magnetic hold-opend devices did not function appropriately;</p> <p>-One smoke door on the 200 hall was open due to the sticky or warped floor holding it open. The magnetic hold-opne device did not function appropriately.</p> <p>During the group interview on 09/24/24, at 11:00 A.M., the residents said the magnetic hold open devices on the doors had not worked since July 2024. The doors were normally opened and propped open with chairs.</p> <p>Reviewed the Resident Council Meeting Minutes, dated July 2024 and August 2024, showed the following:</p> <p>-On 07/08/24, the residents complained about the fire/smoke doors being closed and not working;</p> <p>-On 08/12/24, the residents asked when the fire/smoke doors would be fixed.</p> <p>2. Review of Resident #3's face sheet (a brief summary of a resident's medical record) showed the following:</p> <p>-admitted [DATE];</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>28865</p> <p>Based on record review and interview, the facility failed fully implement their abuse policy to prevent the hiring of staff that may be unable to work in the facility when staff failed to completed a Nurse Aide (NA) Registry (a registry that indicated a list of individuals who had a previous incident involving abuse, neglect, or misappropriation of property that would prevent the employee from working in a certified long-term care facility) check prior to starting employment and continued resident contact for three staff. The facility census was 41.</p> <p>Review of the facility's policy titled, Nursing Policy and Procedure subject of Abuse Prevention Program, dated 05/3/19, showed the following information:</p> <p>-Pre-employment screening will be completed on all employees to include a criminal history check, background check, reference check from previous employers, professional licensure, certification or registry check as applicable, misconduct registry, and Office of Inspector General.</p> <p>1. Review of Dietary Aide (DA) F's personnel record showed the following information:</p> <p>-Hire/start date of 08/07/24;</p> <p>-The facility did not have documentation of a check the NA Registry.</p> <p>During an interview on 10/01/24, at 4:30 P.M., the Business Office Manager (BOM) said the DA had never had a job before so she did not feel the NA Registry check was necessary.</p> <p>2. Review of Licensed Practical Nurse (LPN) E's personnel record showed the following information:</p> <p>-Hire/start date of 08/26/24;</p> <p>-The facility did not have documentation of a check the NA Registry.</p> <p>During an interview on 10/01/24, at 4:30 P.M., the BOM said the NA Registry check for the LPN was overlooked and should have been completed prior to hire.</p> <p>3. Review of Registered Nurse (RN) G's personnel record showed the following information:</p> <p>-Hire/start date of 09/16/24;</p> <p>-The facility did not have documentation of a check the NA Registry.</p> <p>During an interview on 10/01/24, at 4:30 P.M., the BOM said the NA Registry check for the RN was overlooked and should have been completed prior to hire.</p> <p>4. During an interview on 10/01/24, at 4:30 P.M., the BOM said she runs NA Registry Checks on all potential employees. This check needed to be completed before the employee began work.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said he expected staff to check the NA Registry to ensure no federal indicator was found on all new employees.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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> 25513</p> <p>Based on interview, and record review, the facility failed to provide timely assistance to all dependent residents for bathing when staff failed to provide routine bathing for two residents (Resident #28 and #14) in a facility with a census of 41.</p> <p>Review of the facility's shower policy, revised 10/13/22, showed the following information:</p> <ul style="list-style-type: none"> <li>-The purposes of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin.</li> <li>-The following information should be recorded on the resident's ADL record and/or in the resident's medical record: the date and time the shower was performed; the name and title of the individual(s) who assisted the resident with the shower; and if the resident refused the shower, the reason(s) why and the intervention taken.</li> <li>-Notify the supervisor if the resident refuses the shower.</li> </ul> <p>1. Review of Resident #28's face sheet (a brief summary of a resident's medical record) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included multiple sclerosis (a chronic disease of the central nervous system), end stage renal disease, diabetes, and depression.</li> </ul> <p>Review of the resident's annual minimum data set (MDS - a federally mandated assessment tool completed by facility staff), dated 09/02/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Moderately impaired cognition;</li> <li>-Did not reject care;</li> <li>-Required partial/moderate assistance with showering, tub/shower transfers, lower body dressing, and personal hygiene;</li> <li>-Required supervision or touching assistance for upper body dressing;</li> <li>-Experienced shortness of breath with exertion.</li> </ul> <p>Review of the resident's care plan, updated 09/02/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Required assist with activities of daily living (ADLs - dressing, grooming, bathing, eating, and toileting) related to multiple sclerosis and required limited-to-extensive assist with ADLs.;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Allow sufficient time for completion and encourage independence. Staff to provide with sequencing as needed;</p> <p>-Required extensive assistance of two staff and at times and required a mechanical lift with transfers;</p> <p>-Required extensive assistance of one staff for showers.</p> <p>Review of the resident's August 2024 and September 2024 ADL charting, under the bathing task, showed the following:</p> <p>-On 08/10/24, staff documented not applicable (NA);</p> <p>-On 09/09/24, staff documented NA;</p> <p>-On 09/15/24, staff documented NA.</p> <p>Review of the resident's shower sheet, dated 09/30/24, showed staff assisted the resident with a bed bath (staff could not find any additional shower sheets for the resident).</p> <p>During an interview on 09/25/24, at 1:04 P.M., the resident said he/she preferred to have a shower once a week, but even every other week would be okay since he/she did not sweat a lot. The resident said he/she had a shower on Monday (09/23/24), but prior to that he/she did not have a shower or bed bath since July 2024, and that was done at the hospital, not at the facility. Last week, his/her family member asked when was the last time he/she had a shower. The resident told the family member July 2024. The resident thought the family member spoke with the Director of Nursing (DON) about it because on Monday, staff gave him/her a shower. In the past, when he/she asked staff about a shower, they told him/her they would get back with him/her, but never did.</p> <p>During an interview on 09/26/24, at 2:47 P.M., Licensed Practical Nurse (LPN) B said he/she did not know about the resident getting or not getting a shower.</p> <p>During an interview on 10/01/24, at 4:45 P.M., the Director of Nursing (DON) said the resident preferred one shower a week, on a day he/she did not attend dialysis (a treatment that removes waste and extra fluid from the blood when the kidneys are no longer able to perform this function). The resident's scheduled day was Friday, but the DON did not know if that was still his/her scheduled day. The DON knew the resident missed a few scheduled showers, but did not know the resident missed so many. The resident's family member did not discuss with her the lack of showers.</p> <p>34906</p> <p>2. Review of Resident #14's face sheet showed:</p> <p>-admitted [DATE] and readmitted [DATE];</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow causing difficulty breathing), Type II diabetes mellitus, fibromyalgia (long-term condition that involves widespread body pain and tiredness), major depressive disorder, and history of falling.</p> <p>Review of the resident's care plan, dated 08/19/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Required assist with ADLs related to unsteady gait/balance at times;</li> <li>-Allow sufficient time for completion and encourage independence. Staff to provide with sequencing as needed;</li> <li>-Required assist of one staff for his/her showers.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Did not reject care;</li> <li>-Set-up or clean-up assistance with showering and showering transfers;</li> <li>-Helper provided verbal cues or touching/steadying assistance as resident completed upper and lower body dressing, putting shoes on, and going from sitting to standing position;</li> <li>-Experienced shortness of breath with exertion.</li> </ul> <p>Review of the resident's shower sheets and ADL charting, dated August 2024, showed staff documented assisting the resident with a total of three showers during August 2024, on 08/02/24, on 08/15/24, and on 08/21/24.</p> <p>Review of the resident's shower sheets and ADL charting, dated 09/01/24 to 09/26/24, showed staff documented assisting the resident with two on 09/09/24 and on 09/24/24.</p> <p>During an interview on 09/25/24, at 3:19 P.M., the resident said the following:</p> <ul style="list-style-type: none"> <li>-Staff did not always have time to assist the resident with showering;</li> <li>-He/she was lucky if staff assisted him/her with one shower per week, and sometimes staff assisted him/her with one shower every two weeks;</li> <li>-He/she needed more frequent showers;</li> <li>-He/she frequently felt dirty;</li> <li>-He/she attempted to wipe him/herself off with a wash cloth, but that was not the same as a shower;</li> <li>-He/she would like to have at least two showers per week.</li> </ul> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. During an interview on 09/26/24, at 2:40 P.M., Certified Nurse Aide (CNA) O said the facility had a mid-shift CNA who primarily gave residents showers. The shower CNA had a schedule, by resident room number, that allotted each resident a shower two times a week. The shower CNA completed shower sheets for each shower he/she gave and also documented the shower in the residents' ADL record. CNA O had not given residents showers in a while.</p> <p>During an interview on 9/26/24, at 2:43 P.M., CNA Q said he/she was usually scheduled as the shower aide. If he/she was not working then other CNAs gave residents showers. He/she had a shower list with residents' room numbers. Each room number was scheduled two times a week, and staff would give additional showers if possible. The shower aide completed a shower sheet for each resident shower he/she attempted or completed. He/she documented any skin issues he/she observed on the shower sheet. If the resident refused a shower, she/she made a notation of the refusal on the sheet and on the shower schedule. Staff would then attempt later that day to give the resident a shower. He/she gave the completed sheets to the charge nurse to review. The shower aide documented showers on the sheets and in the residents' ADL record.</p> <p>During an interview on 10/01/24, at 9:51 A.M., CNA C said the following:</p> <ul style="list-style-type: none"> <li>-Each resident should get two showers per week;</li> <li>-At times, staff cannot complete all the assigned showers due to emergencies or staff calling in sick to work;</li> <li>-Some of the residents complain that they want more showers.</li> </ul> <p>During interviews on 09/26/24, at 2:47 P.M., and on 10/01/24, at 9:35 A.M., LPN B said the following:</p> <ul style="list-style-type: none"> <li>-The certified nurse assistants (CNAs) completed showers;</li> <li>-The CNAs were supposed to give each residents two showers per week, unless the resident requested otherwise;</li> <li>-Part of the time, the CNAs did not get the assigned resident showers completed when staff called in sick to work.</li> <li>-The aides document the resident's shower on a shower sheet and in the electronic medical record.</li> </ul> <p>During an interview on 10/01/24, at 10:06 A.M., the Assistant Director of Nursing (ADON) said the following:</p> <ul style="list-style-type: none"> <li>-Staff should be assisting residents with two showers per week;</li> <li>-He/she did not audit to ensure the showers were completed;</li> <li>-The DON completed the shower audits.</li> </ul> <p>During interviews on 10/01/24, at 1:01 P.M. and 4:45 P.M., the DON said the following:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff should assist all residents with at least one shower weekly;</p> <p>-The residents were scheduled for two showers per week;</p> <p>-Part of the time, staff were unable to complete all the assigned showers, but if not completed, staff attempt to complete those the following day;</p> <p>-No one audited the showers to ensure they were being done, but the charge nurses knew who was on the shower list each day and they can make a list of which residents needs showers the following day;</p> <p>-Recently, the DON and corporate nurse found a problem with the tasks in the residents' ADL record. Residents' shower days were not scheduled, some tasks were duplicated, and at times the system would not let the CNAs save documentation. The DON and corporate nurse fixed the bathing ADL task and now expected staff to document showers in that resident's ADL record;</p> <p>-If staff had difficulty documenting the shower in the ADL record, staff should let her know, and document on a shower sheet. Prior to fixing the ADL task record, staff completed shower sheets as their documentation.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said residents should be scheduled for a shower two times a week, unless noted differently based on the residents' preference. If staff could not shower a resident on his/her scheduled day, they should attempt the shower the following day. Staff documented showers on shower sheets and in the electronic medical record. The facility did not have a dedicated shower aide every day. The DON should ensure residents receive their scheduled showers.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25513</p> <p>Based on record review, observation, and interview, the facility failed to provide care per standards of practice when staff failed to obtain a physician's order for treatment and administered a treatment without an order for reddened skin on one resident (Resident #1) and when the facility failed to obtain a urine sample for an ordered urinalysis for one resident (Resident #11) in a timely manner. The facility's census was 41.</p> <p>1. Review of the facility's policy/procedure titled, Medication Orders, revised November 2014, showed the following:</p> <ul style="list-style-type: none"> <li>-The purpose of this procedure was to establish uniform guidelines in the receiving and recording of medications orders;</li> <li>-Orders must be written and maintained in chronological order;</li> <li>-When recording treatment orders, specify the treatment, frequency and duration.</li> </ul> <p>Review of Resident #28's face sheet (a brief summary of a resident's medical record) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included diabetes, morbid obesity, and erythema intertrigo (A skin condition that appears as red patches in skin folds where skin rubs together. It's caused by a combination of friction, moisture, and lack of ventilation. The affected area can become inflamed and may itch, burn, or be painful.).</li> </ul> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 09/02/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Required partial/moderate assistance with bathing, lower body dressing, and personal hygiene;</li> <li>-Required substantial/maximal assistance with toileting hygiene;</li> <li>-Application of ointments/medications other than to feet.</li> </ul> <p>Review of the resident's care plan, last reviewed on 09/02/24, showed the following:</p> <ul style="list-style-type: none"> <li>-At risk for impaired skin integrity due to resident required assistance with activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) and had a diagnosis of diabetes and multiple sclerosis (a chronic disease of the central nervous system);</li> <li>-Report any skin breakdown;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Apply barrier cream as ordered;</p> <p>-Complete weekly skin assessment per schedule;</p> <p>-Notify physician of any new skin impairment and implement treatment orders.</p> <p>Review of the resident's skin observation tool, dated 09/21/24, showed a nurse documented the following:</p> <p>-Right (front) iliac crest (the curved part at the top of the hip), rash;</p> <p>-Left (front) iliac crest, rash;</p> <p>-Groin, rash;</p> <p>-Redness noted to the abdominal folds and groin. Staff cleaned cleaned and applied nystatin (treats fungal or yeast infections of the skin).</p> <p>Observation and interview on 09/24/24, at 1:20 P.M., showed the following:</p> <p>-Certified Nurse Aide (CNA) P and Nurse's Aide (NA) R entered the resident's room and assisted him/her to bed.</p> <p>-The resident had moist reddened skin under the left side of his/her abdominal fold.</p> <p>-CNA P said the skin under the resident's abdominal fold was red due to moisture.</p> <p>-The CNA did not know how long the area has been red because it was a problem the resident had off and on.</p> <p>-The resident said at night, staff placed a pillowcase between his/her abdominal folds to help wick the moisture and it seemed to help.</p> <p>-The nurses used to apply a powder to his/her skin folds, but did not anymore.</p> <p>Review of the resident's skin observation tool, dated 09/30/24, showed a nurse documented redness noted to abdominal folds and groin. Staff cleaned cleaned and applied nystatin.</p> <p>Review of the resident's September 2024 Physician Order Sheet (POS) and September 2024 nurse's Medication Administration Record (MAR) showed no order for nystatin.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 10/01/24, at 4:25 P.M. and 6:04 P.M., Licensed Practical Nurse (LPN) B said nurses completed residents' skin observations weekly. Who completed the assessments varied and depended on when the task showed up on the electronic medical record. If a nurse found a skin issue, such as redness or a rash, the nurse notified the physician and obtained an order if applicable. Nystatin required a physician's order and staff should not administer unless they have an order. The resident had a history of yeast under his/her skin folds. The LPN did not know the resident had redness under his/her abdominal fold. He/she had not observed the resident's skin folds and he/she did not know he/she needed to.</p> <p>During an interview on 10/01/24, at 4:45 P.M., the Director of Nursing (DON) said the nurses complete skin observations on all residents weekly. In the electronic medical record, the skin assessment tasks populated and alerted staff the assessment was due. If a nurse observed redness, he/she notified the physician. If the resident had redness due to a rash in his/her skin fold so the physician had a standing order for Nystatin powder. The standing orders were listed in the protocol book and staff entered them per batch update located in the electronic medical record. When the nurse entered the order it self-populated to the nurses treatment administration record. The DON did not know the resident had redness under his/her skin fold or that the nurse applied Nystatin. The staff should have an order for Nystatin. The DON reviewed the resident's skin assessment and TAR and said she did not find the order for Nystatin.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said staff should follow physician's orders when administering medications and should not administer medications without an order. The nurses complete skin assessments on residents upon admission and then weekly. The Assistant Director Of Nursing (ADON) and charge nurses completed the skin assessments. If they find an issue with a resident's skin, they notify the physician and obtain orders if applicable. The physician has standing orders for minor treatments. If the nurses used or followed a standing order, they should enter that into the resident's orders.</p> <p>2. Review of Resident #11's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included diabetes, dementia, and stroke.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Severely impaired cognition;</p> <p>-Required substantial/maximal assistance with toileting hygiene, bathing, lower body dressing, and toilet transfer;</p> <p>-Always incontinent of bowel and bladder.</p> <p>Review of the resident's care plan, reviewed 08/27/24, showed the following:</p> <p>-The resident had urinary/bowel incontinence related weakness, inability to be aware of continence needs, and poor mobility.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Assist with clothing change as needed;</p> <p>-Provide perineal care after incontinent episodes;</p> <p>-Labs as ordered and notify the physician of results.</p> <p>Review of the resident's progress note dated 09/26/24, at 9:22 A.M., late entry for 09/25/24, at 12:00 P.M., showed the nurse noticed the resident choking and gagging while eating lunch. The nurse notified the physician and downgraded his/her diet to puree.</p> <p>During an interview 09/26/24, at 11:23 A.M., LPN B said the resident did not feel well today. He/she vomited breakfast. He/she messaged the physician who said okay. The corporate nurse heard the LPN and told him/her to contact the physician again and get more.</p> <p>Review of the resident's progress notes dated 09/26/24, at 12:22 P.M., showed a nurse documented he/she messaged the physician about the resident's increased confusion, not responding, vomiting, and fatigue. The physician ordered blood tests and a urinalysis. If staff were unable to obtain a clean catch urinalysis and may catheterize the resident for the sample.</p> <p>Review of the resident's September 2024 Physician Order Sheet (POS) showed an order, dated 09/26/24, for staff to obtain a urinalysis.</p> <p>Observation on 09/26/24, at 1:00 P.M., showed CNA S and CNA T assisted the resident to the bathroom. After they finished, the aides both asked the resident if he/she wanted to lay down. The resident just looked at the aides and did not respond. The aides asked again, and the resident just stared at the aides, and did not answer. CNA S said the resident usually would tell the staff what he/she wanted. This was a change from his/her normal behavior.</p> <p>During interviews on 10/01/24, at 11:40 A.M. and 4:25 P.M., LPN B said when a physician ordered a urinalysis for a resident, the nurse entered the order in the electronic medical record, and let the aides know of the order to get the urine. When staff obtained the urine for the urinalysis, the nurse entered the information into the laboratory website, printed the requisition and face sheet, placed the forms with the specimen, then contacted the shipping company for pickup. The nurse would document collection in the nurses notes. LPN B said he/she thought staff obtained the resident's urine for the urinalysis. After reviewing the resident's electronic record, LPN B said he/she did not find verification staff sent the specimen. He/she did not know the reason staff had not yet obtained the specimen, and perhaps they needed to catheterize the resident to obtain a sample. When the nurses were not able to complete an order such as obtaining a urine sample, the nurse passed it on to the oncoming nurse.</p> <p>During an interview on 10/01/24, at 4:30 P.M., CNA J said usually the nurse told the aides when they needed to collect a urine sample. He/she thought the aides obtained the resident's sample, but he/she did not know when. He/she did not obtain it.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Cassville Health Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 County Farm Road Cassville, MO 65625	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/24, at 4:45 P.M., the Director of Nursing (DON) said if staff observed a change in a resident's behavior, or if he/she had other symptoms of a urinary tract infection, the nurse contacted the physician and obtained an order for a urinalysis. If the resident was continent, staff would place a collection device on the toilet, if the resident was incontinent, the nurse would obtain permission to catheterize the resident. Staff would attempt to collect the sample via a bedpan or toilet before catheterizing. Hopefully staff could obtain the sample the same day, but if not, the nurse passed that information to the oncoming nurse. When staff obtain the sample, the nurse labeled the specimen cup, and entered the order into the laboratory website, printed the requisition and resident's face sheet and placed it with the specimen, then contacted the shipping company for pick up. The shipping company made daily trips to the facility. If staff could not obtain the specimen timely, within one to two days, the nurses should contact the physician.</p> <p>During an interview conducted on 10/01/24, at 7:05 P.M., the Administrator said staff should obtain a urine specimen for a urinalysis within the same shift the physician ordered it, but at most within 24 hours. If staff could not obtain the sample during that shift, the nurse should pass that information to the oncoming nurse. If the staff could not obtain the sample within that timeframe, the nurse should contact the DON, the Administrator, and the physician.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25513</p> <p>Based on interview and record review, the facility failed to communicate and collaborate, consistent with professional standards of practice, with the dialysis (a process of filtering and removing waste products from the bloodstream when the kidneys can no longer sufficiently do so) center, failed to monitor fluid intake as care planned, and failed to implement interventions to manage dialysis treatment such as consistent weights to monitor fluid retention and dietary restrictions to manage elevated laboratory results for one resident (Resident #28), out of a sample of two residents. The facility census was 41.</p> <p>Review of the facility's Care of a Resident with End-Stage Renal Disease Policy, revised September 2010, showed the following:</p> <ul style="list-style-type: none"> <li>-Residents with end stage renal disease (ESRD - a medical condition in which a person's kidneys cease functioning on a permanent basis) will be cared for according to currently recognized standards of care.</li> <li>-Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.</li> <li>-Education and training of staff includes specifically the nature and clinical management of ESRD (including infection prevention and nutritional needs); the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; timing and administration of medications, particularly those before and after dialysis; and the care of grafts and fistulas (a connection between two parts);</li> <li>-Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed including: how the care plan will be developed and implemented, and how information will be exchanged between facilities;</li> <li>-The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.</li> </ul> <p>Review of the current Dialysis Service Agreement, between the facility and the dialysis center, showed the following:</p> <ul style="list-style-type: none"> <li>-Clinic responsibilities: Provide the skilled nursing facility (SNF)/resident with access to medical records in compliance with state and federal laws and provide nutritional guidelines to resident and/or SNF;</li> <li>-SNF/resident responsibilities: participate in the development of the plan; notify the resident, physician/practitioner or nurse about any changes in resident's health; participate in education, activities or other efforts with respect to improving the resident's renal diet; and ensure the resident is prepared to spend an extended length of time at the clinic and has received proper nourishment and any medications prescribed for reasons unrelated to the services, as appropriate, before coming to the clinic.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-It is essential that a communications process be established between the SNF and the clinic. The care of the resident receiving services must reflect ongoing communication, coordination and collaboration between the SNF and clinic. The communications process should include how the communication will occur, who is responsible for the communication, and where the communication and responses will be documented in the medical record including but not limited to: timely medication administration (initiated, administered, held or discontinued) by the SNF and clinic; physician/practitioner treatment orders, laboratory values and vital signs; nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provisions of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access.</p> <p>1. Review of Resident #28's face sheet (a brief summary of the resident's history) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included ESRD, dependence on renal dialysis, diabetes, and depression.</p> <p>Review of the resident's September 2024 Physician Order Sheet (POS) summary showed an order, dated 07/17/24, for a renal (dialysis) diet.</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 07/31/24, at 4:34 P.M., a nurse documented the resident could not complete dialysis due to a clogged shunt (a passage that is made to allow blood or other fluid to move from one part of the body to another). The resident had an appointment on 08/02/24 to fix the shunt. The resident should have nothing by mouth after midnight on 08/02/24 and would have inpatient dialysis at that time.</p> <p>-On 08/02/24, at 10:33 A.M., a nurse documented the resident could have nothing by mouth to prepare for a procedure later.</p> <p>-On 08/03/24, at 5:07 A.M., a nurse documented the resident left for dialysis after replacement of a new shunt yesterday (08/02/24).</p> <p>Review of the resident's September 2024 POS summary showed an order, dated 08/29/24, to monitor the resident left arm shunt for warmth, color, swelling, bleeding, and dressing condition. Bruits and thrills (signs of good blood flow in an arteriovenous (AV) fistula) of shunt checked daily, every day shift.</p> <p>Review of the resident's nurses' notes dated 08/31/24, at 10:05 P.M., showed a nurse documented dialysis staff sent the resident to the hospital due to a clogged shunt. emergency room staff removed the clog and they completed dialysis on the resident.</p> <p>Review of the resident's care plan, last updated on 09/02/24, showed the following:</p> <p>-Received dialysis related to diagnosis of ESRD requiring dialysis;</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Renal diet;</p> <p>-1500 ml fluid restriction:</p> <p>-The resident attended dialysis on Tuesday/Thursday/Saturday;</p> <p>-The resident had an unaccessed dialysis shunt in his/her left arm and a Central Port in his/her chest which was used for dialysis.</p> <p>-Do not take blood pressure from this site.</p> <p>-Monitor labs per physician order. Labs are also obtained at the dialysis clinic;</p> <p>-Monitor left arm shunt site and central port in upper chest for warmth, color, swelling, bleeding and dressing condition. Bruits and thrills of shunt checked daily or per order.</p> <p>-Monitor weight per physician order. Know that weight may vary due to dialysis.</p> <p>-Report any increased lethargy an itching to dr. Report any complications following dialysis such as hypotension (low blood pressure), fever and bleeding.</p> <p>-Send a meal or snack if requested.</p> <p>Review of the resident's laboratory results from the dialysis center, dated 09/05/24, showed the following:</p> <p>-Phosphorus (goal 3.5-5) = 7.7.</p> <p>-The resident's phosphorus was high. High phosphorus could lead to bone disease. The resident needed to limit milk to 1/2 cup per day, and avoid cheese, dairy products, chocolate, [NAME] and highly processed foods. The resident needed to make sure he/she took Auryxia, the phosphorus binder, four tablets with each meal. Diet, dialysis, and binders are necessary for good control.</p> <p>Review of the resident's weight summary, dated 09/05/24, showed staff documented the resident weighed 355.4 pounds (lbs) (a decrease of 20 lbs in 16 days).</p> <p>Review of the resident's nurses note dated 09/06/24, at 8:21 A.M., a nurse documented the resident's shunt was not working and the resident had an appointment to fix it today.</p> <p>Review of the resident's weight summary showed staff documented the following:</p> <p>-On 09/11/24, the resident weighed 370 lbs (a decrease of 14.6 lbs);</p> <p>-On 09/18/24, the resident weighed 368.6 lbs.</p> <p>Review of the resident's September 2024 activities of daily living (ADL) charting, under the nutrition task, showed staff documented the following:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Morning meal: Staff documented fluid intake for that meal 16 out of 26 days, and noted resident unavailable 7 out of 26 days (the unavailable days corresponded with the resident's dialysis days when he/she received breakfast prior to 6:00 A.M.);</p> <p>-Noon meal: Staff documented fluid intake for that meal 16 out of 26 days, and resident unavailable, 7 out of 26 days (the RU days corresponded with the resident's dialysis days);</p> <p>-Evening meal: Staff documented fluid intake for that meal, 11 out of 26 days.</p> <p>Review of the resident's September 2024 nurse treatment administration record (TAR) showed the following:</p> <p>-A treatment to monitor left arm shunt site for warmth, color, swelling, bleeding and dressing conditions. Bruits and thrills of shunt checked daily, every day shift.</p> <p>-The nurses documented checking the resident's shunt 17 out of 26 days (the resident received a new port on his/her right chest).</p> <p>Observation and interview on 09/25/24, at 1:00 P.M., showed the following:</p> <p>-The resident said he/she went to dialysis three times a week.</p> <p>-He/she had a shunt on her left arm, but it kept getting clogged. About a week ago, he/she got a new port on his/her right chest.</p> <p>-Observation showed the resident had to blue caps on his/her left and a central line access on his/her upper left chest.</p> <p>-The nurses did not do anything with his/her ports or shunts, including checking for bruits and thrills. They told him/her that they did not know much about it and it was the dialysis center's job to take care of them.</p> <p>-Staff used to weigh him/her and obtained his/her vital signs prior to dialysis, but they have stopped. The resident did not know the reason they stopped.</p> <p>-The resident thought the facility and dialysis center no longer used written communication forms, they just called each other for information.</p> <p>-The resident had a 1500 milliliter (ml) fluid restriction. He/she did not think staff monitored his/her fluid intake, but he/she did and tried to stay within the restriction. He/she asked that staff only pass ice with no water. That way he/she could suck on the ice when his/her mouth became dry.</p> <p>Observation and Interview on 10/01/24, at 12:55 P.M., showed the following:</p> <p>-The resident said the facility staff and dialysis clinic staff did not use a communication form. This process stopped about a month ago.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Prior to that, facility staff completed the communication form and placed it in the book located in the bag that hung on the back of the resident's wheelchair. When the resident arrived at dialysis, dialysis staff would remove the paper and add any pertinent information then place it back into the resident's book.</p> <p>-Observation showed a bag on the back of the resident's wheelchair. Inside the bag, buried beneath a large blanket, was a one inch binder that contained communication forms. The last form completed was dated 07/27/24. The forms were not chronological and were not completed three days a week.</p> <p>-The resident said when he/she had blood work completed at dialysis, the dialysis staff printed the laboratory results, reviewed the values with him/her then placed it in the dialysis book.</p> <p>-The resident said facility staff did not consistently look in the resident's dialysis book for laboratory results. There had been times when dialysis staff added new laboratory results and there was still old results in the book.</p> <p>Observation on 10/01/24, at 1:00 P.M., showed the physician's notebook in a file cabinet drawer did not contain any of the resident's recent or past laboratory results.</p> <p>During an interview on 10/01/24, at 4:20 P.M., Certified Nurse Aide (CNA) N said if a resident had a fluid restriction, the aides typically found out from the resident, and they would confirm that with the nurse. Staff documented the resident's fluid intake from meals in the electronic medical record. The resident had a fluid restriction and they only passed ice to him/her, not ice water. The CNA did not know how much fluid the resident was allowed.</p> <p>During an interview on 10/01/24, at 4:30 P.M., CNA J said he/she did not know how he/she would know if a resident had a fluid restriction. The residents typically received fluids with meals and he/she entered each residents intake in the electronic medical record. He entered intakes for all residents. Some residents only wanted ice passed, which could be a preference or it could be due to a restriction. He/she did not know if the resident had a fluid restriction.</p> <p>During interviews on 09/26/24, at 3:35 P.M., and 10/01/24, at 11:40 A.M. and 4:25 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-Communication between the facility and dialysis center was hit and miss. Dialysis center staff were good about calling the facility if something was going on with the resident.</p> <p>-Staff used to weigh the resident before dialysis, but stopped.</p> <p>-The nurses assessed the residents' ports and shunt when they returned from dialysis. They checked for bleeding or anything abnormal, and documented the assessment in the resident's progress notes.</p> <p>-Dietary served the resident breakfast before he/she left to dialysis, and typically he/she returned before lunch.</p> <p>-Most residents did not receive morning medications before dialysis because they timed the most important medications for after dialysis. It did not make much sense to give residents their medication prior to dialysis for the dialysis machines to just clean their blood of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If a resident had a fluid restriction, staff monitored and documented their fluid intake at meals to ensure residents did not drink too much fluid.</p> <p>-Recently, the resident had a lot of issues with his/her shunt. One to two weeks ago he/she received a new port.</p> <p>-The resident returned to the facility, from the dialysis center, around lunchtime. The resident had a bag that hung on the back of his/her wheelchair. Staff placed the communication notes in the resident's bag, and dialysis staff documented on the note and sent it back to the facility with the resident.</p> <p>-The LPN had not completed those forms since he/she had been a nurse which was a few months.</p> <p>-Dialysis center staff typically called instead of documenting information on the communication form. When dialysis center staff called the facility, the nurse documented the information relayed by the dialysis clinic to the resident's progress note.</p> <p>-Any nurse could look in the resident's bag for the paperwork when the resident returned.</p> <p>-If a resident had a fluid restriction, the resident typically drank all of their fluids at meal time. The aides knew that each resident received two cups of fluid with each meal, they calculated the intake, and entered it into the electronic medical records.</p> <p>-The nurses should review the resident's fluid intakes. The resident had a 1500 ml fluid restriction.</p> <p>During an interview on 09/27/24, at 3:10 P.M., LPN A said when the resident returned from dialysis, staff checked the bag located on the back of his/her wheelchair, for paperwork, including laboratory results and communication forms. Sometimes dialysis staff placed paperwork in the bag, sometimes they did not. If the dialysis center sent laboratory results, the nurse faxed the report to the physician.</p> <p>During an interview interviews on 09/27/24, at approximately 11:00 A.M. and 12:10 P.M., and on 10/01/24, at 2:20 P.M. and 4:45 P.M., the Director of Nursing (DON) said the following:</p> <p>-Staff sent the communication forms to the dialysis center, but the dialysis center stopped completing them and returning them to the facility. The last one that she could find was at the end of July. The communication form should include the resident's vital signs, weight before and after dialysis, which dialysate they used, and if there were any issues during the treatment.</p> <p>-The DON had a meeting next Monday with the dialysis clinic to discuss communication.</p> <p>-The dialysis center placed the communication forms and laboratory results in the bag that's on the back of the resident's wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Last week, the resident had issues with his/her fistula. It was at that time she noticed the dialysis center was not communicating via written communication. The dialysis center did not write information regarding the issues the resident had with clots in his/her shunt. The dialysis center, at times, called the facility to relay information, but they also told the DON that dialysis center staff called the facility and nobody answered. The DON said she was at the desk, when dialysis staff said they called, and nobody called.</p> <p>-Staff should document in the resident's progress note when dialysis staff called the facility to relay information.</p> <p>-Dialysis staff placed the resident's laboratory results in the bag hanging on the back of the resident's wheelchair.</p> <p>-The nurses checked the bag, and if they found any laboratory results, they placed them in the physician's book for the physician to review. The nephrologist also reviewed laboratory results received at the dialysis center.</p> <p>-Dialysis staff called the facility when a resident's laboratory results were abnormal.</p> <p>-Staff documented any conversation with the dialysis staff in the resident's progress note.</p> <p>-When the resident had a clot in her shunt, dialysis staff called and facility staff documented the information in the notes.</p> <p>-The resident has had two shunt revisions on his/her left arm within the last month. They were both outpatient procedures. He/she now had a right port.</p> <p>-The staff checked the resident's the insertion site to make sure that the dressing was intact and the nurses should check the site every shift.</p> <p>-The DON did not know how often staff weighed the resident, but thought it was ordered weekly.</p> <p>-At one time staff took the resident's pre-and post dialysis weight, but dialysis staff also weighed the resident and it did not make sense for both to do so.</p> <p>-Facility staff would send the communication form to the dialysis clinic, but the dialysis clinic did not send the communication forms back to the facility.</p> <p>-Sometimes the dialysis clinic placed the laboratory results in the resident's bag, but they did not always put them in the binder. The dialysis center completed his/her blood work monthly. If there was an issue, they completed blood work more frequently. Typically, when another resident who received dialysis returned from dialysis, he/she gave the DON his/her laboratory results which then reminded her (the DON) to look for Resident #28's laboratory results.</p> <p>-Today, when the DON looked in the resident's bag, she found forceps which meant dialysis center staff must have removed stitches. There was no documentation or communication from the dialysis clinic to the facility regarding removing the stitches or why they sent the forceps.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Updating care plans was a group effort, but the Assistant Director of Nursing (ADON) ensured they were completed.</p> <p>-When a resident returned from a procedure, such as getting a new port, the resident did not always return with specific orders to assess the port. The facility had standing orders for the nurses to monitor the port.</p> <p>-The DON reviewed the resident's orders and did not find an order for weights. Usually resident had orders for weekly weights. The DON thought the resident had ordered weekly weights.</p> <p>-If a resident had a fluid restriction, it usually originated from a nephrologist recommendation. The restriction was considered part of the diet order and staff entered it as an order.</p> <p>-Staff should document fluid intake with meals, and when the nurses and/or certified medication technicians administered medication, they should keep track of how much fluid they gave the resident with their medications. The nurse at the end of the shift should add up the intake and enter the number of milliliters in the medication administration record. The aides knew residents had a fluid restrictions by reviewing a simplified version of the care plan in the electronic medical record.</p> <p>-The DON said she could see that staff were not consistently documenting the resident's fluid intake.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-Staff should follow physician's orders.</p> <p>-Communication with dialysis should include a communication form that was passed back-and-forth between the facility and the dialysis clinic.</p> <p>-Dialysis staff also called the facility with information and facility staff should document that information in the resident's progress notes.</p> <p>-The nurses should check the residents' shunts or ports as ordered.</p> <p>-The physician determined the fluid restriction amount. If a resident had a fluid restriction, staff needed to follow the guidelines. Staff should document the resident's fluid intake in the electronic medical record. If the resident was not compliant with the fluid restriction, staff should notify the physician and document the notification in the electronic medical record.</p> <p>-Residents should have a physician order to complete, at a minimum, weekly weights.</p>		

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NAME OF PROVIDER OR SUPPLIER  Cassville Health Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 County Farm Road Cassville, MO 65625	
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25513</p> <p>Based on observation, interview, and record review, the facility failed to ensure two residents received behavioral health services to maintain their highest practical psychosocial well-being when the facility failed to care plan and implement resident specific interventions and failed to follow-up on psychological services for one resident (Resident #24), and failed to follow-up with possible on psychological services after the resident exhibited an increase in his/her mood score and expressed desire to speak with a psychologist for one resident (Resident #28). The facility had a census of 41.</p> <p>1. Review of Resident #24's face sheet (a brief summary of the resident's history) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included above the knee amputation of the left leg, diabetes, depression, psychosis (mental state where a person has difficulty distinguishing reality from what is not real), and anxiety.</p> <p>Review of the resident's September 2024 Physician Order Sheet (POS) showed the following:</p> <p>-An order, dated 11/05/23, for duloxetine (an antidepressant) 30 milligrams (mg), one time a day related to depression. Take with 60 mg tablet;</p> <p>-An order, dated 11/05/23, for duloxetine 60 mg, one time a day related to depression. Take with 30 mg tablet.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/26/24, showed the following information:</p> <p>-Cognitively intact;</p> <p>-Felt down, depressed, or hopeless, never or one day;</p> <p>-Took an antidepressant</p> <p>-Took an antipsychotic.</p> <p>Review of the resident's progress note dated 01/26/24, at 3:51 P.M., showed a nurse documented that he/she asked the resident about seeing a psychologist related to his/her recent loss of limb. The resident agreed and thought it may be a good idea because he/she was feeling very down and defeated lately. The physician was agreeable to refer the resident to his/her psychologist of choice.</p> <p>Review of the resident's September 2024 POS showed an order, dated 06/14/24, for Seroquel (an antipsychotic), 200 mg, at bedtime related to unspecified psychosis.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly MDS, dated [DATE], showed the following information:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Little interest or pleasure in doing things, two to six days (several days);</li> <li>-Felt down, depressed, or hopeless, two to six days (several days);</li> <li>-Took an antidepressant;</li> <li>-Took an antipsychotic.</li> </ul> <p>Review of the resident's care plan, updated 08/28/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Required psychoactive medications for psychosis;</li> <li>-Administer psychotropic medications as ordered and report any side effects noted, such as nausea/vomiting, over sedation, increased agitation;</li> <li>-Reduce stimulations, including noise and lighting level, when feeling anxious or agitated.</li> </ul> <p>(Staff did not care plan regarding the resident's wish to see a psychologist or specific non-pharmacological interventions to help with mood.)</p> <p>Review of the resident's September 2024 POS showed an order. dated 09/20/24, to discontinue duloxetine 30 mg (per gradual dose reduction guidelines).</p> <p>Review of the resident's progress notes showed staff did not document regarding a referral for a psychologist.</p> <p>Observation and interview on 09/23/24, at 3:00 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat in his/her wheelchair in a dark room.</li> <li>-The resident said he/she had been depressed and on antidepressant medication since his/her amputation. He/she had complications with his/her amputation requiring another surgery. Now he/she had problems with his/her knee and could not use the prosthesis.</li> <li>-The resident said he/she did not think the facility had a psychologist who visited the facility. Staff had not asked the resident if he/she wanted to talk to a psychologist. He/she would talk to someone if they were available. His/her health issues were a lot to deal with, and add his/her age and that made it even harder.</li> <li>-The resident spoke in a flat tone with a somber expression, and did not smile during interaction.</li> </ul> <p>During an interview on 09/26/24, at 2:47 P.M., Licensed Practical Nurse (LPN) B said the resident had been very sick recently with one thing after another. The resident might be a little bit depressed, but he/she did not know for sure because of the resident's prolonged illness.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/24, at 2:37 P.M., Certified Nurse Aide (CNA) H said signs of depression included the resident appeared depressed or sad or if the resident told the CNA he/she was depressed. If a resident said he/she was depressed, the CNA would let the nurse and Director of Nursing (DON) know. The CNA had not seen the resident depressed.</p> <p>During an interview on 09/27/24, at 3:10 P.M., LPN A said it was hard to tell if the resident was depressed because the resident had not felt well for quite a while.</p> <p>During an interview on 10/01/24, at 2:00 P.M., the Social Services Designee (SSD) said the resident had not brought up anything to her related to talking with a psychologist. The resident had been sick recently. She had not asked the resident if he/she wanted to talk with a psychologist. That was not a typical question she asked residents. She did not know anything about the resident wanting to talk to a psychologist in January 2024.</p> <p>During an interview on 10/01/24, at 2:20 P.M., the DON said the following:</p> <p>-In January 2024, the resident exhibited pain medication seeking behaviors and she thought maybe the resident was masking emotional pain with pain medication. After the DON talked with the resident about her pain medication use, the resident started confiding in her about past issues.</p> <p>-About the time, the physician made an adjustment to one of her medication's.</p> <p>-The DON remembered talking to the resident about a psychologist, but scheduling psychologist appointment at that time was difficult because the resident had multiple appointments for his/her leg. At first the resident was hesitant with talking to a psychologist because he/she had never talked to anyone before and he/she didn't want someone to make her feel crazy.</p> <p>-After the resident started confiding in the DON, he/she did not express the need or want to speak to a psychologist therefore no one made an appointment.</p> <p>2. Review of Resident #28's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included multiple sclerosis (a chronic autoimmune disease that damages the protective coating around nerve fibers in the brain and spinal cord), diabetes, depression, and end stage renal disease (ESRD) is a chronic kidney disease that occurs when the kidneys are no longer able to function properly and permanently).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognitively intact;</p> <p>-Felt down, depressed, or hopeless, two to six days (several days);</p> <p>-Patient Health Questionnaire (PHQ-9- a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) total severity score = 1 which indicated no or minimal depression;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Took no antidepressants.</p> <p>Review of the resident's physician order, dated 07/17/24, showed an order for Celexa (an antidepressant medication), 10 mg, every day.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderately impaired cognition;</li> <li>-Little interest or pleasure in doing things, 12 to 14 days (nearly every day);</li> <li>-Felt down, depressed, or hopeless, 12 to -14 days (nearly every day);</li> <li>-Felt tired or had little energy, 12 to 14 days (nearly every day);</li> <li>-Poor appetite or overeating, 12 to 14 days (nearly every day);</li> <li>-Felt bad about self, or a failure, or had let self or family down, 12 to 14 days (nearly every day);</li> <li>-Trouble concentrating on things such as reading the newspaper or watching television, 7 to 11 days (half or more of the days);</li> <li>-PHQ-9 total severity score = 17 which indicated moderately severe depression.</li> <li>-Took an antidepressant.</li> </ul> <p>Review of the resident's care plan, last updated 09/02/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Psychosocial well-being at risk related to diagnosis of depression;</li> <li>-Allow to express feelings and speak with psychiatric/counselor if wanted/requested;</li> <li>-Current psychological medications included Celexa for depression;</li> <li>-Facility staff to provide additional recreational tools inside their room or facility;</li> <li>-Encourage to attend/participate in activities;</li> <li>-Notify physician if symptoms of psychosocial duress is noted, such as withdrawn, increased isolation in room, prolonged decreased appetite, prolonged change in mood;</li> <li>-Approach in a calm manner, introduce yourself and explain all procedures. Provide encouragement and socialization during tasks;</li> <li>-Required psychoactive medication for diagnosis of depression;</li> </ul> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Administer medications as ordered and report any side effects noted, such as nausea/vomiting, sedation, increased agitation;</p> <p>-May have psychological services as needed/requested;</p> <p>-Offer one-on-one visits and activities;</p> <p>-Offer to take to an activity to increase socialization.</p> <p>Observation and interview on 09/25/24, at 1:00 P.M., showed the resident sat in his/her wheelchair. The resident said he/she was depressed and wanted to talk to someone (a psychologist) about his/her depression, but no one had offered that service to him/her.</p> <p>During an interview on 9/26/24, at 6:15 P.M., LPN B said the resident was depressed. Recently, within the last few days, the LPN noticed a shift in the resident's mood, and today he/she appeared more blah. The LPN attributed the change to seasonal depression.</p> <p>During an interview conducted on 09/27/24, at 3:10 P.M., LPN A said he/she did not know the resident well, but he/she typically laid in bed, all of the time, except when he/she went to dialysis.</p> <p>During an interview on 10/01/24, at 2:00 P.M., the SSD said the resident was is depressed and as far as she knew, the resident was not offered counseling services. She had not asked the resident if he/she wanted to talk with a psychologist. That was not a typical question she asked residents.</p> <p>During an interview on 10/01/24, at 2:20 P.M., the DON said the resident, at one time, took two antidepressants for his/her depression. He/she developed serotonin syndrome (a potentially life-threatening drug reaction that occurs when there's too much serotonin in the body) and the physician had to discontinue one of the antidepressants. The resident had never verbalized to her that he/she wanted to speak to a psychologist.</p> <p>3. During an interview on 09/26/24, at 2:47 P.M., LPN B said the following:</p> <p>-He/she had not seen a psychologist visit the facility.</p> <p>-If a resident appeared depressed, withdrawn, slept more than usual, had labile (fluctuating) emotions, or erratic behaviors, he/she would notify the physician, follow the physician's instructions, and documented the change and notification in the progress notes.</p> <p>-As far as the MDS and PHQ9 scores, the nurses or Assistant Director of Nursing (ADON) completed the mood interview. If there was an increase or a change in the score, staff would notify the DON, ADON, and the physician.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on 09/27/24, at 3:10 P.M., LPN A said signs and symptoms of depression included self-isolating, not eating, not talking, sadness, not wanting to talk about anything happy, and generally not acting like themselves. If he/she noticed any of these symptoms, he/she would notify the DON. If this was new behavior, then the nurse would also notify the physician, follow physician orders, and document the symptoms and notification in the resident's progress notes. The LPN did not know who completed residents' MDS mood interviews. The LPN did not know if a psychologist visited the facility.</p> <p>5. During an interview on 09/27/24, at 2:37 P.M., CNA H said signs of depression included the resident appearing depressed or sad, or if the resident told the CNA he/she was depressed. If a resident said he/she was depressed, the CNA notify the nurse and DON know.</p> <p>6. During an interview on 09/27/24, at approximately 3:15 P.M., LPN E said at other facilities he/she worked at, social services completed the MDS mood interview, but he/she did not know if that's who did it at this facility.</p> <p>7. During an interview on 10/01/24, at 2:00 P.M., the SSD said the following:</p> <ul style="list-style-type: none"> <li>-She had been the social services designee since April 2024.</li> <li>-She completed a wide range of duties which included completing the mood interview on the MDS.</li> <li>-When a resident's MDS was due, the electronic medical record created a task alerting staff to complete it.</li> <li>-If the SSD noticed a change in a resident's mood interview score or if the resident's score was consistently high, she reviewed the resident's medications and care plan to ensure staff included that information on the care plan, and discussed the resident's mood interview in the care plan meeting.</li> <li>-The facility was working on a system to address behavioral/mental health needs.</li> <li>-If a resident needed or wanted to speak with a psychologist, she would tell the DON about the resident's request and they would refer the resident to the a local counseling center. The SSD would schedule the appointment.</li> <li>-They did not have a psychologist that visited the facility.</li> <li>-The SSD did not have a legend that showed her what was considered a high mood interview score.</li> <li>-Asking a resident if he/she wanted to speak with a psychologist was not a typical question she would ask residents, but she usually asked when completing the mood interview.</li> <li>-All staff completed and updated residents' care plans.</li> </ul> <p>8. During an interview on 10/01/24, at 2:20 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The SSD completed the mood interview.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The SSD had not brought up any concerns related to mood interviews recently, but they did discuss it when she completed the assessment.</p> <p>-If there was a score change with the mood interview, the DON reviewed the resident's physician's orders then notified the physician. The physician may need to adjust the resident's medication at that time. Staff documented the physician notification in the resident's progress note.</p> <p>-The MDS Coordinator, who worked remotely, would let her (the DON) know if there was a big jump in a resident's mood interview score.</p> <p>-Within the last few months, they had a community coordinator came to the facility and talk to the residents about services, but they did not talk to administration about those services.</p> <p>-There was a program that provided group therapy three times a week, at the community center and the community center would provide transportation. At this time, they did not have any residents attending that program.</p> <p>-The DON asked the community coordinator to speak to residents because she did not think that residents knew there was an option to talk to somebody.</p> <p>-If a resident needed or wanted to speak with a psychologist, staff notified the physician and the physician would write an order. Staff asked the resident if he/she had a psychologist who he/she had seen in the past, if so, staff would schedule an appointment with that psychologist. If not, facility staff would schedule an appointment with the local counseling center.</p> <p>-They were trying to get a psychologist to come into the facility, but had not found one yet. The DON planned on talking with the local counseling center to possibly set up a psychologist to visit, but she thought they would need several residents to make it worth the psychologist's time. The facility used to have a psychologist and the DON did not know what happened to that psychologist.</p> <p>-The DON said updating care plans was a group effort. The ADON reviewed the care areas generated by the MDS, and included those areas in the care plan. She also added specific information related to that specific resident. They reviewed care plans quarterly concurrently with the MDS.</p> <p>9. During an interview on 10/01/24, at 7:05 P.M., the Administrator said they did not have a psychologist who visited the facility. If a resident had increased signs of depression, they would notify the physician. If a resident needed psychology services, the facility would look at outpatient services and would obtain an order from the physician.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>34906</p> <p>Based on observation, interview, and record review, the facility failed to ensure all physician ordered medications were safe and fully effective when the staff had three expired medications in the facility's medications carts affect at least two residents (Resident #30 and #46). The facility census was 41.</p> <p>Review of the facility's policy titled, Storage of Medications, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility shall store all drugs and biologicals in a safe, secure, and orderly manner;</li> <li>-The nurse staff shall be reasonable for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner;</li> <li>-The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.</li> </ul> <p>1. Observations on 09/26/24, at 9:45 A.M., of the nurse medication cart and the medication room with Licensed Practical Nurse (LPN) B showed the following:</p> <ul style="list-style-type: none"> <li>-One expired box of Naloxone nasal spray (a medication used to treat narcotic overdose in an emergency situation) 4 milligrams (mg) for Resident #30. The box showed a manufacturer's expiration date of 06/2024. The medication was located in the medication room crash cart (emergency cart);</li> <li>-One expired bottle of Nitrostat (a medication used to treat chest pain) sublingual (SL- under the tongue) tablets for Resident #46. The bottle showed a manufacturer's expiration date of 02/2024. The medication was located in nurse medication cart.</li> </ul> <p>Observation on 09/26/24, at 10:50 A.M., of the front certified medication cart (CMT) medication cart with CMT D showed the one stock bottle of Geri-kot (used to treat constipation) 8.6 mg with an manufacturer's expiration date of 03/2024.</p> <p>During interviews on 09/26/24, at 10:45 A.M., and on 10/01/24, at 1:01 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-He/she tried to check the medication carts periodically and tried to go thru the medications in medication room to check for expired medications;</li> <li>-He/she audited the medication room medications every two weeks;</li> <li>-The night nurses were supposed to start auditing the medication carts for expired medications this month (September 2024), but were not documenting the audits;</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she thought he/she had removed Resident #30's expired Naloxone from the medication cart for return to the pharmacy and replacement. but he/she may have left the medication on the crash cart in the medication room and suspected another nurse may have placed the medication in the cart, not realizing the medication was expired.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34906</p> <p>Based on observation, interview, and record review, the facility failed ensure a medication error rate less than 5% percent when staff made two errors out of 25 opportunities (8% error rate) when staff failed to administer ordered medications to residents (Resident #11 and #2) during medication pass observation. The facility census was 41.</p> <p>Review of the facility policy/procedure titled, Medication Orders, revised November 2014, showed the following:</p> <ul style="list-style-type: none"> <li>-Medications should be reordered from the pharmacy in a timely manner to ensure no lapse of administration of medications;</li> <li>-For medications not received from pharmacy after reorder, nursing staff to follow up with pharmacy on availability and time frame to be delivered;</li> <li>-Staff may pull medication from STAT (emergency) safe, if available, notify the physician of any need in order change and notify the resident's representative if any new orders were obtained.</li> </ul> <p>1. Review of Resident #11's face sheet (a brief summary of a resident's medical record) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE] with a readmitted [DATE];</li> <li>-Diagnoses included diabetes mellitus, type II with diabetic neuropathy (nerve damage that can cause numbness and pain), wedge compression fracture (a spinal fracture when the front of the vertebra collapses) of thoracic (T) 11-12 vertebra (mid back), dorsalgia (pain in the back or spine), and chronic pain.</li> </ul> <p>Review of the resident's Physician Order Summary (POS) report showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 01/12/24, for pregabalin (medication used to treat nerve and muscle pain) capsule 50 milligrams (mg), give one capsule by mouth three times a day related to diagnoses of wedge compression fracture of vertebra and dorsalgia.</li> </ul> <p>Review of the resident's September 2024 Nurse Administration Record showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 01/12/24, for pregabalin capsule 50 mg, give one capsule by mouth three times a day (A.M., noon, and at hour of sleep);</li> <li>-On 09/24/24, staff documented a code 9: for all three doses. Code '9' indicated other/see progress notes.</li> </ul> <p>Observation and interview on 09/24/24, at 11:48 A.M., with Licensed Practical Nurse (LPN) A showed the following:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Cassville Health Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 County Farm Road Cassville, MO 65625	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she was responsible for checking resident blood sugars, administering insulin, and administering controlled medications;</p> <p>-The resident had an order for pregabalin at that time;</p> <p>-The facility did not currently have the medication in the facility for the resident, because they were awaiting the medication from the pharmacy;</p> <p>-He/she thought the pharmacy was awaiting a new physician's prescription before dispensing the medication.</p> <p>25513</p> <p>2. Review of Resident #2's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included unspecified osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down)</p> <p>Review of the resident's September 2024 POS and Medication Administration Record (MAR) showed the following:</p> <p>-An order, dated 12/19/23, for Tylenol 325 mg, two tablets every day;</p> <p>-On 09/24/24, the certified medication tech (CMT) documented a 9 which indicated other/see progress notes.</p> <p>Observation and interview on 09/24/24, at 3:12 P.M., showed the following:</p> <p>-CMT V prepared all of the resident's afternoon/evening medications for administration except for the Tylenol 325 mg.</p> <p>-The CMT said the facility did not have any Tylenol 325 mg tablets. The Tylenol was a stock medication that they usually kept in the medication cart. Earlier that day, the CMT could not find the bottle of Tylenol in the cart, and looked in the medication storage room, but did not find any there either. Since the facility did not have any Tylenol 325 mg tablets at that time, he/she would document the medication was unavailable.</p> <p>During an interview on 10/01/24, at 2:20 P.M., the Director of Nursing (DON) said the following:</p> <p>-If a CMT did not find a specific medication, specifically a stock medication, the CMT should talk to her first before documenting the medication was not available.</p> <p>-The facility may have that medication somewhere else and may not truly be out of the medication.</p> <p>-The DON would look for the medication and if she could not find it, she would get the medication from a local pharmacy, especially if the medication was a common stock medication.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-When staff told her they did not have any Tylenol 325 mg tablets, she went to the store and bought a bottle. She did not know the resident did not receive that ordered dose of Tylenol.</p> <p>3. During interviews on 10/01/24, at 1:01 P.M. and 2:20 P.M., the DON said the following:</p> <p>-If staff could not find a specific medication, they should notify her in case they had the medication in another cart or in the medication storage room.</p> <p>-Not administering an ordered medication, except when a resident refused, was a medication error.</p> <p>-He/she expected the pharmacy to notify the facility if they had an issue filling a prescription and the reason;</p> <p>-Medications ordered from the pharmacy should arrive the same day as ordered;</p> <p>-If the medication did not arrive with the pharmacy delivery, the CMT or nurse should call the pharmacy, check on the status of the order, and notify the DON, so he/she could follow up and try to get with pharmacy or try to get the medications from an alternative pharmacy;</p> <p>-Additionally, the nurse should check to see if the medication is in the emergency kit (E-kit);</p> <p>-If the nurse cannot locate the medication in the E-Kit, the nurse would notify the physician for further instructions to see if the physician could substitute the ordered medication for a different meds or change the order.</p> <p>4. During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-The nurses should follow physician orders when administering medications.</p> <p>-If an ordered medication was not available, staff should check the facility for the medication, and if they cannot locate the medication, they should notify the physician and contact the pharmacy.</p> <p>-The pharmacy the facility used was located out of town. Because of that, the facility should have a back up plan such as checking local pharmacies if necessary. When the facility resorted to buying a medication at a local pharmacy it depended on the medication and timeframe of delivery/availability of the facility's contracted pharmacy.</p>		

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<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> 25513</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication error when staff failed to administer insulin per physician orders, failed to document notification of the partial insulin doses, and failed to develop and implement specific interventions related to diabetes for one resident (Resident #24). The facility also failed to administer multiple doses of two medications ordered to manage one resident's (Resident #28) chronic kidney disease. The facility census was 41.</p> <p>Review of the facility policy/procedure titled, Medication Orders, revised November 2014, showed the following:</p> <ul style="list-style-type: none"> <li>-A current list of orders must be maintained in the clinical record of each resident.</li> <li>-Orders must be written and maintained in chronological order.</li> <li>-Medications should be reordered from the pharmacy in a timely manner to ensure no lapse of administration of medications.</li> <li>-If medications were not received from pharmacy after reorder, nursing staff were to follow up with pharmacy on availability and time frame to be delivered;</li> <li>-Staff may pull medication from STAT safe, if available, and notify the physician of any need in order change and notify the resident's representative if any new orders were obtained.</li> </ul> <p>1. Review of Resident #24's face sheet (a brief summary of the resident's medical and admission history) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included diabetes.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 07/25/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Received insulin seven out of seven days.</li> </ul> <p>Review of the resident's care plan, updated 08/28/24, showed the resident at risk for nutritional problems related to diabetes. (The care plan did not include specific interventions related to blood glucose and insulin usage).</p> <p>Review of the resident's current Physician Order Sheet (POS) showed the following:</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 07/19/24, for Humalog KwikPen 100 units/milliliter (ml) (a fast acting insulin), inject as per following sliding scale:</p> <ul style="list-style-type: none"> <li>-If blood glucose reading was 60 to 120 milligrams/deciliter (mg/dL), staff to administer 0 units of insulin;</li> <li>-If blood glucose reading was 121 to 175 mg/dL, staff to administer 2 units of insulin;</li> <li>-If blood glucose reading was 176 to 225 mg/dL, staff to administer 4 units of insulin;</li> <li>-If blood glucose reading was 226 to 275 mg/dL, staff to administer 5 units of insulin;</li> <li>-If blood glucose reading was 276 to 325 mg/dL, staff to administer 6 units of insulin;</li> <li>-If blood glucose reading was 326 to 375 mg/dL, staff to administer 8 units of insulin;</li> <li>-If blood glucose reading was 376 to 425 mg/dL, staff to administer 9 units of insulin;</li> <li>-If blood glucose reading was 426 to 475 mg/dL, staff to administer 10 units of insulin;</li> <li>-If blood glucose reading was 500 mg/dL, staff to call physician;</li> <li>-The order did not include insulin dosage for blood glucose 476 to 500 mg/dL;</li> <li>-Insulin to be administered before meals and at bedtime for diabetes;</li> </ul> <p>-An order, dated 07/19/24, for Tresiba (a long-acting insulin) 100 unit/ml, inject 15 unit subcutaneously (under the skin) one time a day for diabetes;</p> <p>-An order, dated 07/19/24, for Tresiba 100 units/ml, inject 20 unit subcutaneously at bedtime for diabetes.</p> <p>Review of the resident's August 2024 nurse Medication Administration Record (MAR) and corresponding MAR progress notes showed the following:</p> <ul style="list-style-type: none"> <li>-On 08/06/24, at bedtime (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 5 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</li> <li>-On 08/07/24, at 12:04 P.M., a nurse documented the resident's blood glucose was 418 mg/dL with partial administration of Humalog insulin. The nurse administered 8 units of insulin per resident's request (the order indicated the nurse should administer 9 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</li> <li>-On 08/10/24, at 7:58 A.M., a nurse documented the resident's blood glucose was 426 mg/dL and he/she administered 10 units of Humalog per orders. The nurse documented on the MAR progress note, he/she administered 7 units of insulin per resident's request. The nurse did not document he/she contacted the physician regarding the partial dose;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 08/12/24, at 12:04 P.M., a nurse documented the resident's blood sugar was 418 mg/dL and partial administration of Humalog insulin. The nurse administered 8 units of insulin per resident's request (the order indicated the nurse should administer 9 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 08/13/24, at bedtime (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 8 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 08/14/24, at 8:47 P.M., a nurse documented the resident's blood glucose was 544 mg/dL and other/see progress note. The nurse documented on the MAR progress note the resident would not allow the nurse to contact the physician. The nurse administered Humalog 14 units per resident's request (the order indicated the nurse should contact the physician for dosage);</p> <p>-On 08/17/24, morning medication (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 10 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 08/19/24, at bedtime (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 8 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 08/20/24, at 9:00 P.M., a nurse documented the resident's blood glucose was 190 mg/dL, no insulin required (the order indicated the nurse should administer 4 units of Humalog insulin);</p> <p>-On 08/22/24, at 9:00 P.M., a nurse documented the resident's blood glucose was 209 mg/dL, no insulin required (the order indicated the nurse should administer 4 units of Humalog insulin);</p> <p>-On 08/27/24, at 8:00 A.M., a nurse documented the resident's blood glucose was 339 mg/dL, partial administration of Humalog insulin. The nurse administered 7 units of insulin per resident's request (the order indicated the nurse should administer 8 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 08/28/24, at bedtime (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 5 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 08/29/24, at 11:00 A.M., a nurse documented the resident's blood glucose was 490 mg/dL, no insulin required (the order had no instructions for insulin dosage for blood glucose level of 476-500 mg/dL). The nurse did not document he/she contacted the physician for dosage instructions;</p> <p>-On 08/30/24, at 9:00 P.M., a nurse documented the resident's blood glucose level was 135 mg/dL, no insulin required (the order indicated the nurse should administer 2 units of Humalog insulin).</p> <p>Review of the resident's September 2024 nurse MAR and corresponding MAR progress notes showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 09/12/24, at 9:00 P.M., a nurse documented the resident's blood glucose was 178 mg/dL, no insulin required (the order indicated the nurse should administer 4 units of Humalog insulin).</p> <p>-On 09/14/24, at 9:00 P.M., a nurse documented the resident's blood glucose was 125 mg/dL, no insulin required (the order indicated the nurse should administer 2 units of Humalog insulin);</p> <p>-On 09/16/24, at 9:00 P.M., a nurse documented the resident's blood glucose was 148 mg/dL, no insulin required (the order indicated the nurse should administer 2 units of Humalog insulin);</p> <p>-On 09/18/24, at 8:15 A.M., a nurse documented the resident's blood glucose was 352 mg/dL, partial administration of Humalog insulin. The nurse administered 5 units of insulin per the resident's request (the order indicated the nurse should administer 8 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 09/18/24, at 4:59 P.M., a nurse documented the resident's blood glucose was 440 mg/dL, partial administration of Humalog insulin. The nurse administered 8 units of insulin per the resident's request (the order indicated the nurse should administer 10 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 09/19/24, at 9:19 A.M., a nurse documented partial administration of Tresiba insulin, and 10. The nurse added a note that showed he/she administered 12 units of insulin per the resident's request (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 09/19/24, at 11:49 A.M., a nurse documented the resident's blood glucose was 475 mg/dL, and partial administration of Humalog insulin. The nurse administered 7 units of insulin per the resident's request (the order indicated the nurse should administer 10 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>Observation on 09/24/24, at 11:22 A.M., of the resident's medication administration showed the following:</p> <p>-Licensed Practical Nurse (LPN) A performed a finger stick blood glucose check on the resident;</p> <p>-The glucometer showed a result of 136 milligrams/deciliter (mg/dL);</p> <p>-The resident told the LPN he/she did not want any insulin (refused dose of 2 units Humalog insulin due per the resident's sliding scale order).</p> <p>During an interview on 09/24/24, at 11:25 A.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident tells the nurse how much insulin he/she wants and the resident did not usually follow by the sliding scale order.;</p> <p>-The nurse told the resident in the past as long as he/she was not asking for more than the order allowed, it was okay to adjust the amount of insulin taken;</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The nurse said when the resident asked for a different amount of insulin than what the physician ordered, he/she made a note in the resident's medical record.</p> <p>Review of the resident's September 2024 nurse MAR and corresponding MAR progress notes showed the following:</p> <p>-On 09/24/24, at bedtime (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 12 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose;</p> <p>-On 09/24/24, at bedtime (no corresponding note with specific time), a nurse documented partial administration of Tresiba insulin, and 12 (the order indicated the nurse should administer 20 units of insulin). The nurse did not document he/she contacted the physician regarding the partial dose.</p> <p>During an interview on 09/25/24, at 11:05 A.M., the resident said staff checked his/her blood glucose four times a day, before meals and at bedtime. The physician ordered a sliding scale for insulin dosage, but the resident did not always follow the order. The resident had been a diabetic for [AGE] years and he/she told the nurses what dosage he/she would take.</p> <p>During interviews on 09/26/24, at 3:35 P.M. and 6:15 P.M., LPN B said the following:</p> <p>-The resident sometimes told the nurses how much insulin he/she would take which was not always the entire dose the physician ordered. The resident would ask to take less, but never asked for more than prescribed.</p> <p>-When the resident did not take the full ordered dose, the nurse notified the physician via secure message, and documented it in the resident's progress notes. Usually the physician just answered ok.</p> <p>-Recently, the resident's blood glucoses were higher due to an ordered steroid.</p> <p>-If the resident's blood glucose was out of range (greater than 500 mg/dL), the nurse contacted the physician.</p> <p>-When the physician wrote an order, the nurse who took the order, entered the order into the electronic medical record. The nurse thought the Assistant Director of Nursing (ADON) or Director of Nursing (DON) reviewed new orders.</p> <p>-The LPN did not see dosage instructions for blood glucose level of 476 to 500 mg/dL.</p> <p>During an interview on 09/27/24, at 3:10 P.M., LPN A said the following:</p> <p>-When the resident requested a partial dose of insulin, the nurses documented the dosage in the MAR progress notes and notified the physician of the partial dose via secure message. The nurse noted the notification in the resident's progress notes.</p> <p>-The nurse did not administer more insulin than prescribed, but did administer less.</p> <p>-Usually the physician answered OK when notified.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The nurse did not know if another nurse or administration staff checked newly entered orders for accuracy.</p> <p>-If the nurse noticed a resident's sliding scale was missing instructions, he/she would message the physician for clarification.</p> <p>Observation and interview on 10/01/24, at 2:20 P.M., with the DON showed the the following:</p> <p>-The resident's physician knew the resident dictated his/her own insulin dosage. Because of that, the physician adjusted his/her sliding scale. The resident was on a high dose sliding scale, and the physician changed it to a low-dose sliding scale. The physician adjusted the resident's sliding scale closer to the dosage the resident historically requested.</p> <p>-The nurses messaged the physician each time the resident requested a different ordered dose.</p> <p>-The DON reviewed the resident's MAR monthly for any trends.</p> <p>-Observation showed the DON searched the physician/facility secure messaging for messages to the physician related to the resident requesting an adjustment of his/her insulin dosage. The DON did not find any messages to the physician regarding the partial dose administrations.</p> <p>-The DON said she verbally had a conversation with the physician around the time the sliding scale changed. The sliding scale order changed on 07/19/24. The DON told the physician that the resident frequently requested a lower insulin dose than ordered. The DON said she should have documented the conversation she had with the physician in the progress notes.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the nurses should follow sliding scale orders for the administration of insulin. If the resident did not take the ordered dose, the nurse should contact the physician and document the notification in the progress note.</p> <p>2. Review of Resident #28's face sheet showed the following:</p> <p>-Readmitted [DATE];</p> <p>-Diagnoses included end stage renal disease (ESRD - a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis) and dependence on renal dialysis (a process of filtering and removing waste products from the bloodstream when the kidneys can no longer sufficiently do so).</p> <p>Review of the resident's July 2024 and August 2024 MAR and corresponding MAR progress notes showed the following:</p> <p>-An order, dated 07/18/24, for Veltassa oral packet (a prescription medication used to treat high levels of potassium), 8.4 grams, give one packet by mouth one time a day (scheduled for 12:00 P.M.);</p> <p>-On 07/20/24, 07/27/24, and 07/31/24, a CMT documented absent from home without medications;</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 08/03/24, 08/10/24, 08/17/24, 08/21/24, 08/24/24, 08/30/24, and 08/31/24, a CMT documented absent from home without medications.</p> <p>Review of the resident's laboratory results from the dialysis center showed the following:</p> <p>-On 08/08/24, potassium level (goal 3.5-5.7)=6.6;</p> <p>-On 08/13/24, potassium level (goal 3.5-5.7)=5.3.</p> <p>Review of the resident's July 2024 and August 2024 MAR and corresponding MAR progress notes showed the following:</p> <p>-An order, dated 07/17/24, for Auryxia oral tablet (a medication that rids the body of extra phosphorus for people with chronic kidney disease on dialysis), give four tablets with meals for kidney failure (scheduled for 7:00 A.M., 12:00 P.M., and 5:00 P.M.);</p> <p>-On 07/18/24, 07/23/24, 07/25/24, and 07/30/24, at 7:00 A.M., a certified medication technician (CMT) documented absent from home without medications;</p> <p>-On 07/20/24, 07/27/24, and 07/31/24, at 7:00 A.M. and 12:00 P.M., a CMT documented absent from home without medications;</p> <p>-On 08/02/24, at 12:00 P.M. and 5:00 P.M., a CMT documented absent from home without medications;</p> <p>-On 08/03/24 and 08/10/24, at 7:00 A.M. and 12:00 P.M., a CMT documented absent from home without medications;</p> <p>-On 08/06/24, 08/08/24, 08/13/24, 08/15/24, and 08/17/24, at 7:00 A.M., a CMT documented absent from home without medications;</p> <p>-On 08/09/24, at 7:00 A.M., a CMT documented other/see progress note.</p> <p>Review of the resident's phosphorus laboratory results from the dialysis center, dated 08/15/24, showed the following:</p> <p>-Phosphorus level (goal 3.5-5) = 7.4.</p> <p>-The resident's phosphorus was high. High phosphorus could lead to bone disease. The resident needed to limit milk to 1/2 cup per day, and avoid cheese, dairy products, chocolate, [NAME] and highly processed foods. The resident needed to make sure he/she took Auryxia, the phosphorus binder, four tablets with each meal. Diet, dialysis and binders are necessary for good control.</p> <p>Review of the resident's August 2024 MAR and corresponding MAR progress notes showed the following:</p> <p>-An order, dated 07/17/24, for Auryxia oral tablet, give four tablets with meals for kidney failure (scheduled for 7:00 A.M., 12:00 P.M., and 5:00 P.M.);</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Cassville Health Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 County Farm Road Cassville, MO 65625	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 08/13/24, 08/15/24, 08/17/24, 08/20/24, and 08/22/24, at 7:00 A.M., a CMT documented absent from home without medications.</p> <p>Review of the resident's phosphorus laboratory results from the dialysis center, dated 08/22/24, showed the following:</p> <p>-Phosphorus level (goal 3.5-5) = 6.9.</p> <p>-The resident's phosphorus was high. High phosphorus could lead to bone disease. The resident needed to limit milk to 1/2 cup per day, and avoid cheese, dairy products, chocolate, [NAME] and highly processed foods. The resident needed to make sure he/she took Auryxia, the phosphorus binder, four tablets with each meal. Diet, dialysis and binders are necessary for good control.</p> <p>Review of the resident's August 2024 MAR and corresponding MAR progress notes showed the following:</p> <p>-An order, dated 07/17/24, for Auryxia oral tablet, give four tablets with meals for kidney failure (scheduled for 7:00 A.M., 12:00 P.M., and 5:00 P.M.);</p> <p>-On 08/24/24, at 7:00 A.M. and 12:00 P.M., a CMT documented absent from home without medications;</p> <p>-On 08/27/24, at 7:00 A.M., a CMT documented absent from home without medications;</p> <p>-On 08/28/24, at 7:00 A.M., a CMT documented other/see progress notes. Waiting on delivery;</p> <p>-On 08/28/24, at 5:00 P.M., a CMT documented other/see progress notes, not applicable;</p> <p>-On 08/29/24, at 7:00 A.M., a CMT documented absent from home without medications;</p> <p>-On 08/29/24, at 12:00 P.M. and 5:00 P.M., for Auryxia, a CMT documented other/see progress notes, not applicable;</p> <p>-On 08/30/24 and 08/31/24, at 7:00 A.M. and 12:00 P.M., for Auryxia, a CMT documented absent from home without medications;</p> <p>-On 08/31/24, at 5:00 P.M., for Auryxia, a CMT documented hospitalized .</p> <p>Review of the resident's annual MDS, dated [DATE], showed the resident had moderately impaired cognition.</p> <p>Review of the resident's care plan, updated 09/02/24, showed the following:</p> <p>-The resident attended dialysis on Tuesday/Thursday/Saturday;</p> <p>-Monitor labs per physician order. Labs are also obtained at the dialysis clinic;</p> <p>-Current medications for dialysis includes Renvela (a medication that rids the body of extra phosphorus for people with chronic kidney disease on dialysis) 800 mg 4 tabs, three times daily.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(The resident did not have an order for Renvela. The care plan did not include Auryxia or Veltassa, or the dietary recommendations due to elevated phosphorus levels.)</p> <p>Review of the resident's September 2024 and corresponding MAR progress notes showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 07/17/24, for Auryxia oral tablet, give four tablets with meals for kidney failure (scheduled for 7:00 A.M., 12:00 P.M., and 5:00 P.M.);</li> <li>-On 09/02/24, at 12:00 P.M., a CMT documented absent from home without medications;</li> <li>-On 09/03/24 and 09/05/24, at 7:00 A.M., a CMT documented absent from home without medications.</li> </ul> <p>Review of the resident's laboratory results from the dialysis center, dated 09/05/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Phosphorus level (goal 3.5-5) =7.7.</li> <li>-The resident's phosphorus was high. High phosphorus could lead to bone disease. The resident needed to limit milk to 1/2 cup per day, and avoid cheese, dairy products, chocolate, [NAME] and highly processed foods. The resident needed to make sure he/she took Auryxia, the phosphorus binder, four tablets with each meal. Diet, dialysis and binders are necessary for good control.</li> </ul> <p>Review of the resident's September 2024 and corresponding MAR progress notes showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 07/17/24, for Auryxia oral tablet, give four tablets with meals for kidney failure (scheduled for 7:00 A.M., 12:00 P.M., and 5:00 P.M.);</li> <li>-On 09/07/24, at 7:00 A.M. and 12:00 P.M., a CMT documented absent from home without medications;</li> <li>-On 09/10/24 and 09/12/24, at 7:00 A.M., a CMT documented absent from home without medications;</li> <li>-On 09/17/24, at 7:00 A.M., 12:00 P.M., and 5:00 P.M., a CMT documented absent from home without medications;</li> <li>-On 09/19/24, at 7:00 A.M., a CMT documented absent from home without medications;</li> <li>-On 09/20/24, at 12:00 P.M., a CMT documented other/see progress note, morning medications administered late;</li> <li>-On 09/21/24, at 7:00 A.M. and 12:00 P.M., a CMT documented absent from home without medications;</li> <li>-On 09/24/24 and 09/26/24 at 7:00 A.M., a CMT documented absent from home without medications;</li> <li>-On 09/28/24, at 7:00 A.M. and 12:00 P.M., a CMT documented absent from home without medications.</li> </ul> <p>Review of the resident's September 2024 and corresponding MAR progress notes showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 07/18/24, for Veltassa oral, 8.4 g, give one packet by mouth one time a day (scheduled for 12:00 P.M.). Order discontinued on 09/27/24.</p> <p>-On 09/02/24, a CMT documented absent from home without medications.</p> <p>-On 09/06/24, a CMT documented hold/see progress note, medication held per charge nurse instructions.</p> <p>-On 09/07/24, a CMT documented absent from home without medications.</p> <p>-On 09/12/24 and 9/13/24, a CMT documented other/progress notes, not applicable.</p> <p>-On 09/14/24 and 9/15/24, a CMT documented other/progress notes, medication unavailable.</p> <p>-On 09/16/24, a CMT documented other/progress notes, not applicable.</p> <p>-On 09/17/24, a CMT documented absent from home without medications.</p> <p>-On 09/18/24-09/19/24, a CMT documented other/progress notes, not applicable.</p> <p>-On 09/20/24, a CMT documented other/progress notes, morning medications administered late.</p> <p>-On 09/21/24, a CMT documented absent from home without medications.</p> <p>-On 09/23/24, a CMT documented other/progress notes, not applicable.</p> <p>-On 09/24/24, a CMT documented other/progress notes, not applicable.</p> <p>-On 09/25/24, a CMT documented other/progress notes, waiting for delivery.</p> <p>-On 09/27/24, a CMT documented other/progress notes, waiting for delivery.</p> <p>Review of the resident's laboratory results from the dialysis center, dated 09/05/24, showed potassium level (goal 3.5-5.7)= 5.1.</p> <p>Observation and interview on 09/25/24, at 1:00 P.M., showed the resident said he/she had a powdered medication (Veltassa) that staff should give him/her every day or at least on the days he/she did not go to dialysis, but staff had not administered it to him/her in at least five days. The resident said he/she had no current issues with diarrhea, but did a few weeks ago.</p> <p>Observation and interview on 10/01/24, at 12:55 P.M., showed on dialysis days, the resident did not think he/she received his/her morning medications with breakfast because staff thought since he/she received dialysis, the medications would be dialyzed out of his/her blood, so there was no point. No one told the resident the physician discontinued the Veltassa.</p> <p>During an interview on 10/01/24, at 11:45 A.M. and at 1:10 P.M., CMT D said the following:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If he/she could not find a medication for administration, he/she checked, in the resident's electronic medical record (EMR), if staff had already ordered the medication and if not, he/she would order it. He/she also would let the nurse know and document in the MAR the medication was not available.</p> <p>-If a medication showed a morning administration time such as 7:00 A.M. and the resident left for dialysis at 5:45 A.M., he/she could not administer that dose of medication. The CMT did not start his/her shift until 6:00 A.M.</p> <p>-The CMT did not have to notify the nurse of the missed dose because the nurses could see which residents had medications due because the EMR alerted them of the scheduled medications and past due medications. On the days the resident was gone to dialysis during medication pass, the CMT documented the resident was absent from the home without medications.</p> <p>During interviews on 09/26/24, at 3:35 P.M. and 6:15 P.M., and on 10/01/24, at 1:12 P.M., LPN B said the following:</p> <p>-The process for requesting refills on medications depended on the medication.</p> <p>-For most medications, staff requested a refill in the electronic medical record.</p> <p>-Usually the pharmacy delivered the medication the next day and sometimes even the same day if they requested it before a certain time.</p> <p>-If the facility did not receive the requested medication by the next day, the nurse called the pharmacy.</p> <p>-The resident's Veltassa was a special medication and the dialysis clinic helped the facility to obtain it. They could not request a refill in the electronic medical record. The facility had to order the Veltassa via mail order which made it difficult, coupled with the resident's lack of payor source made it even more difficult.</p> <p>-The CMTs should notify the charge nurse if a resident did not have an ordered medication. The CMTs did not tell him/her the resident was out of Veltassa.</p> <p>-If staff could not administer a medication due to lack of availability, the nurse contacts the pharmacy and secure message to the physician.</p> <p>During an interview on 09/27/24, at 3:10 P.M., LPN A said the following:</p> <p>-Staff usually reordered residents' medications in the electronic medical record. The CMT requested refills of the medications on the CMT MAR and the nurses requested refills for the medications on the nurses' MAR. However, the nurses could request refills for the CMT medications if needed.</p> <p>-The CMTs and nurses tried to request refills before the medication reached blue line on the medication card, which was seven days.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Usually, if staff requested a refill before noon, the pharmacy delivered it the same night, but if not, they would deliver it the next day.</p> <p>-If the facility did not have a specific medication, the nurse would check if staff requested a refill, if not, then he/she would request the refill. If staff already requested a refill but did not have the medication, the nurse would call the pharmacy.</p> <p>-If staff could not administer a medication, the nurse notified the physician and documented the notification in the notes.</p> <p>Review of the resident's progress notes, dated 09/27/24, showed the DON documented the following:</p> <p>-At 12:04 P.M., late entry on 09/13/24, the resident had several episodes of loose stools. The resident's previous potassium level, drawn on 09/05/24, was 5.1. The physician ordered staff to hold Veltassa until the diarrhea resolved.</p> <p>-At 12:22 P.M., the resident's Veltassa was held since 09/13/24. The resident's potassium level continued to remain within range. The physician discontinued the medication.</p> <p>During interviews on 09/27/24, at approximately 12:00 P.M., and 10/01/24, at 2:20 P.M. and 4:45 P.M., the DON said the following:</p> <p>-The DON remembered she needed to enter a progress note regarding the held medication when the surveyor asked her about the medication.</p> <p>-On 09/13/24, the resident had diarrhea and they held his/her Veltassa because it was contraindicated, and could cause diarrhea.</p> <p>-The resident had several episodes of diarrhea prior to 09/13/24.</p> <p>- On 09/13/24, the DON told a CMT to hold the Veltassa until she got it clarified. The DON forgot to add the hold to the MAR.</p> <p>-If a physician ordered a medication to be held, the nurse entered the hold order to carry over onto the MAR. However, if the hold was for for any length of time, the DON usually just discontinued the medication and would restart it with a new order, if needed, at a later date.</p> <p>-The resident's Valtessa was suppose to auto-ship, but there were issues with the payer source and that was the reason the medication was not delivered to the facility timely.</p> <p>-If staff did not have a medication to administer, they should let her know.</p> <p>-If staff did not have a medication to administer, the nurse notified the physician then documented the notification in the resident's progress notes.</p> <p>-Not administering an ordered medication, except when a resident refused, was a medication error.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-CMTs should notify her and the charge nurse for every medication error. She or the charge nurse would notify the physician and complete an incident report regarding the error. Any notes documented in the incident report auto-populated to the resident's progress note.</p> <p>-The DON received emails from the pharmacy asking for approval to deliver the resident's Veltassa because the resident had to pay for the medication, and it was costly.</p> <p>-The DON did not know the resident was not receiving the Valtessa until she received the emails.</p> <p>-The DON asked the physician if they could hold the medication until they figured out the billing, however after reviewing the resident's potassium level which showed it was stable, the physician determined that they no longer needed the medication at that time, plus the resident had diarrhea often.</p> <p>-The facility followed a liberalized medication administration time. Staff typically administered residents' medications after they returned from dialysis. If they received their medications prior to dialysis, it would be pointless because the medications would be dialyzed out of the resident's blood.</p> <p>-The resident had an order to take medication with breakfast to help with meal absorption. The resident should get that medication when he/she ate breakfast, which was prior to dialysis.</p> <p>-If staff were not able to consistently administer a resident's medications, they should tell the nurse or the DON.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-If a nurse or CMT made a medication error, the nurse completed an incident report and contacted the physician and the DON. A medication error included not administering a medication due to unavailability.</p> <p>-If the pharmacy did not deliver a requested medication, staff should contact the pharmacy and figure out when the medication would be delivered.</p> <p>3. During an interview on 09/26/24, at 6:30 P.M., the corporate nurse said she had worked for the company for about six weeks. When she came into the facility, she found there was a problem with staff not consisten[TRUNCATED]</p>		

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<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>48534</p> <p>Based on observation, interview, and record review, the facility failed ensure food was protected from possible contamination per standards of practice when the facility failed to keep the ceiling in the kitchen and microwave free of debris and when the facility allowed dogs in the dining room during meals. The facility's census was 41.</p> <p>1. Review of the facility's policy titled General Sanitation of Kitchen, undated, showed that food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p> <p>Observations on 09/23/24, at 9:39 A.M., on 09/24/24, at 8:48 A.M., and 09/25/24, at 11:15 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-A three-foot by two-foot area of peeling paint on the ceiling above the food preparation table (the peeling paint could fall and contaminate food or food contact surfaces);</li> <li>-A four-foot by four-foot size piece of material that appeared to be used to repair an area of the ceiling. A three-foot line on the edge of the material is separating from the ceiling and causing a two-inch gap between the ceiling and the material above the food preparation table;</li> <li>-The microwave in the kitchen had a twelve-inch area, under the turn table ring where paint had peeled off. Under the peeled paint in the microwave the surface was yellow, brown and orange in color, and appeared to be rust.</li> </ul> <p>During an interview on 09/25/24, at 1:04 P.M., with Dietary Aide (DA) K said the following:</p> <ul style="list-style-type: none"> <li>-The chipping paint on the ceiling had been that way since at least June 2024;</li> <li>-The gap in the ceiling was getting bigger;</li> <li>-The chipping paint could fall into food being prepared, contaminate the food, and make residents sick;</li> <li>-Cooks are responsible for cleaning the microwave.</li> </ul> <p>During an interview on 09/25/24, at 1:11 P.M., [NAME] L said the following:</p> <ul style="list-style-type: none"> <li>-The paint chipping on the ceiling above the food preparation table had been that way since June 2024;</li> <li>-He/she reported the chipping paint to the Dietary Manager;</li> <li>-The chipping paint could fall into food, contaminate the food, and make the residents sick;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-He/she was not aware of the chipping paint and discoloration on the bottom of the microwave;</p> <p>-Kitchen staff had daily and weekly cleaning list. Cooks are responsible for cleaning the microwave;</p> <p>-He/she doesn't use the microwave in the kitchen very often since meals are served out of the dinette in the dining room.</p> <p>During an interview on 9/26/24 at 1:11 P.M., the Dietary Manager said the following:</p> <p>-He/she reported the chipping paint and the gap in the ceiling to maintenance by way of the maintenance repair request book located at the nurses desk;</p> <p>-The maintenance staff were responsible for repairing and maintaining the walls, ceilings, floors and vents in the kitchen;</p> <p>-He/she was not aware of the chipping paint and discoloration on the bottom of the microwave;</p> <p>-The microwave should be a cleanable surface.</p> <p>During an interview on 10/01/24, at 2:52 P.M., the Maintenance Supervisor said the following:</p> <p>-He was updating the lights in the kitchen and when the old light fixture was taken down the chipping paint and the gap in the ceiling was exposed;</p> <p>-The maintenance supervisor said the parts for repairing the ceiling above the food preparation table have been ordered.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-The maintenance staff are responsible for repairs to the floors, walls, and ceilings in the kitchen;</p> <p>-The ceiling in the kitchen above the food preparation table has been in that condition since June 2024;</p> <p>-The maintenance staff are working on getting material to fix the ceiling;</p> <p>-The chipping paint could fall off the ceiling and contaminate the food being prepared and possibly make residents sick;</p> <p>-He was not aware of the chipping paint and discoloration inside the microwave in the kitchen.</p> <p>34906</p> <p>2. Review of the Food and Drug Administration (FDA) Food Code 2022 showed the following:</p> <p>-Animals carry disease-causing organisms and can transmit pathogens to humans</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>through direct and/or indirect contamination of food and food-contact surfaces.</p> <p>-Except as specified food employees may not care for or handle animals that may be present.</p> <p>Observation on 09/23/24 at 12:10 PM showed a dog ran into the dining room and the Director of Nursing (DON) picked up the dog from the dining room floor and carried the dog around the dining room during lunch time with residents present in the dining room.</p> <p>During an interview on 09/23/24, at 1:00 P.M., Resident #12 said the following:</p> <p>-The DON brought two dogs to the facility daily and sometimes the Activity Director brought his/her dogs to the facility;</p> <p>-These dogs frequently walked around the dining room tables looking for food scraps during resident meal time;</p> <p>-He/she did not like the dogs in the dining room when he/she was trying to eat</p> <p>During an interview on 09/24/24, at 10:30 A.M., Resident #38 said the following:</p> <p>-He/she did not like the dogs running around in the facility;</p> <p>-The dogs walk into the dining room during resident meals;</p> <p>-The smaller dog urinated on the floor of the facility at times;</p> <p>-He/she did not like the dogs being in the dining room.</p> <p>During an interview on 09/26/24, at 11:00 A.M., Certified Medication Technician (CMT) D said the following:</p> <p>-There were two dogs in the facility, both belonged to the DON;</p> <p>-Staff tried to keep the dogs out of dining room, but they wandered into the dining room at times.</p> <p>During an interview on 10/01/24, at 11:40 A.M., HK I said the following:</p> <p>-The dogs came into the dining room during resident meal time;</p> <p>-Some of the residents complained about the dogs in the dining room and about the dogs urinating and defecating in the facility.</p> <p>During an interview on 09/26/24, at 11:31 A.M., the Housekeeping Supervisor said the following:</p> <p>-The DON brought his/her two dogs to the facility every day and the dogs urinated on the floor in the facility and pooped in the floor of the facility at times;</p> <p>-The dogs wandered into the dining room during resident mealtime;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Cassville Health Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 County Farm Road Cassville, MO 65625	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-During lunch, the dogs walked into the dining room approximately two to three times per week.</p> <p>During an interview on 09/26/24, at 2:19 P.M., the Dietary Manager said the following:</p> <p>-Animals, including dogs, should not be in the dining room when food was being served;</p> <p>-The DON's two dogs had been coming to the facility for several months;</p> <p>-The DON's two dogs had been going into the dining room when food was being served on numerous occasions;</p> <p>-He/she told the DON and Administrator that animals, including dogs, could not be in the dining room when food was being served.</p> <p>During an interview on 09/26/24, at 3:45 P.M., the Social Service Designee (SSD) said the following:</p> <p>-The two dogs belonged to the DON and the DON brought the dogs to the facility every day that he/she worked;</p> <p>-He/she and other staff attempted to keep the dogs out of the dining room, but he/she was sure the dogs went to the dining room.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-The DON's dogs were not allowed to into the dining room during meal time;</p> <p>-The DON should keep his/her dogs out of the dining room.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48534</p> <p>Based on observation, interview, and record review, the facility failed to provide a functional, sanitary, and comfortable environment for residents, staff and the public, when staff failed to keep resident room floors a cleanable surface and failed to ensure the ceilings in good repair. The facility census was 41.</p> <p>Review of the facility's policy titled, Quality of Life - Homelike Environment, dated May 2017, showed the following:</p> <p>-The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characterizes include clean, sanitary, and orderly environment;</p> <p>-Staff shall provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences.</p> <p>1. Observation on 09/23/24, at 10:43 A.M., of room [ROOM NUMBER] showed the floor had a buildup of a black, gummy substance on it.</p> <p>There were four chipped tiles with missing pieces causing the floor to not be a cleanable surface.</p> <p>Observation on 09/23/24, at 10:44 A.M., of the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] showed the floor had a buildup of a black substance on it. Pieces of tile were missing from the floor, leaving gaps between the tiles. The tiles were separating and the grout between the tiles was black.</p> <p>Observation on 09/23/24, at 3:01 P.M., of room [ROOM NUMBER] showed two chipped tiles with pieces of tile missing.</p> <p>Observation on 09/26/24, at 3:00 P.M., of room [ROOM NUMBER] showed the entire tile floor appeared brownish yellow in color (in contrast with the cream-colored tiles of the hallway), with a tacky texture and the appearance wax build up. A urine smell permeated the room.</p> <p>Observation on 09/26/24, at 3:00 P.M., of room [ROOM NUMBER] showed the entire tile floor appeared brownish yellow in color (in contrast with the cream-colored tiles of the hallway), with a tacky texture and the appearance wax build up. A urine smell permeated the resident's room.</p> <p>During an interview on 09/26/24, at 11:20 A.M., Housekeeper (HK) M said the following:</p> <p>-He/she mopped the resident rooms daily and sometimes more than once per day as needed;</p> <p>-He/she changed the mop heads every three rooms (after cleaning three rooms);</p> <p>-He/she used a flat rectangular microfiber mop head and triple (a floor cleaner);</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-HK M reported to the HK Supervisor and to the Administrator that some of the resident rooms were not cleanable due to a buildup of wax.</p> <p>During an interview on 10/01/24, at 11:40 A.M., HK I said the following:</p> <p>-Many of the resident floors were discolored a yellowish-brown color;</p> <p>-The chemicals the facility used to clean the floors did not work;</p> <p>-He/she had never seen the floor cleaning machine used in the resident rooms;</p> <p>-The mop heads HK used were not effective to clean with, the mop heads frequently became caught in the wax build up on the floors and would fall off the mop handle;</p> <p>-The nurse aides were supposed to use the mop bucket in the dirty utility room to clean up urine spills, and then notify HK;</p> <p>-HK changed out the dirty utility room mop water and mop head daily;</p> <p>-The Cardinal Hall had an odor of urine every day.</p> <p>During an interview on 09/26/24, at 11:31 A.M., the HK Supervisor said the following:</p> <p>-Some of the resident floors have a black and yellow buildup of wax and urine, which turned into a gummy substance that cannot be mopped up. When this occurred maintenance needed to strip the wax off the floors and then re-wax the floors, but maintenance had not stripped or re-waxed most of the rooms;</p> <p>-In November 2023, the Administrator, the Maintenance Supervisor, and the Housekeeping Supervisor made a list of the resident floors maintenance needed to strip and re-wax, but Maintenance had not completed most of the rooms;</p> <p>-Housekeepers deep cleaned two resident rooms per day in the facility;</p> <p>-During the deep clean all the resident furniture, staff moved out of the rooms and cleaned all surfaces in the room;</p> <p>-During the deep cleans, maintenance should use the floor cleaning machine and then buff the floors, but that did not usually occur;</p> <p>-The Maintenance Supervisor informed the HK Supervisor the maintenance department did not have time or were busy doing other jobs when asked to clean the floors;</p> <p>-Approximately 2 to 3 months ago, the Administrator, the Maintenance Supervisor, and the HK Supervisor discussed the need for maintenance to use the floor cleaning machine during the resident room deep cleaning days, but they were not doing so;</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The flat microfiber mop heads used to mop, were not working to clean some areas of the floor, and instead pushed the dirt around;</p> <p>-On 09/12/24 or 9/13/24, the HK Supervisor ordered better mop heads (the loop heavy duty type), but they were on back order, therefore the facility continued to use the flat microfiber type.</p> <p>During an interview on 10/01/24, at 2:30 P.M., the Maintenance Supervisor said the following:</p> <p>-The floors on Cardinal Hall were discolored due to normal aging of the tile;</p> <p>-He/she did not clean floors, he only refinished the floors;</p> <p>-The facility had an issue with the floor cleaning chemicals reacting with the wax which created a gummy substance and caused the wax to slide around, but the issue resolved when the facility changed chemicals;</p> <p>-None of the floors were scheduled to be stripped and re-waxed because the wax lasts for [AGE] years and will just gradually wear away as maintenance buffed the floors;</p> <p>-The floors were cleaned using the cleaning machine and buffed during the deep clean days;</p> <p>-Every resident room was deep cleaned monthly.</p> <p>During an interview on 10/01/24, at 9:35 A.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-Housekeeping mopped the resident room floors daily or more if needed;</p> <p>-If a resident urinated in the floor, staff should use towels to dry up the majority of the urine and then the nursing staff were supposed to clean up the urine spill with a mop and mop bucket located in the dirty utility rooms;</p> <p>-Housekeeping changed the dirty utility room mop head and mop water daily;</p> <p>-Some of the residents on the Cardinal Hall urinated on the floor and staff attempt to clean the floors, but the floors became dirty again shortly after cleaning.</p> <p>During an interview on 10/01/24, at 1:01 P.M., the Director of Nursing (DON) said the following:</p> <p>-If a urine spill occurred, the aides should clean up the majority of the urine from the floor, with a towel and then use the mop and mop bucket located in the dirty utility room to clean the remainder of the spill;</p> <p>-Nursing should then notify housekeeping so they can replace the mop water and the mop head after each use;</p> <p>-Maintenance and HK said the chemicals HK used to clean the resident room floors had a chemical reaction with the wax which caused a gummy substance on the resident floors;</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/she mopped the floors in some of the resident rooms in the past, and the floors did not appear clean after mopping;</p> <p>-Maintenance ordered new wax and was supposed to be in the process of stripping and re-waxing the floors one room at a time;</p> <p>-Some of the resident rooms were not cleanable due to the buildup of wax;</p> <p>-He/she said staff try to mop the rooms frequently after urine spills, but he/she thought the wax was compromised and that made it difficult to get rid of the urine smell in the rooms.</p> <p>During an interview on 10/01/24, at 7:05 P.M., the Administrator said the following:</p> <p>-It took the Administrator and maintenance department a long time to figure out what was causing the discoloration of the floor tile of the resident rooms on Cardinal Hall</p> <p>-Maintenance determined in July 2024, the cleaning chemicals used by housekeeping were interacting with the wax on the floors, and the facility switched to a different cleaning chemical;</p> <p>-Maintenance was supposed to go through and strip and re-wax each resident room;</p> <p>-During the deep clean of resident rooms, staff should pull out all the resident furniture and sweep and mop the floors;</p> <p>-Maintenance did not use the floor machine to clean or buff the floors during the deep clean;</p> <p>-Maintenance used the floor machine when stripping and re-waxing the rooms;</p> <p>-If CNAs clean up a urine spill from the floor, should notify housekeeping to change out the mop water, instead of CNAs continuing to use the same mop water for the remainder of the day.</p> <p>34906</p> <p>2. Observation on 09/26/24 at 3:00 P.M., of the Cardinal Hall (a resident hallway) showed the following:</p> <p>-An approximate 4 by 4-foot dried brown stain on the ceiling between rooms 21-22 paint. The texture was missing, exposing sagging sheet rock, and dangling dry wall tape;</p> <p>-A 5 by 6-inch area of dried brown streaks starting at the top edge of the wall running down the wall, lateral to the ceiling stain.</p> <p>During an interview on 09/24/24, at 10:30 A.M., Resident #38 said the following:</p> <p>-A couple of months ago, the facility had water leaking from the ceiling outside of his/her room in the hallway on Cardinal Hall;</p> <p>(continued on next page)</p>		

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