STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189 Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #40 and #293), in a review of 16 sampled residents, and one additional resident (Resident #35), were treated in a manner to promote dignity and respect, when the facility failed to cover a urinary catheter (a tub inserted into the bladder that drains urine from the bladder into a collection bag outside of the body) collection bag. The facility census was 43. Review of the facility policy, Quality of Life-Dignity, dated August 2009, showed the following: -Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality; -Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered. 1. Review of Resident #40's significant change Minimum Data Set (MDS), a federally mandated assessment required to be completed by facility staff, dated 06/03/24, showed the following: -He/She was cognitively impaired; -He/She was dependent for toileting needs; -He/She had a urinary catheter. Review of the resident's undated Care Plan showed the following: -He/She had a urinary catheter for urinary retention; -Ensure urinary catheter bag cover is used for dignity. Observation on 07/08/24 at 10:35 A.M. showed the resident sat in his/her wheelchair in the common area. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/08/24 at 12:35 P.M. showed the resident sat in his/her wheelchair at a dining room table, eating lunch. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/09/24 at 8:41 A.M. showed the resident sat in his/her wheelchair in the common area. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/10/24 at 8:44 A.M. showed the resident sat in his/her wheelchair in the common area. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/11/24 at 10:39 A.M. showed the resident sat in his/her wheelchair in the common area. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. 2. Review of Resident #293's Baseline Care Plan, dated 06/28/24, showed the following: -He/She required minimal assistance with mobility; -He/She had a urinary catheter. Review of the resident's admission MDS, dated [DATE], showed the following: -He/She was cognitively intact; -He/She was independent for toileting needs; -He/She had a urinary catheter. Observation on 07/08/24 at 12:28 P.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating lunch. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/08/24 at 1:34 P.M. showed staff pushed the resident from the dining room to his/her room in his/her wheelchair. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/09/24 at 6:27 A.M. showed Certified Nurse Assistant (CNA) B pushed the resident in his/her wheelchair to the dining room. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/09/24 at 7:11 A.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating breakfast. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/09/24 at 1:49 P.M. showed therapy staff walked with the resident in the hallway. The resident's urinary catheter bag, which contained urine, hung from the resident's walker. The catheter bag was not covered with a dignity cover. Observation on 07/10/24 at 11:45 A.M. showed Nurse Aide (NA) C pushed the resident in his/her wheelchair to the dining room. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/10/24 at 12:18 P.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating lunch. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/11/24 at 11:55 A.M. showed the resident sat in his/her wheelchair at a table in the dining room, waiting for lunch. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. 3. Review of Resident #35's quarterly MDS, dated [DATE], showed the following: -He/She was cognitively impaired; -He/She required substantial to maximum assistance for toileting needs; -He/She had a urinary catheter. Review of the resident's undated Care Plan showed he/she had a urinary catheter. Observation on 07/08/24 at 12:34 P.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating lunch. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/09/24 at 07:31 A.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating breakfast. Other residents were in the area. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. Observation on 07/11/24 at 9:21 A.M. showed two staff transferred the resident from his/her wheelchair to a recliner in the common room, where other residents were present. The resident's urinary catheter bag, which contained urine, hung under his/her wheelchair and was not covered with a dignity cover. 4. During an interview on 07/11/24 at 11:06 A.M. Nurse Aide (NA) E said urinary catheter bags should always have a dignity cover on them. During an interview on 07/11/24 at 11:11 A.M. CNA F said urinary catheter bags should always have a dignity cover. During an interview on 07/11/24 at 2:51 P.M., the Infection Preventionist/Registered Nurse A said urinary catheter bags should always be in a dignity cover. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/24 at 2:42 P.M., the Director of Nursing (DON) said she expected urinary catheter bags to have dignity cover. She was aware of this issue and the facility did not currently have enough dignity covers for all residents with urinary catheters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 50675 Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account by not reconciling each month. The facility managed funds for 25 residents. The census was 43. Request for a facility policy regarding the reconciliation of the resident funds account was made and none provided. 1. Record review of the reconciliation of resident funds, provided by the Business Office Manager (BOM), showed no reconciliation for the full resident trust account. 2. Record review of the Corporate Accountant's attempted reconciliation of the resident trust account, for accounts ending in #370665 and #342130, for the period 06/2023 through 06/2024, showed no reconciliations. During an interview on 07/10/24 at 3:37 P.M., the BOM said she only reconciled the petty cash accounts. Corporate staff reconciled the bank accounts. During an interview on 7/11/24 at 9:46 A.M., the Corporate Accountant said the facility BOM reconciled the petty cash only. They only reconciled the two bank accounts. During an interview on 07/16/24 at 9:55 A.M., the BOM said Corporate transfers $1,500 each month to the resident trust account so the account does not go into a negative. During an interview on 07/15/24 at 11:48 A.M., the Facility Management Company Staff said the operating account transfers $1,500 monthly to the resident trust account so there were no negative issues. The reconciliation does not deduct out the amount the facility transfers and the reconciliation does not have a $0 difference/balance. The resident petty cash may have been started with facility funds but no documentation can be located to verify if the petty cash funds start up funds were from the facility or the resident funds. During an interview on 7/16/24 at 2:48 P.M., the Administrator said he expected the resident funds account to be reconciled correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 36219 Based on observation, interview and record review, the facility failed to ensure the telephone number and contact information for the state survey agency and the elder abuse hotline were posted in the facility. The facility census was 43. Review of the undated facility policy titled, Resident Rights, showed the following: -Employees shall treat all residents with kindness, respect, and dignity; -Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter. 1. Observation on 7/8/24 at 11:35 A.M. throughout the facility showed no posted state survey agency or elder abuse hotline contact information. Observation on 7/9/24 at 7:18 A.M. throughout the facility showed no posted state survey agency or elder abuse hotline contact information. Observation on 7/10/24 at 8:30 A.M. throughout the facility showed no posted state survey agency or elder abuse hotline contact information. Observation on 7/11/24 at 8:50 A.M. throughout the facility showed no posted state survey agency or elder abuse hotline contact information. Observation on 7/11/24 at 3:12 P.M. in the front foyer area (visible through a window as you walk in the front door of the facility) hung the elder abuse hotline phone number. The number was not readily visible to those inside the front door in the front foyer area (the number hung on the back of a wall). 2. During the group resident council interview on 07/09/24 at 10:00 A.M., the residents in attendance said they did not know where the state survey agency or elder abuse hotline contact information was posted at the facility. 3. During an interview on 7/11/24 at 8:40 A.M., Resident #6 said the following: -He/She did not know how to contact the state agency or hotline; -He/She had not seen the state agency or hotline numbers posted anywhere in the facility; -He/She had only seen the Resident's Rights posters in the hallways. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18540 State Highway 16, Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 7/11/24 at 8:55 A.M., the Human Resources staff said she looked throughout the facility and could not find the state survey agency or elder abuse hotline contact information posted. During an interview on 7/11/24 at 3:12 P.M., the Administrator said the following: -Social services was responsible for posting the hotline number and state agency contact number; -He would expect the hotline number and state agency contact information to be posted and was not aware it was not posted throughout the facility; -The hotline number was posted in the front sitting room under the side window of the breezeway but not the state agency contact number was not posted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50675 Based on interview and record review, the facility failed to timely serve a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Notice of Medicare Non-Coverage (NOMNC) (CMS-10123) in writing, at least two days before the Medicare days were exhausted, to three residents (Residents #344, #343 and #34), in a review of three sampled residents. The facility census was 43. Request for a facility policy regarding the issuing of NOMNCs was made and none provided. Record review of the undated, Form Instructions for the NOMNC, showed the NOMNC must be delivered at least two calendar days before Medicare coverage services end. Record review of the CMS Survey and Certification memo, dated 1/9/09, showed the following: -The NOMNC is issued when all covered Medicare services end for coverage reasons; -If the SNF believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by the use of either the SNF Advance Beneficiary Notice (ABN) (CMS-10055) or one of the five uniform denial letters; -The SNF ABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have; -If the SNF provides the beneficiary with either the SNF ABN or a denial letter at the initiation, reduction or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. 1. Review of Resident #343's NOMNC showed the following: -The resident's last skilled day (facility initiated discharge from services) was 3/6/24; -The facility provided the resident with the form and he/she signed it on 3/5/24; -The resident was not provided the form within 48 hours of discharge. 2. Review of Resident #34's NOMNC showed the following: -The resident's last skilled day (facility initiated discharge from services) was 3/18/24; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	-The facility provided the resident's representative with the form and he/she signed it on 3/18/24; -The resident's representative was not provided the form within 48 hours of discharge. 3. Review of Resident #344's NOMNC showed the following: -The resident's last skilled day (facility initiated discharge from services) was 4/24/24; -The facility provided the resident's representative with the form and he/she signed it on 4/23/24; -The resident's representative was not provided the form within 48 hours of discharge. During an interview on 7/9/24 at 1:00 P.M., the Social Services Director (SSD) said the following: -She was unaware the notices needed to be given at least two days before discharge; -She said he/she had never been trained in giving ABNs/ NOMNCs. During an interview on 7/11/24 at 3:12 P.M., the Administrator said the following: -The Business Office Manager or SSD, in collaboration with Therapy, were to issue the notices; -He expected the notices to be issued according to regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189 Based on observation, interview and record review, the facility failed to accurately complete comprehensive assessments for three residents (#25, #2, #18) in a review of 16 sampled residents. The facility census was 43. Review of the undated facility policy titled, Minimum Data Set (MDS), Completion and Submission Timeframes, showed the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy did not address accuracy. Review of the Centers for Medicare and Medicaid Services (CMS) Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, version 1.18.11, October 2023, showed the following: -The Omnibus Budget Reconciliation Act (OBRA) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents; -The RAI process is the basis for the accurate assessment of each resident; -The treatments, procedures and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity and quality of life; -Code peritoneal or renal dialysis which occurs at the nursing home or at another facility. -Section I shows for physician diagnoses, include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. Review of the Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Chapter 3, Section M, defines the different stages of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) as follows: -Stage II: Partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue). May also present as an intact or open/ruptured blister; -Stage III: full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining (destruction of tissue or ulceration extending under the skin edges) or tunneling (a passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #25's quarterly MDS dated [DATE] showed no documentation the resident received dialysis. Review of resident's POS dated July 2024 showed an order for renal dialysis scheduled Tuesday, Thursday Saturday with a start date 11/13/23. Review of resident's undated Care Plan showed the resident received hemodialysis three times weekly. Observation and interview with resident on 07/08/24 at 11:16 A.M. showed the following: -He/She had been on dialysis for about three years; -He/She goes to dialysis treatment three times weekly. (The resident's MDS completed on 6/20/24 was not accurate and did not identify the resident received dialysis.) 2. Review of Resident #2's physician progress note, dated 6/30/21, showed the resident had diagnoses that included severe intellectual disability (mental retardation). Review of the resident's quarterly MDS, dated [DATE], showed under section A, no documentation the resident had diagnoses that included severe mental illness, mental retardation or other related conditions. Review of the resident's physician progress note, dated 5/22/24, showed his/her diagnoses included severe intellectual disability (mental retardation). During an interview on 7/9/23 at 1:24 P.M., the MDS coordinator reviewed the resident's Physician Progress Note, dated 5/22/24, and said she did not know the resident had intellectual disability (mental retardation) and the MDS was inaccurate. 3. Review of Resident #18's summarization of episode note (entry for readmission information) showed the resident was readmitted to the facility, from the hospital, on 5/30/24. Review of the resident's nursing admission screening/history, dated 5/30/24, showed staff documented the resident had the following: -Left buttocks- two stage II pressure ulcers; -Coccyx (small triangular bone at the base of the spinal column) - one stage II pressure ulcer. Review of the resident's significant change/ five day MDS, dated [DATE], showed the resident had three stage III pressure ulcers that were present upon admission/entry or reentry. Review of the resident's medical record showed no evidence to support the resident's buttocks or coccyx wounds worsened from a stage II to a stage III. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24 at 1:18 P.M., the MDS coordinator said after reviewing the resident's nursing admission screening/history, dated 5/30/24, the MDS was inaccurate. The resident's pressure ulcers were all stage II and not stage III. 4. During an interview on 07/11/24 at 1:03 P.M., the MDS coordinator said the following: -She was responsible for accurately completing all MDS assessments and used a combination of nursing notes, resident interviews, and visual assessments to complete; -She followed the RAI manual; -Missing Resident #25's dialysis was a complete oversight and error on her part. During an interview on 07/11/24 at 2:42 P.M., the Director of Nursing (DON) said the following: -She was responsible for signing off on the MDS as being completed and she expected the MDS to be accurate; -She expected the MDS to be completed per the RAI manual guidelines and to reflect current resident conditions and diagnoses. 50675

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50675 Based on observation, interview and record review, facility staff failed to post required nurse staffing information, which included the facility name, resident census and total actual hours worked by both licensed and unlicensed nursing staff, directly responsible for resident care, per shift, daily. The facility census was 43. Review of the facility policy, titled Posting Direct Care Daily Staffing Numbers, dated 7/2016, showed the following: -The facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents; -Within two hours of the beginning of each shift, the number of Licensed Nurses ((Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Licensed Vocational Nurses (LVNs)) and the number of unlicensed personnel (Certified Nurse Aides (CNAs)), directly responsible for resident care, will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format; -Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include: a. The name of the facility; b. The date for which the information is posted; c. The resident census at the beginning of the shift for which the information is posted; d. 24-hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift; g. The actual time worked during that shift for each category and type of nursing staff; h. The total number of licensed and non-licensed nursing staff working for the posted shift; -Within two hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	-The form may be typed or handwritten. Should the form be handwritten, it must be legibly printed in black ink and must be written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in the facility's daily staffing information; -The previous shift's forms shall be maintained with current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it shall be forwarded to the Director of Nursing Services' office and filed as a permanent record; -Records of staffing information for each shift will be kept for a minimum of 18 months or as required by state law (whichever is greater). 1. Observation on 7/8/24 at 10:13 A.M., during a tour of the facility, showed no nurse staff posting. During an interview on 7/8/24 at 2:03 P.M., the Administer in Training said she took the staff postings down because a resident was tearing them off the bulletin board. 2. Observation on 7/9/24 at 5:45 A.M., during a tour of the facility, showed no nurse staff posting. 3. Observation of a bulletin board behind the nurses station, on 7/10/24 at 12:03 P.M., showed a nurse staffing sheet posted with only census information. There were no licensed or unlicensed staffing numbers or hours listed for each shift. During an interview on 7/10/24 at 2:38 P.M., the Director of Nursing reviewed the nurse staffing sheet on the bulletin board behind the nursing station and confirmed only the census information was on the sheet. 3. Review of the facility provided, 18 months of nurse staffing sheets, showed approximately 1/3 of the sheets were blank and did not include the required information. Interview on 7/11/24 at 1:00 P.M., the Director of Nursing confirmed many of the nurse staffing posting sheets were blank and did not include the required information. She said she expects the sheets to be filled out per regulations. During an interview on 7/11/24 at 3:12 P.M., the Administrator said he expected the daily staffing sheets to be posted each day, completed accurately and posted conspicuously.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34536

Based on observation, interview, and record review, the facility failed to maintain the range hood free of a buildup of grease and debris; failed to maintain the air conditioner and microwave free of a buildup of debris; failed to ensure food items were labeled, dated, covered and discarded when expired; failed to ensure a water dispenser and a water dispensing unit was free of a buildup of debris; failed to ensure staff utilized safe food handling practices when preparing ready to eat food items; failed to ensure staff handled ready to eat foods safely; failed to ensure staff wore hair restraints properly; and failed to ensure the ice machine was equipped with an appropriate air gap to prevent back siphonage. The facility census was 43.

1. Review of the undated facility policy, Cleaning Instructions: Hoods and Filters, showed stove hoods and filters will be cleaned according to a cleaning schedule or at least monthly.

Observation on [DATE] at 10:18 A.M. and on [DATE] at 7:49 A.M. showed the range hood had three filters that protected the stove, griddle and fryer. The filters had a heavy buildup of black and dark brown fuzzy debris with yellow and dark brown grease accumulation. The fire suppression system had a buildup of shiny yellow grease with drip formations on the nozzle caps. A sticker on the outside of the range hood showed the hood had been professionally cleaned on [DATE].

During interview on [DATE] at 11:15 A.M., the Dietary Manager said she was unaware dietary was responsible for cleaning the hood filters. The professional company did not clean the filters when they were onsite in February. She had worked in the dietary department for a year and had been the manager for six months. The filters needed to be cleaned.

During interview on [DATE] at 2:10 P.M., the Maintenance Supervisor said he was unsure when the range hood filters were last cleaned. It had probably been a while since this had been done.

2. Observation on [DATE] at 10:25 A.M. and on [DATE] at 7:49 A.M. showed an air conditioner sat in the window frame in the kitchen. The exterior vents had a heavy buildup of dark colored fuzzy debris. The cool air blew through the vents towards the microwave and metal food preparation counter. An open plastic container that held large blocks of butter sat uncovered on a tray with the toaster on the metal preparation counter.

Observation on [DATE] at 10:26 A.M. and on [DATE] at 7:49 A.M. showed a microwave sat on a metal preparation counter. Rust-colored debris was visible inside the microwave around the bottom edges of the unit. A large rust-colored area on the top inside center portion of the microwave appeared to have exposed metal and peeling/chipped areas.

3. Review of the facility policy, Food Receiving and Storage, revised [DATE], showed the following:

-Foods shall be received and stored in a manner that complies with safe food handling practices;

-All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date);

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the Food Service Manager or designee and documented according to state-specific requirements; -All foods belonging to residents must be labeled with the resident's name, the item and the use by date. Observation on [DATE] at 10:31 A.M. inside the upright home-type freezer in the kitchen showed the following: -Three black bowls of vanilla ice cream sat uncovered; -A plastic bag of burritos were open to air and not sealed; -An open plastic bag of hamburger patties was open to air and not sealed. Observation on [DATE] at 10:40 A.M. inside the reach-in refrigerator showed the following: -A container of macaroni salad was loosely covered with tinfoil and had a resident's first name and room number written on the foil. The item was not dated; -Two small Styrofoam cups contained a white substance and were not labeled or dated; -A large Ziploc bag contained several peanut butter/jelly sandwiches. The bag was not dated; -A bottle of soda had been opened, but was not labeled with anyone's name; -A large plastic pitcher of dark colored liquid was labeled Cran and was dated ,d+[DATE]. Observation on [DATE] at 10:42 A.M. above the water dispenser on the metal shelf showed an open packet of low calorie drink mix that was open to air and unsealed. Observation on [DATE] at 7:49 A.M. showed a 2-ounce packet of punch drink mix was open to air and sat upright next to the water dispenser. The mix was open and unsealed. Observation on [DATE] at 10:45 A.M. of the triple door reach-in refrigerator showed the following: -A large clear container with a red lid was labeled Chicken noodle ,d+[DATE]; -A clear plastic pouch/bag of scrambled egg mix was closed with a metal binder clip. The bag was not dated; -A large clear container with a red lid contained shredded cheese and was not dated; -A plastic grocery sack held two egg cartons stacked on top of each other and four loose eggs sat on top of the top carton. The sack of eggs/carton sat on the second to bottom shelf directly over a container of cheese and a cantaloupe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 11:53 A.M. showed the Dietary Manager reheated the chicken noodle in the container dated ,d+[DATE] and placed it on a resident's hall tray for the lunch meal. Observation on [DATE] at 11:05 A.M. showed a metal shelf above the top of the steam table. The shelf contained the following: -The lid on a 16-ounce container of paprika was open and unsealed; -The lid on a 12-ounce container of basil was open and unsealed; -The lid on a 12.5-ounce container of ginger was open and unsealed; -The lid on a 16-ounce container of pumpkin pie spice was open and unsealed. 4. Observation on [DATE] at 10:41 A.M. and on [DATE] at 7:49 A.M. showed a tall upright water dispenser sat on the metal preparation counter. The dispensing spout had a buildup of dark colored crusty debris on the edges of the dispenser. A water filter and water line were connected to the unit. The water filter was labeled install [DATE] with a black marker. During interview on [DATE] at 8:20 A.M., the Dietary Manager said the following: -The water dispenser was cleaned with lime remover once a week; -She was not sure who was responsible for changing the water filter connected to the water dispenser. During an interview on [DATE] at 12:32 P.M., the Maintenance Supervisor said the facility purchased and installed the water dispenser in [DATE]. He was unsure why the filter had a different date on it. 5. Review of the undated facility policy, Bare Hand Contact with Food and Use of Plastic Gloves, showed the following: -Single-use gloves will be worn when handling food directly with hands to ensure that bacteria are not transferred from the food handler's hands to the food product being served. Bare hand contact with food is prohibited; -Staff will use clean barriers such as single-use gloves, tongs, deli paper and spatulas when handling food; -Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 11:10 A.M. showed the Dietary Manager removed some butter from the open container near the toaster and placed the butter in a skillet on the stovetop. Without washing his/her hands, she put on gloves, and removed two pieces of bread from a loaf. She used a knife to butter one slice of bread and placed it face down in the skillet on the stove. She buttered a second slice of bread and placed the slice of bread on the edge of the stove top. She wore the same gloves, opened the refrigerator door by the handle, and brought a container of cheese slices to the preparation counter. Using the same gloves, she removed a cheese slice from the container and placed the cheese on top of the bread slice in the skillet. She then removed the bread slice from the edge of the stove top and placed it on top of the cheese and bread in the skillet. 6. Review of the undated facility policy, Personal Hygiene and Health Reporting, showed hair should be neat and clean. Hair restraints must be worn around exposed foods, in the kitchen or food services areas and dining rooms. Observation on [DATE] during the lunch meal service between 11:53 A.M. and 1:01 P.M. and at 2:15 P.M. showed Dietary Staff L placed beverages, nutritional supplements and dessert items on each meal tray. He/She wore a hair restraint; however, the hair restraint did not contain his/her bangs and longer strands of hair on the sides of his/her face that were loose outside of the hair restraint. Observation on [DATE] at 7:49 A.M. showed Dietary Staff M wore a hair restraint; however, not all his/her hair from the back and sides of his/her head was contained inside the hair restraint. Dietary Staff M prepared drinks in the kitchen, placed the drinks on breakfast trays and carried the breakfast trays to the kitchen door for facility staff to deliver to residents in the dining room. 7. Observation on [DATE] at 2:44 P.M. and on [DATE] at 8:04 A.M. of the facility ice machine located in the staff breakroom, showed the approximately 2-inch drain pipe was not equipped with an air gap. The pipe sat down inside the drain and did not have adequate spacing for the required air gap. 8. Observation on [DATE] at 2:15 P.M., in the facility kitchen showed the cover over a four-bulb four bulb fluorescent light fixture located above the microwave and food preparation table was cracked and had a 3-inch by 3-inch hole in the cover. During an interview on [DATE] at 3:04 P.M., the Maintenance Director said the following: -He was responsible for monitoring the facility light fixtures and covers; -He checks light fixtures and covers on an ongoing basis; -He was unaware of the identified cracked cover with a 3-inch by 3-inch hole; -He expected facility light fixtures and covers to be maintained and without damage. 9. During interview on [DATE] at 8:20 A.M., the Dietary Manager said the following: -If family brought in food, snacks or drinks for residents, the food items should be separated from facility foods and labeled/dated; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-She was unaware the range hood filters needed to be cleaned. She had just learned this task was dietary's responsibility; -Maintenance staff changed the air conditioner filter and dietary staff cleaned the vents and outside cover either weekly or monthly; -Staff cleaned the microwave every shift. She will look closer at the inside to check the rust color inside. She was unaware of any damage inside the microwave; -Leftovers were good for three days, the date on the label is the date food was placed/stored in the refrigerator; -Pre-packaged foods that have not been opened goes by the manufacturers expiration date, salad dressing and condiments go by expiration date on bottle, if poured into dispensing container it is good for three days; -Shredded cheese was used quickly (usually in two to three days after opening) and she was unsure of how long shredded cheese lasted; -The cooks and aides checked the refrigerators for food labeling dates twice a week; -The four loose eggs were leftover from breakfast yesterday and the carton had been thrown away; -Freezer items should be sealed and dated; -Spice lids should not be open; -Opened drink packets should be sealed; -Any employee that entered the kitchen should wear a hair restraint and all hair should be covered; -She was unaware the ice machine did not have an air gap; -Gloves and handwashing should be performed when touching food items, should switch gloves in between different food items, and after touching dirty items, such as door handles, counter tops, etc. During an interview on [DATE] at 12:32 P.M., the Maintenance Supervisor said the following: -Dietary staff were responsible for cleaning the range hood baffle filters regularly and he would assist them if needed; -Dietary staff were responsible for cleaning the air conditioner monthly. He replaced the filters when needed; -He was unaware the microwave had possible rust/debris inside; -He was unaware the ice machine did not have an air gap. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49528

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36219

Based on observation, interview, and record review, the facility failed to use appropriate infection control procedures for hand hygiene to prevent the spread of bacteria or other infectious causing contaminates for one sampled resident (Resident #18) and one additional resident (Resident #35); failed to ensure urinary catheter (tube inserted into the bladder to drain urine) drainage bags did not touch the floor for three residents (Residents #35, #40, and #293); failed to utilize the appropriate personal protective equipment (PPE), including gowns, when providing care for residents who required Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission ofmulti-drugg-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) for six sampled residents (Residents #11, #12, #24, #25, #143, and #293) and one additional resident (Resident #35); and failed to ensure soiled washcloths used to provide incontinence care were disposed in a sanitary manner for one resident (Resident #18), in a review of 16 sampled residents. The facility census was 43.

Review of the facility policy, Hand Washing, dated July 2019, showed the following:

-It is the policy of this facility that hand hygiene is the primary means to prevent the spread of infection;

-The use of gloves does not replace proper handwashing;

-Employees must wash their hands for at least 20 second using antimicrobial or non-antimicrobial soap and water under the following conditions:

-When hands are visibly soiled (handwashing with soap and water);

-Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);

-Before and after assisting a resident with personal care;

-Upon and after coming in contact with a resident's intact skin;

-Before and after assisting a resident with toileting (hand washing with soap and water);

-After contact with a resident's mucous membranes and body fluids or excretions;

-After handling soiled or used linens, dressings, bedpans, catheters and urinals;

-After handling soiled equipment or utensils;

-After removing gloves or aprons.

Review of the undated facility policy titled, Enhanced Barrier Precautions, showed the following:

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-EBPs are utilized to prevent the spread of MDROs to residents; -EBPs are used as an infection prevention and control intervention to reduce the spread of MDROs to residents; -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply; a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room); c. Face protection may be used if there is also a risk of splash or spray; -Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: c. Transferring; d. Providing hygiene; f. Changing briefs or assisting with toileting; g. Device care or use (central line, urinary catheter,feedingg tube, tracheostomy/ventilator, etc.) and h. Wound care (any skin opening requiring a dressing); --EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization; -EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk; -Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE; -PPE is available outside of the resident rooms. Review of the undated facility policy titled, Urinary Catheter Care, showed the following: -The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections; -Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility policy, Catheter Care, dated 9/2014 showed to place soiled linen in designated container. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #12's physician's orders, dated July 2024, showed the following: -Right stump open area: Apply betadine (antiseptic) and cover with abdominal (ABD) pad cut to fit; -Change daily until healed (start date 7/10/24). Review of the resident's undated care plan showed the following: -Blister opened to right stump; -Apply betadine and ABD until healed. Observation on 7/10/24 at 3:03 P.M. showed the following: -The resident sat on his/her bed; -The Assistant Director of Nursing (ADON) entered the resident's room; -No signage was on the resident's room or door regarding EBP; -The ADON washed her hands and applied gloves; -The ADON did not apply a gown; -No additional PPE other than gloves was noted in the resident's room; -The resident removed the soiled dressing from his/her stump; -The dressing was soiled with yellow-tan drainage and had an odor; -The open wound was approximately the size of a quarter; -The wound bed was moist and mostly covered with yellow slough; -The ADON applied betadine to the wound bed; -The ADON removed her gloves, applied alcohol based hand rub and applied clean gloves; -The ADON applied a clean, dry dressing and secured the dressing with tape. Observation on 7/11/24 at 8:41 A.M. in the resident's room showed the following: -No signage was on the resident's room or door regarding EBP; -No additional PPE other than gloves was noted in the resident's room. During an interview on 7/11/24 at 1:36 P.M. Housekeeper N said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing tells housekeeping when the PPE cart is needed in the resident room then housekeeping puts the cart in the resident's room; -Housekeeping does not put the EBP sign on the resident's room/door; -The resident does not have an EBP sign on his/her door or a PPE cart in his/her room. During an interview on 7/11/24 at 1:35 P.M. the Infection Preventionist/Registered Nurse A (IP/RN A) said the following: -The red EBP signs are available at the nurses' station; -Any nurse can put up the red EBP signs but currently the ADON is responsible and eventually she will be the one responsible. 2. Review of Resident #143's admission care plan dated 7/3/24 showed the following: -Cognitively intact; -Two unstageable pressure ulcers (obscured full-thickness skin and tissue loss) with suspected deep tissue injury in evolution; -Pressure ulcer care. Review of the resident's undated care plan showed the following: -Documented pressure ulcer on right heel; -Use gown and gloves with dressing, bathing, transfers, changing linens, providing hygiene, changing briefs or when caring for wound in his/her room. Review of the resident's physician's orders, dated July 2024, showed an order to cleanse wound to right heel, pat dry, Calmoseptine (barrier cream) to periwound (area around the wound), pack wound with silver alginate (wound dressing with antibacterial silver for moderate to highly exudating (the fluid that is secreted from a wound during the healing process) wounds)) (place inside the wound, do not cover good skin only apply to wound bed) cover with gauze and wrap with Kerlix gauze twice daily (original order dated 6/19/24). Observation on 7/10/24 at 8:30 A.M. in the resident's room showed the following: -The resident sat on his/her bed; -There was a red EBP sign on the wall outside the resident's room; -The wound care consultant and the Assistant Director of Nursing (ADON) entered the resident's room; -The wound care consultant washed his/her hands and applied gloves; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The wound care consultant did not wear a gown; -The wound care consultant assessed the open wound on the resident's right heel; -The wound care consultant cleansed and debrided (process of removing dead tissue) the wound bed; -There was yellow slough (dead cells that accumulate in the wound exudate) present in the wound bed; -There was a moderate amount of bleeding with and after the debridement; -With gloved hands, the ADON applied a dry dressing to the resident's right heel wound and placed the resident's right foot on a disposable pad (the wound continued to bleed); -The ADON did not wear a gown when providing the treatment to the resident's wound. Observation on 7/10/24 at 9:06 A.M. in the resident's room showed the following: -The resident sat on his/her bed; -There was a red EBP sign on the wall outside the resident's room; -IP/RN A entered the room, washed his/her hands and applied gloves; -IP/RN A did not apply a gown; -IP/RN A removed the gauze dressing and cleansed the wound with wound cleanser; -There was a moderate amount of dried blood on and surrounding the wound; -IP/RN A removed her gloves, used alcohol based hand rub and applied clean gloves; -IP/RN A cut the silver alginate (wound treatment preparation), packed it into the wound, covered the wound with a gauze pad and secured the dressing with Kerlix gauze and tape; -IP/RN A removed her gloves and washed her hands. During an interview on 7/10/24 at 3:08 P.M. the ADON said she forgot to wear a gown while performing wound care on Resident #12 and Resident #143. 3. Review of Resident #18's Summary of Episode (readmission information), dated 7/11/24, showed his/her diagnoses included acute kidney failure (when the kidneys suddenly can't filter waste products from the blood) and neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Observation on 7/10/24 at 11:48 A.M., showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Certified Nursing Assistant (CNA) G and Nursing Assistant (NA) C donned Personal Protective Equipment (PPE-gown and gloves) and entered the resident's room; CNA G and NA C did not perform hand hygiene (wash hands with soap and water or use hand sanitizer) before donning PPE; -NA C filled a plastic wash basin with warm water and CNA G performed pericare, including the cleaning of the resident's urinary catheter insertion site, with warm water, body wash and wash cloths; -CNA G placed each soiled cloth on the bedside nightstand. No barrier was used between the nightstand and the cloths; -CNA G dried the resident's peri area with a dry towel and placed the towel on top of the soiled cloths on the nightstand; -CNA G, still wearing soiled gloves, went to a cloth bag hanging on the resident's bathroom door and reached in the bag for a clearplasticc bag; he/she placed the soiled wash cloths and towel in the bag; -CNA G doffed his/her gown and gloves, and without performing hand hygiene with soap and water or using hand sanitizer, went to the resident to adjust his/her bedding; -CNA G and NA C left the room and did not clean the resident's bedside nightstand. Interview on 7/10/24 at 1:30 P.M., showed CNA G said he/she did not realize that he/she had not completed hand hygiene before and after care, before touching the resident or items after procedure. While he/she was doing the care, he/she did not have anywhere to put the soiled items except the nightstand. During an interview on 7/10/24 at 2:38 P.M., the Director of Nursing said she expected the staff toprepareе for catheter care by getting the bags for soiled items and barriers prepared and to use hand hygiene before staff begancatheterd care. 4. Review of Resident #25's quarterly MDS, dated [DATE], showed he/she had moisture associated skin damage (MASD). Review of the resident's undated care plan showed the following: -Potential for impaired skin integrity; -Provide skin care per facility guidelines and as needed (PRN). Review of the resident's Physician Order Sheet (POS), dated July 2024, showed the following: -An order for house barrier (a topical cream applied directly to the skin surface to help maintain the skin's physical integrity) to bilateral buttocks every shift and PRN every shift for skin care (original order dated 09/13/23); (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order for collagenase powder (an enzyme derived product used to help the healing of burns and skin ulcers), apply to right gluteal fold topically every day shift for MASD to right gluteal fold, mix collagen powder with A&D ointment apply to area cover with a dressing daily may discontinue when area is healed (original order dated 09/22/23). Observation on 07/08/24 at 11:16 A.M. showed no signage for EBP on or near the resident's room door or wall. No PPE supply cart was available inside or outside the resident's room. Observation on 07/10/24 at 8:51 A.M. showed IP/RN A wore gloves and applied house barrier (collagenase powder and A&D ointment) to the resident's bilateral gluteal fold and crease, where MASD was observed. The resident's skin was blanchable, with an area of maceration along the bilateral gluteal clefts. IP/RN A identified two new open areas on the resident's buttock, one on the right inner thigh, below the gluteal fold, and one on the lower right buttock, above the gluteal fold. Both open areas were bleeding. IP/RN A did not wear a gown when providing care to the resident. 5. Review of Resident #11's quarterly MDS, dated [DATE], showed suctioning and tracheostomy (an opening into the trachea, or windpipe, from outside the neck, to help air and oxygen reach the lungs) were required. Review of the resident's undated care plan showed the following: -At risk for infection related to laryngectomy (a surgery to remove part or all of your larynx, or voice box); -Difficulty with communication related to tracheostomy; -Use gown and gloves with dressing, bathing, transfers, changing linens, providing hygiene, changing briefs or when caring for tracheostomy in his/her room; -Use universal precautions as appropriate. Review of the resident's POS, dated July 2024, showed the following: -Remove laryngectomy tube and clean daily with toothbrush and replace same tube every day and evening shift for secretions (original order dated 02/26/24); -Replace tracheostomy inner cannula every day shift every Wednesday (original order dated 06/05/24); -Replace tracheostomy outer cannula every day shift every 30 days (original order dated 06/12/24); -Suction tracheostomy every six hours to maintain airway (original order dated 04/29/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18540 State Highway 16, Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/09/24 at 05:30 A.M. showed Licensed Practical Nurse (LPN) H prepared the resident for a breathing treatment when the resident coughed up secretions. LPN H, did not wear gloves or a gown, and cleaned the secretions from the resident's tracheostomy with a tissue. LPN H did wash his/her hands after cleaning the secretions from the resident, and starting the resident's breathing treatment. EBP signage was posted on the wall next to the resident's door and EBP PPE cart was available in the resident's room, under the sink. 6. Review of Resident #40's significant change MDS, dated [DATE], showed he/she had a urinary catheter. Review of the resident's undated Care Plan showed the following: -He/She had a urinary catheter for urinary retention; -The urinary catheter will remain without signs and symptoms of infection; -Ensure the bag isn't touching the floor from the bed or wheelchair placement. Observation of resident's room on 07/08/24 at 10:43 A.M. showed no EBP signage on or near the room door or wall, as directed by facility policy for resident's on EBP. Observation on 07/08/24 at 10:35 A.M., 12:17 P.M. and 12:35 P.M. showed the resident sat in his/her wheelchair in the dining room. The urinary catheter bag hung under the resident's wheelchair and touched the floor. Observation on 07/08/24 at 1:54 P.M. showed the resident lay in bed. The urinary catheter bag was hooked on the side of the resident's bedframe and lay directly on the floor. Observation on 07/09/24 at 5:11 A.M. showed the resident lay in bed. The urinary catheter bag lay directly on the floor. Observation on 07/10/24 at 8:44 A.M. showed resident sat in his/her wheelchair in the common area. The urinary catheter bag hung under the resident's wheelchair and touched the floor. 7. Review of Resident #293's Baseline Care Plan, dated 06/28/24, showed the following: -Active diagnoses of urinary tract infection; -He/She required minimal assistance with mobility; -He/She had a urinary catheter. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Had a urinary catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/08/24 at 11:46 A.M. showed EBP signage was posted on the wall beside the door outside the resident's room. Observation on 07/08/24 at 12:28 P.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating lunch. The urinary catheter bag hung under the resident's wheelchair and touched the floor. Observation on 07/09/24 at 6:27 A.M. showed Certified Nurse Assistant (CNA) B pushed the resident in his/her wheelchair to the dining room. The resident's catheter bag hung under the wheelchair and dragged on the ground. Observation on 07/09/24 at 7:11 A.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating breakfast. The urinary catheter bag hung under the resident's wheelchair and touched the floor. Observation on 07/09/24 at 8:52 A.M. showed the resident sat in a recliner in his/her room. The resident's catheter bag was hooked on the side of the footrest and touched the floor. Observation on 07/09/24 at 2:09 P.M. showed no easily accessible PPE in or around the resident's room. Observation on 07/10/24 at 10:16 A.M. showed CNA I emptied the resident's urinary catheter bag. He/She wore gloves but did not wear a gown. No PPE supply cart was available in or outside of the resident's room. Observation on 07/10/24 at 11:45 A.M. showed NA C pushed the resident in his/her wheelchair to the dining room. The resident's catheter bag hung under his/her wheelchair and dragged on the floor. Observation on 07/10/24 at 12:18 P.M. showed the resident sat in his/her wheelchair at the dining room table, eating lunch. The resident's catheter bag hung under his/her wheelchair and touched the floor. Observation on 07/11/24 at 11:55 A.M. showed the resident sat in his/her wheelchair at the dining room table. The resident's catheter bag hung under this/her wheelchair and touched the floor. 8. Review of Resident #24's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent for toileting needs; -Intermittent catheterization. Review of the resident's POS, dated July 2024, showed the resident had a urinary catheter. Review of the resident's undated Care Plan showed the following: -He/She had a urinary catheter for retention, placing him/her at risk for UTI; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Use gown and gloves with dressing, bathing, transfers, changing linens, providing hygiene, changing briefs or when performing straight catheter in his/her room. Observation on 07/08/24 at 11:20 A.M. showed EBP signage hung on the wall outside the resident's room, and a PPE cart sat in the hallway below the signage. Observation on 07/09/24 at 8:58 A.M. showed the following: -The resident lay in bed. His/Her catheter bag was hooked on the side of his/her bed frame; -CNA B and CNA J assisted to dress the resident. CNA B wore full PPE (gown, gloves, face shield), while CNA J only wore gloves; -Once the resident was dressed, CNA B emptied the resident's urinary catheter bag; -CNA B and CNA J removed their gloves and washed their hands, assisted to transfer the resident from his/her bed to the wheelchair with a mechanical lift, and then changed the resident's shirt. Neither CNA wore gloves or a gown while transferring or putting on the resident's shirt. -CNA B did not wear gloves and placed the resident's urinary catheter into the dignity bag; -NA K, who was also in the room, stripped the resident's bed, wearing only gloves. 9. Review of Resident #35's quarterly MDS, dated [DATE], showed the following: -Cognitively impaired; -Substantial to maximum assistance for toileting needs; -Has a urinary catheter. Review of the resident's undated Care Plan showed the following: -At risk of UTI due to a urinary catheter for neurogenic bladder; -He/She will be free of signs and symptoms of infection; -Use gown and gloves with dressing, bathing, transfers, changing linens, providing hygiene, changing briefs or when caring for catheter in his/her room. Observation on 07/08/24 10:40 A.M. showed EBP signage was on the wall outside the resident's room door, and a PPE cart was located in the resident's room under the sink. Observation on 07/08/24 at 12:34 P.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating lunch. The resident's catheter bag hung under the wheelchair and touched the ground. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/09/24 at 5:09 A.M. showed the resident lay in his/her bed. The resident's catheter bag was hooked on the side of the bed frame and lay directly on the floor. Observation on 07/09/24 at 5:33 A.M. showed LPN H, did not wear gloves or a gown, and placed the resident's urinary catheter bag in a pink basin. He/She did not wash his/her hands before or after handling the urinary catheter bag. Observation on 07/09/24 at 07:31 A.M. showed the resident sat in his/her wheelchair at a table in the dining room, eating lunch. The urinary catheter bag hung under the resident's wheelchair and touched the floor. Observations on 07/10/24 at 10:13 A.M. and 11:15 A.M. showed the resident lay in bed. The resident's urinary catheter bag was hooked on the side of the bed frame and lay directly on the ground. During an interview on 07/11/24 at 11:06 A.M., NA E said the following: -EBP are for residents with tracheostomies, catheters, and infections; -Staff should wear gown, gloves, and mask/goggles, when providing direct care for residents on EBP: -Catheter bags should never touch the ground due to the risk for infection. During an interview on 07/11/24 at 11:11 A.M., CNA F said the following: -EBP are for residents with catheters and infections, like COVID-19; -When providing direct care for residents on EBP,staff shouldd wear gown and gloves, and a mask if needed; -Catheters should never touch the ground; -He/She received a brief one-on-one training about EBP. During interviews on 07/10/24 at 4:04 P.M. and 07/11/24 at 2:51 P.M., the IP/RN A said the following: -She took over as the Infection Preventionist on 6/1/24; -When providing direct care for a resident on EBP, staff should always wear gowns and gloves and staff should use a face shield if there is a potential for body/contaminated fluid exposure, like when emptying a catheter or irrigating a wound; -She had not provided any additionaltrainings for staff since she became the infection preventionist; the Director of Nursing (DON) provided a training prior to this; -She expected staff to change gloves and wash hands if the gloves were soiled, or if staff touched dirty items, before going back to clean items; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She considered providing perineal (the area between the tops of the thighs) care a dirty activity and expected staff to change gloves and wash hands; -Catheter bags should never touch the ground; -For the few residents who had a very low bed due to fall risks, staff should put the catheter in a pink basin as a barrier to the ground; -She made a mistake when providing wound care for two residents and forgot to wear a gown and mask; she remembered when she exited the second room; -She expected all staff to know and follow the appropriate PPE guidelines for EBP. During an interview on 07/11/24 at 2:42 P.M., the DON said the following: -Catheter bags should always be kept off the floor; -She provided EBP training just a few months ago and would expect all staff to know and follow the appropriate PPE guidelines. 50189 50675

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 34536 Based on observation and interview, the facility to maintain essential kitchen equipment in good working order. The facility census was 43. 1. Observation on 7/8/24 at 1:50 P.M. of the three-compartment sink in the facility kitchen showed the drain pipe for the third sink well (used for sanitizer solution) leaked below the sink into a plastic tub on the floor. The tub was full of water and slowly ran over the edge of the tub into the floor drain. Observation 7/9/24 at 7:49 A.M. of the three-compartment sink showed the sanitizer well sink drain leaked below the sink and water dripped directly on the floor. The tub that had previously caught the dripping water (the day before) had been removed. During interviews on 7/8/24 at 1:53 P.M. and on 7/9/24 at 8:20 A.M., the Dietary Manager said the pipes under the three-compartment sink leaked and the seals were broken. The sink also did not have hot water. Maintenance and the Administrator were aware of these issues. The problems had been ongoing for the last year. The kitchen staff did not currently use the three-compartment sink. Staff used to use the three-compartment sink to wash large items by hand or they would use the sink for washing dishware if the dish machine was broken down. Maintenance had tried fixing the unit in the past, but the repairs never ended up working. She had asked management to fix the three-compartment sink multiple times since she had been employed at the facility (approximately one year). When a piece of equipment broke or was not working, she notified maintenance first and then notified the administrator. During an interview on 7/9/24 at 12:32 P.M., the Maintenance Supervisor said the sink had not worked properly for at least six months. He had tried different repairs in the past but nothing worked. He thought the facility was supposed to replace the three-compartment sink. During an interview on 7/9/24 at 11:35 A.M., the Administrator said the three-compartment sink needed to be replaced. The facility was trying to find someone to custom build the sink due to the size constraints in that portion of the kitchen. The sink had not worked properly for approximately one year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189 Based on observation, interview, and record review, the facility failed to complete inspections of bed frames, mattress, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for three residents (Residents #24, #25 and #40), in a review of 16 sampled residents. The facility census was 43. Review of the facility policy, Bed Safety, dated December 2007, showed the following: -The resident's sleeping environment shall be assessed for the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment; -a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; -b. Review the gaps within the bed system are within the dimension established by the Food and Drug Administration (FDA). Note: The review shall consider situation that could be caused by the resident's weight, movement or bed position; -d. Ensure that bed rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g. avoid bowing, ensure proper distance from the headboard and footboard, etc.); -e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. altered mental status, restlessness, etc.); -The maintenance department shall provide a copy of inspections to the Administrator and report results to the Quality Assurance (QA) committee for appropriate action. Copies of the inspection results and QA Committee recommendations shall be maintained by the Administrator and/or Safety Committee. 1. Review of Resident #40's significant change Minimum Data Set (MDS), a federally mandated assessment required to be completed by facility staff, dated 06/03/24, showed the following: -Cognitively intact; -Upper and lower extremity impairment on one side; -Partial/moderate assistance with rolling left/right in bed. Review of resident's undated Care Plan showed he/she was able to roll side to side independently with mobility bars (assist/bed rail). Review of the resident's Bed Rail Assessment, completed 05/28/24, showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was non-ambulatory; -He/She had an alteration in safety awareness due to cognitive decline; -He/She had poor bed mobility; -Bilateral bed rails; -Bed rails/assist bar indicated and serve as an enabler to promote independence; -No documentation of entrapment zone measurements. Observation on 07/08/24 at 10:43 A.M. showed the resident's bed had assist bars on both sides of the bed in the raised position. Observations on 07/08/24 at 1:54 P.M., on 7/9/24 at 5:11 A.M., and on 07/10/24 at 2:13 P.M., showed the resident lay in bed. The resident had assist bars on both sides of his/her bed in the raised position. 2. Review of Resident #24's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -No impairment of upper or lower extremities; -Substantial/maximal assistance with rolling left/right in bed. Review of the resident's physician order sheets (POS), dated July 2024, showed an order for mobility bars for bed positioning (original order dated 07/19/23). Review of the resident's undated Care Plan showed the following: -He/She expressed desire for bed rails to increase bed mobility; -Need for mobility bars will be assessed quarterly; -Mobility bars bilaterally to facilitate bed mobility. Review of the resident's Bed Rail Assessment, completed 07/03/24, showed the following: -The resident was non-ambulatory; -Has poor bed mobility; -Has expressed a desire to have bed rails/assist bars for safety and/or comfort; -Bilateral bed rails; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Country Aire Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18540 State Highway 16 Lewistown, MO 63452	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed rails/assist bar are indicated and serve as an enabler to promote independence; -No documentation of entrapment zone measurements. Observations on 07/09/24 at 5:20 A.M. and 7:10 A.M. showed the resident lay in bed on a low-air loss mattress. The resident had assist bars on both sides of his/her bed in the raised position. 3. Review of Resident #25's quarterly MDS, dated [DATE], showed the following: -Cognition was intact; -Substantial/maximal assistance with rolling left/right in bed. Review of the resident's undated Care Plan showed bilateral bed mobility bars for improved bed mobility. Review of the resident's bed rail assessment, completed on 06/20/24, showed the following: -The resident was non-ambulatory; -Poor bed mobility; -Has expressed a desire to have bed rails/assist bar for safety and/or comfort; -Bilateral bed rails; -Bed rail/assist bar are indicated and serve as an enabler to promote independence; -No documentation of entrapment zone measurements. Observation on 07/08/24 at 11:16 A.M. showed the resident had a low-air loss mattress. The resident had quarter bed rails on both sides of his/her bed in the raised position. 4. During an interview on 07/11/24 at 11:58 A.M., the Maintenance Supervisor said the following: -He put the bed rails/assist bars on the beds; -He measured bed rails/assist bars on placement, but did not have a form or paper he completed and filed/tracked; -He did not check specialty mattress (low air loss, etc) manufacturer guidelines to ensure compatibility with the bed rails; -He did not conduct regular measurement checks for entrapment zones. During an interview on 07/1/24 at 2:42 P.M. the Director of Nursing (DON) said the following: -Maintenance staff was responsible for measuring the entrapment zones; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Measurements should be completed and documented when the bed rails were first placed, then quarterly, or with any bed changes; -Maintenance should also check to ensure bed frames/mattresses are compatible with the bed rails. During an interview on 07/11/24 at 3:12 P.M., the Administrator said the following: -Maintenance and nursing should work together to ensure entrapment zone measurements were completed; -He expected measurements to be completed, tracked, and reported per facility policy.