STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265485	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Nursing Home	1260 North Johnson Street Kahoka, MO 63445

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42592 Based on observation, interview, and record review, the facility failed to assess the use of pressure alarms used in a resident's bed and chair as a restraint for one resident (Resident #48), in a review of 22 sampled residents. The facility implemented the pressure alarms upon the resident's admission to the facility as an intervention to prevent falls. Staff documented the alarms caused the resident to become agitated. The resident expressed he/she hated the alarms and felt restrained to his/her chair and trapped. The facility census was 59. 1. Review of Resident #48's undated Continuity of Care Document (CCD), showed the following: -Diagnoses included dementia with behavioral disturbances, Parkinsonism (a clinical syndrome characterized by tremors (involuntary shaking), bradykinesia (slowness of movement), rigidity (stiffness), difficulty maintaining balance), delusional disorders, need for assistance with personal care, weakness, abnormalities of gait and mobility, repeated falls, muscle weakness, major depressive disorder, and restless leg syndrome; -The resident has a durable power of attorney for healthcare decisions. Review of the resident's Progress Notes, dated 6/8/24 at 10:10 A.M., showed the resident required two staff with a gait belt and walker to transfer. He/She did not remember to use the call light, so a pressure alarm was in place on both his/her bed and chair. It was noted that when the pressure alarm was going off, the resident was found up and walking without assistance. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 6/13/24, showed the following: -Severe cognitive impairment; -No inattention, disorganized thinking, or altered level of consciousness; -No behaviors, rejection of care, or wandering; -Utilized a walker and wheelchair for mobility; -Dependent on staff for ambulation and wheelchair mobility; (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had one fall within a month of admission; -Bed alarm and chair alarm used daily. Review of the resident's Progress Notes, dated 6/25/24 at 6:05 P.M., showed the resident was found standing and going through his/her closet without assistance. His/Her pressure alarm was sounding. Staff redirected the resident back to his/her recliner and put the pressure alarm back in place for safety. Review of the resident's Progress Notes, dated 7/2/24 at 12:43 P.M., showed the resident had behaviors of moodiness. Reported behaviors included shutting off his/her pressure alarm and throwing it onto the other bed in the room. Staff replaced the pressure alarm in his/her chair resulting in the resident becoming agitated and saying his/her spouse said he/she did not need that. Staff explained to the resident that his/her spouse wanted the pressure alarm for safety due to being a fall risk, his/her lack of safety awareness, and not using the call light. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No inattention, disorganized thinking, or altered level of consciousness; -No behaviors, rejection of care, or wandering; -Utilized a walker and wheelchair for mobility; -Supervision or touching assistance for ambulation; -Independent for wheelchair mobility; -Bed alarm and chair alarm used daily. Review of the resident's care plan, updated on 12/6/24, showed the following: -He/She required limited to extensive assistance with activities of daily living; -He/She walked with a walker and assist of one or two staff with a gait belt; -Pressure alarm at all times; -Potential for falls related to weakness, decreased mobility, poor safety judgement, antidepressant therapy and history of falls; -Encourage the resident to wait for assistance and answer call light promptly; -The resident had periods of confusion/forgetfulness, which caused difficulty thinking and decision making. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed no evidence staff evaluated the use of the bed alarm and chair alarm as a restraint prior to implementing the alarms or after the resident became agitated and upset after the alarms were utilized. Observation on 1/21/25 at 12:57 P.M. showed the resident sat on a pressure alarm in his/her recliner in his/her room. During an interview on 1/21/25 at 12:57 P.M., the resident and his/her spouse said the following: -The resident admitted to the facility due to falls at home; -He/She had not had any falls since admission; -He/She had a bed and chair alarm due to a history of falling. Observation on 1/22/25 at 1:07 P.M. showed the resident sat in his/her recliner chair in his/her room with a pressure alarm in place in the recliner. Observation on 1/23/25 at 5:26 A.M. showed the resident lay on a pressure alarm in bed. Observation on 1/23/25 at 6:17 A.M. and 2:52 P.M. showed the resident sat in his/her recliner chair in his/her room with a pressure alarm in place in the recliner. During an interview on 1/24/25 at 1:12 P.M., the resident's spouse said the following: -The resident had the bed and chair alarms since he/she was admitted ; -The resident did not like the alarms; -The resident had a lot of falls at home and didn't remember to use the call light, which was why he/she needed the alarms. During interviews on 1/24/25 at 1:12 P.M. and 4:46 P.M., the resident said the following: -He/She hates the alarms; -The alarm made him/her afraid to get up, because when it goes off, everyone came running; -He/She felt restrained to the chair; he/she just wanted to be able to get up and use the bathroom; -He/She thought it was ridiculous to be trapped in the chair and almost pee yourself, because sometimes it took staff a while to answer the call lights; -He/She felt trapped, which made him/her mad because all he/she wanted was some freedom; -He/She wanted to do better and be safe, but did not want to be trapped in the same spot all day. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 3:29 P.M. the Director of Nursing (DON) said the following: -The facility did not currently have any restraints in use; -A restraint was something that prevented a resident from doing something. She did not feel the chair or bed alarms prevented residents' movement. During an interview on 1/28/25 at 4:45 P.M. the Administrator said she did not consider an alarm to be a restraint. 50189

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38016 Based on interview and record review, the facility failed to provide a written notice of discharge with required information to the resident and/or resident representative for two residents (Residents #13 and #48), in a review of 22 sampled residents, when the facility initiated a transfer to the hospital. The facility did not provide any other written documentation to the resident or resident representative of the reason and date for transfer/discharge, where the resident was transferred/discharged , ombudsman contact information, information on how to appeal a transfer/discharge, or how to contact the mental health advocacy group for residents with intellectual disabilities or mental illness. The facility census was 59. Review of the undated facility policy, Discharges, showed the following: -Social services will ensure that when the facility anticipates discharging a resident, that the resident is able to make their own choices regarding discharge plans; -Family/Power of Attorney will be involved in the discharge plan and given information; -Their attending physician will also be notified; -Information regarding their right to appeal the discharge will be given to the resident, family or responsible party. 1. Review of Resident #13's face sheet, showed the resident had emergency contacts who were his/her family members. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 01/26/24, showed the resident had moderate cognitive impairment. Review of the resident's Nursing Progress Notes, dated 04/05/24 at 8:00 P.M., showed the resident had a temperature of 101-102 degrees Fahrenheit (normal 98.6 degrees) and was sent to the hospital for evaluation. The resident was admitted with Coronavirus Disease 2019 (COVID-19) (respiratory virus) and hip pain. Review of the resident's medical record showed no documentation the facility issued the resident a written notice of transfer to the hospital. 2. Review of Resident #48's Face Sheet, showed the resident had a durable power of attorney for healthcare decisions. Review of the resident's Progress Notes, dated 7/16/24 at 8:55 A.M., showed the resident was unable to ambulate or sit up right, continually leaning to the left and coughing, non-productively. Ambulance called for transport to hospital for evaluation. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the resident's Progress Notes, dated 7/16/24 at 3:28 P.M. showed the resident was admitted to the hospital. Review of the resident's Progress notes, dated 7/30/24 at 1:15 P.M. showed the resident returned to the facility (from the hospital). Review of the resident's Progress Notes, dated 9/17/24 at 2:32 P.M. showed the resident's family member reported the resident had an episode where his/her head, neck, and arms hyperextended and he/she quit breathing for a moment. Vital signs showed a pulse of 47. Review of the resident's Progress Notes, dated 9/17/24 at 3:29 P.M., showed the decision was made to send the resident to the hospital for further evaluation. Review of the resident's Progress Notes, dated 9/17/24 at 3:46 P.M. showed the ambulance arrived and the resident was transferred to the hospital. Review of the resident's Progress Notes, dated 9/23/24 at 2:17 P.M. showed the resident was being discharged from the hospital after being admitted for a cardiac dysrhythmia (irregular heartbeat) and syncopal episodes (sudden and temporary loss of consciousness that typically resolves quickly), and having a pace maker inserted. Review of the resident's Progress Notes, dated 9/23/24 at 4:00 P.M. showed the resident returned to the facility. Review of the resident's medical record showed no documentation the facility provided the resident's representative with a written notice of transfer when the resident was transferred to the hospital on 7/16/24 and 9/17/24. 3. During an interview on 01/23/25 at 9:06 A.M., the Director of Nursing (DON) said the following: -The facility did not provide a written notice of transfer for facility-initiated transfers; -She did not know they were supposed to issue a written notice of transfer; -Staff calls the family and verbally lets them know when a resident is going to the hospital; -She did not think the families get information on how to appeal, ombudsman contact information, or information on mental health advocacy on facility initiated transfers. During an interview on 01/28/25 at 4:45 P.M., the Administrator said the facility did not issue a written notice of transfer (when a resident was transferred to the hospital) and was unaware there was a requirement written transfer notices had to be issued. 42592 50189

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 38016 Based on interview and record review, the facility failed to provide a written notice of bed hold policy with required information to the resident and/or resident representative for three residents (Resident #13, #61, and #48), in a review of 22 sampled residents, when the residents were transferred to the hospital for medical evaluation and treatment. The facility census was 59. 1. Review of Resident #13's undated Face Sheet showed the resident had emergency contacts that were his/her family members. Review of the resident's annual Minimum Data Set (MDS), a federally required assessment completed by staff, dated 1/26/24, showed the resident had moderate cognitive impairment. Review of the resident's Nursing Progress Notes, dated 04/05/24 at 8:00 P.M., showed the resident had a temperature of 101-102 degrees Fahrenheit (normal 98.6 degrees) and was sent to the hospital for evaluation. The resident was admitted with Coronavirus 2019 (COVID-19, respiratory infection) and hip pain. Review of the resident's medical record showed no documentation the facility provided the resident or the resident's representative with a bed hold policy when he/she admitted to the hospital on 4/5/24. 2. Review of Resident #61's face sheet showed the resident had a durable power of attorney (DPOA) for health care. Review of the resident's Progress Notes, dated 1/15/25 at 11:06 A.M., showed the resident was working with therapy and became very short of breath and had to be put on his/her oxygen at 3.5 liters per nasal cannula. The resident's family member was present and insisted the resident be seen at the emergency room . The resident was sent to the hospital via private car due to family choice of emergency room . Review of the resident's Progress Notes, dated 01/17/25 at 4:01 P.M., showed the resident returned to the facility (from the hospital) at 2:00 P.M. Review of the resident's medical record showed no documentation the facility provided the resident or the resident's representative with a bed hold policy when he/she admitted to the hospital on 1/15/25. 3. Review of Resident #48's Face Sheet, showed the resident had a durable power of attorney for healthcare decisions. Review of the resident's Progress Notes, dated 7/16/24 at 8:55 A.M., showed the resident was unable to ambulate or sit up right, continually leaning to the left and coughing, non-productively. Ambulance called for transport to hospital for evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the resident's Progress Notes, dated 7/16/24 at 3:28 P.M. showed the resident was admitted to the hospital. Review of the resident's Progress notes, dated 7/30/24 at 1:15 P.M. showed the resident returned to the facility (from the hospital). Review of the resident's Progress Notes, dated 9/17/24 at 2:32 P.M. showed the resident's family member reported the resident had an episode where his/her head, neck, and arms hyperextended and he/she quit breathing for a moment. Vital signs showed a pulse of 47. Review of the resident's Progress Notes, dated 9/17/24 at 3:29 P.M., showed the decision was made to send the resident to the hospital for further evaluation. Review of the resident's Progress Notes, dated 9/17/24 at 3:46 P.M. showed the ambulance arrived and the resident was transferred to the hospital. Review of the resident's Progress Notes, dated 9/23/24 at 2:17 P.M. showed the resident was being discharged from the hospital after being admitted for a cardiac dysrhythmia (irregular heartbeat) and syncopal episodes (sudden and temporary loss of consciousness that typically resolves quickly), and having a pace maker inserted. Review of the resident's Progress Notes, dated 9/23/24 at 4:00 P.M. showed the resident returned to the facility. Review of the resident's medical record showed no documentation the facility provided the resident's representative with a bed hold policy when he/she admitted to the hospital on 7/16/24 and 9/17/24. 4. During an interview on 01/23/25 at 9:06 A.M., the Director of Nursing (DON) said the facility did not give bed hold information to residents or representatives because they do not do bed holds. The facility takes all residents back. During an interview on 01/28/25, at 4:45 P.M., the Administrator said the facility did not issue a bed hold policy with transfers/discharges and was unaware of a requirement a bed hold notice had to be issued with transfers/discharges. 42592 50189

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to complete a significant change status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment, required to be completed by facility staff, for four residents (Residents #18, #8, #13 and #28), in a review of 22 sampled residents. This assessment should have been completed within 14 days after the facility determined, or should have determined, there had been a significant change (major decline or improvement in the resident's status) in the resident's physical or mental condition which had an impact on more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The facility census was 59. Review of the Long Term Care Facility RAI User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting; -Impacts more than one area of the resident's health status; -Requires interdisciplinary review and/or revision the care plan. -Significant Change in Status Assessment (SCSA) was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of Activity of daily living (ADL) decline or improvement). -significant change is a major decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self limiting; -Impacts more than one area of the resident's health status; and -Requires interdisciplinary review and/or revision of the care plan. 1. Review of Resident #18's quarterly MDS, dated [DATE], showed the following: -Supervision required for oral hygiene; -Supervision assistance with upper body dressing; -Independent when moving from sitting on the side of the bed to lying flat in bed and when moving from lying on his/her back to sitting on the side of the bed; -Supervision required to move from a sitting to a standing position, for chair to bed transfers and for toilet transfers; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Independent to walk 50 and 150 feet; -Always continent of bowel; -Pain rarely interferes with day to day activities. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Maximum assistance required for oral hygiene and upper body dressing; -Moderate assistance required when moving from sitting on the side of the bed to lying flat in bed and when moving from lying on his/her back to sitting on the side of the bed; -Moderate assistance required for chair to bed transfers and toilet transfers; -Maximum assistance when moving from a sitting to a standing position; -Did not complete walking up 50 or 150 feet; -Occasionally incontinent of bowel; -Pain occasionally interferes with day to day activities. Review of the resident's medical record showed no documentation staff completed a significant change assessment when the resident had a decline in two or more activities of daily living (ADL). During an interview on 1/22/25 at 9:58 A.M., the resident's family member said the resident had a major decline in his/her ADL function in the last three months. 2. Review of Resident #8's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included arthritis, stroke, seizure, and mild cognitive impairment; -Independent with eating, oral hygiene, roll left and right, sit to lying, lying to sitting on side of bed and wheel 150 feet; -Required set up assistance from staff for upper body dressing and personal hygiene; -Required supervision/touch assistance from staff for toileting hygiene, lower body dressing, sit to stand, chair/bed-to-chair transfer, and toilet transfer; -Required partial/moderate assistance from staff for putting on/taking off footwear, and tub/shower transfer; -Required substantial/maximal assistance from staff to shower/bathe; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Frequently incontinent of bladder, continent of bowel; -Scheduled pain medication regimen and non-medication interventions for pain; -Pain occasionally at a three (on a scale of one to ten, with ten being the worst pain possible); -Resident weighed 287 pounds (lbs); -Therapeutic diet; -Edentulous. Review of the resident's quarterly MDS, dated [DATE], showed the resident weighed 283 lbs. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Required partial/moderate assistance from staff for eating, and toilet transfer; (a change from eating independently and supervision/touch assist for toileting transfer); -Required substantial/maximal assistance from staff for toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting on side of bed, and personal hygiene, sit to stand, chair/bed-to-chair transfer, and tub/shower transfer; (all changes from either independent, set up assistance, supervision/touch assistance or partial/moderate assistance); -Dependent on staff for oral hygiene, shower/bathe, roll left and right, and wheel 150 feet; (all changes from either independent or substantial/maximal assistance); -Occasional bowel incontinence; (change from continent of bowel); -New as needed (PRN) pain medication; -One fall since prior assessment; -New swallowing disorder; -252 lbs (31 lb weight loss since August), significant wt loss not on a program. Review of the resident's medical record showed no documentation staff completed a significant change assessment within 14 days when the resident had a decline in two or more ADL areas. 4. Review of Resident #13's annual MDS, dated [DATE], showed the following: -Moderate cognitive impairment; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of dementia, post traumatic stress disorder, (PTSD - a mental health condition triggered by a terrifying event, either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) and Parkinson's (a progressive brain disorder that causes movement problems and is characterized by tremors, stiffness and difficulty with balance and coordination); -No difficulties hearing; -No functional range of motion (ROM) limitations; -Required setup or clean up assistance from staff for personal hygiene; -Required partial/moderate assistance from staff for roll left and right; -Required substantial/maximal assistance from staff for toilet hygiene and upper body dressing; -Dependent on staff for shower/bathing and to put on/take off footwear. Review of the resident's quarterly MDS, dated [DATE], showed the following: -New moderate hearing difficulty, speaker has to increase the volume and speak distinctly; -Limits to functional ROM in both lower extremities; (change from no functional range of motion); -Required partial/moderate assistance from staff for toilet hygiene and upper body dressing; (change from either set up or substantial/maximal assistance); -Required substantial/maximal assistance from staff for shower/bathing, put on/take off footwear, personal hygiene, roll right and left; (all changes from either dependent, set up assistance or partial/moderate assistance); -New swallowing disorder, loss of liquids/solids from mouth, when eating or drinking; -New mechanically altered diet. Review of the resident's medical record showed no documentation staff completed a significant change assessment within 14 days when the resident had a status change in two or more ADL areas. 3. Review of Resident #28's significant change in status MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included dementia and contracture (tightening of muscles) of right knee and left knee; -New limitation in ROM both lower extremities; -Independent with roll left and right, sit to lying, lying to sitting; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Nursing Home	1260 North Johnson Street Kahoka, MO 63445

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required partial/moderate assistance from staff for eating, upper body dressing; -Required substantial/maximal assistance from staff for oral hygiene, toilet hygiene, lower body dressing, shower/bathe, and putting on/taking off footwear; -Dependent on wheelchair for mobility; -Weighed 160 lbs., significant weight loss (not planned); -No mechanically altered diet; -No signs or symptoms or pain management medications or interventions; -No antidepressant medication. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Required supervision/touching assistance from staff members for eating; (change from partial/moderate assistance); -Weighed 164 lbs.; -New antidepressant medication. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Independent with wheelchair mobility; (change from dependent status); -Required partial/moderate assistance from staff for roll left and right; (change from independent status); -Required substantial/maximal assistance from staff for upper body dressing; (change from partial/moderate assistance); -Dependent on staff for oral hygiene, toilet hygiene, shower/bathe, lower body dressing and putting on/taking off footwear; (all changes from substantial/maximal assistance); -New pain medication and non-pharmacological interventions for pain; -Weighed 147 lbs (10% significant weight loss since 09/04/24 assessment); -New mechanically altered diet; -Continued on antidepressant medication since the 09/04/24 assessment. Review of the resident's medical record showed no documentation staff completed a significant change assessment within 14 days when the resident had a status change in two or more ADL areas. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/24/25 at 11:04 A.M., the MDS coordinator (MDSC) said the following: -When completing the MDS, staff used residents' charts and Certified Nurse Assistants (CNA's) chart on specific areas during the look back period; -The facility had an interdisciplinary team (IDT) meeting and reviewed the results of the residents' assessments; -A SCSA was completed if a resident had two or more changes to the resident's condition; -Staff compared the MDS to the last MDS if it was a quarterly or a comprehensive; --A significant change occurred when there were two changes, for example a resident goes from one assist to two assist. She goes back to last quarterly assessment and did not know to go back to last comprehensive assessment; -She did not use the Resident Assessment Manual (RAI) manual much, as she thought the manual was for ICD10 codes. During an interview on 01/24/25 at 3:33 P.M., the Director of Nursing said the following: -She expected staff to complete a SCSA when the resident has had a change and demonstrated they would not return to their previous level of function; -She expected the SCSA to be initiated within two to three days of a change in condition; -Staff are expected to complete the SCSA as defined by the MDS criteria in the RAI manual; -The MDSC was responsible to complete the SCSA MDS. 50189

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to follow proper technique for medication administration of insulin pens and eye drops for three residents (Resident #2, #58, and #21), in a review of 22 sampled residents. The facility census was 59. 1. Review of resident #58's Continuity of Care Document (CCD) showed a diagnosis of diabetes mellitus (too much sugar in the blood stream). Review of the resident's care plan, dated 12/26/24, showed the following: -The resident had diabetes; -Administer insulin as ordered. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 01/22/25, showed the resident received seven insulin injections in the last seven days. Observation on 01/23/25 at 7:00 A.M., showed the following: -Registered Nurse (RN) B administered 40 units of Tresiba (an injectable long-acting insulin used to treat diabetes mellitus) insulin via pen to Resident #58; -Immediately after administering the dose, RN B removed the needle and did not wait for a count of five or six after administration. Review of the Tresiba administration instructions for use on Tresiba.com showed to give an injection, wipe the skin with an alcohol swab and let dry, insert the needle in desired spot, press and hold the dose button, after the dose counter reaches zero, slowly count to six. 2. Review of Resident #2's CCD showed a diagnosis of diabetes mellitus. Review of the resident's quarterly MDS, dated [DATE], showed the resident has a diagnosis of diabetes mellitus and received seven insulin injections in the last seven days. Observation on 01/23/25 at 6:50 A.M., showed the following: -RN B administered eight units of Humalog (an injectable fast-acting insulin used to treat diabetes) insulin via Kwikpen to Resident #2 ; -Immediately after administering the dose, RN B removed the needle and did not wait for a count of five after administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Humalog KwikPen administration instructions, for use on [NAME] Lilly and Company website (maker of Humalog KwikPen), showed to give an injection, wipe the skin with alcohol swab and let dry, insert the needle into the skin, push the dose knob in and slowly count to five before removing the needle. During an interview on 01/24/25 at 11:56 A.M., RN B said he/she usually held the insulin pen for a count of five or six and thought he/she did with both of the injections. 3. Review of Resident #21's CCD showed an order for ketotifen/an eye drop used to treat itchy eyes and discomfort caused by allergies) 0.025% drops, instill one drop into both eyes two times a day for allergic conjunctivitis (eye inflammation caused by allergies). Observation on 01/23/25 at 6:07 A.M. showed the following: -Certified Medication Technician (CMT) C explained to the resident he/she had the resident's eye drops to administer; -CMT C pulled the resident's lower eye lid down and administered one drop of ketotifen to the left eye and then repeated the process with the right eye; -CMT C then wiped the excess from the resident's face with a tissue and walked away from the resident; -CMT C did not hold any pressure to the lacrimal gland or encourage the resident to keep his/her eyes closed for any period of time. Review of administration of Ketotifen ophthalmic eye drops, on Medlineplus.gov, showed to instill the eye drops, pull down the lower lid of the eye to form a pocket, instill the ordered about of drops, close the eye for two to three minutes, place a finger on the tear duct and apply gentle pressure and wipe any excess liquid from they face with a tissue. During an interview on 01/24/25 at 1:28 P.M., CMT C said the following: -When administering eye drops, pressure should be held for a couple of seconds to make sure the medication gets into the eye appropriately; -He/She did not hold pressure when administering the resident's eye drops and should have. During an interview on 01/24/25 at 3:30 P.M., the Director of Nurses (DON) said she would expect medication to be administered following professional standards of practice. 42592

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview and record review, the facility failed to ensure two residents (Resident #42 and #1), a review of 22 sampled residents, received care and treatment to promote healing and prevent new pressure ulcers (a 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) from developing. Facility staff failed to update Resident #42's care plan, implement identified interventions needed to promote healing and prevent worsening of a wound, prevent direct pressure to a pressure wound, or provide pressure reducing surfaces to promote healing of his/her unstageable pressure ulcer to his/her right heel. The facility failed to implement a system to ensure low air loss mattresses, utilized for one resident with pressure ulcers (Resident #1) was maintained on the correct weight setting to promote healing. The facility census was 59. Review of the facility's policy, Pressure Ulcers/Skin Breakdown Clinical Protocol, last revised 2007, showed the following: -The nurse shall assess and document/report a full assessment of pressure ulcers including location, stage, length, width and depth, presence of exudates or necrotic tissue. The nurse shall document a pain assessment and the resident's current treatments, including support surfaces; -The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents; -The physician will help identify medical interventions related to wound management; for example, treating soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc.; -During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive or non-healing wounds; -The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated, or new wounds develop, despite existing interventions. Review of the facility's policy, Prevention of Pressure Ulcers, last revised March 2005, showed the following: -Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue; -The most common site of a pressure ulcer is where the bone is near the surface of the body, including the back of the head, around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles and toes; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition; -The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician and family and addressed; -Identify risk factors for pressure ulcer development; -For a person in bed, determine if the resident needs a special mattress. If a special mattress is needed, use one that contains foam, air, gel, or water as indicated; -Ensure the resident drinks plenty of fluids and eats a well-balanced diet; -Routinely assess and document the condition of the resident's skin, per facility wound and skin care program, for any signs and symptoms of irritation or breakdown; -Immediately report any signs of a developing pressure ulcer to the supervisor; -The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate; -Use pillows or wedges to keep bony prominences, such as knees or ankles, from touching each other; -When in bed, every attempt should be made to float heels (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician; -Dietitian will assess nutrition and hydration and make recommendations based on the individual resident's assessment. Monitor nutrition and hydration status. Monitor laboratory values notify physician when appropriate. Encourage proper dietary and fluid intake. If a normal diet is not possible, talk to physician about supplements. Administer vitamins, mineral and protein supplements in accordance with physician orders and dietitian recommendations; 38016 1. Review of Resident #42's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/02/24, showed the following: -Severe cognitive impairment; -Diagnosis of diabetes mellitus (inability to regulate blood sugar), osteoporosis (decrease in bone mass causing bones to be fragile) and dementia; -Independent with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer and ambulation with a walker; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Requires partial/moderate assistance from staff for lower body dressing and putting on/taking off footwear; -Requires substantial/maximal assistance from staff for to shower/bathe self, -Receives insulin (medication to treat diabetes); -No pressure ulcers present. Review of the resident's care plan, dated 02/05/24, showed the following: -The resident will be free from skin breakdown with good skin integrity; -Assist resident out of bed three to four times a day; -Encourage and assist resident with turning and repositioning every two hours and as needed; -Inspect skin at least weekly during showers and as needed; -Report any reddened or open areas to the physician. (The care plan did not include any identified wounds.) Review of the resident's care plan, updated on 03/01/24, added feather tic mattress (a mattress made of strong, stiff, tightly woven material (ticking) that was filled to make a mattress. Typically then laid over a firmer, non-feather mattress) on bed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Required supervision/touching assistance from staff members for sit to lying, lying to sitting on side of bed, sit to stand and tub/shower transfer; -Required substantial/maximal assistance from staff for lower body dressing; -Dependent on staff for putting on/taking off footwear. -No pressure ulcers present. Review of the resident's Nurses Progress Notes, dated 12/23/24 at 9:30 A.M., documented by the Wound Care Nurse, showed the following: -Skin inspection during a shower showed an open area noted to the resident's right heel; -The open area measured 2 centimeters (cm) in length by 1.5 cm in width, with a depth of 0.2 cm; -The tissue was 100% dark, soft tissue; the wound margins were not attached to the wound bed; -The resident's heel was soft and boggy to touch; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Peri-wound (area around the wound) is white in coloration (also known as macerated skin (macerated skin appears soft, wrinkled, white or gray and may feel soggy or spongy. The skin may also be translucent or waterlogged, and is caused by too much moisture to the skin.) that extends out 0.5 cm around the wound with heel being tender to touch; -Physician notified and requested a treatment order; -Nursing intervention will be in place to float the resident's heels while in bed; -Power of attorney notified of resident's skin condition. Review of the resident's Nurses Progress Notes, dated 12/23/24 at 3:11 P.M., documented by the Wound Care Nurse, showed physician's office notified of right heel; new order received to startbetadinee (germicide used to prevent infection in wounds) paint to the resident's right heel two times daily until healed, ordered by the nurse practitioner. Review of the resident's Physician's orders, dated 12/23/24, showed Betadine paint to the resident's right heel two times daily until healed. Review of the resident's care plan did not show an update that a wound was found or of the intervention to float the resident's heels. Review of the resident's Nurses Progress Notes, dated 12/31/24 at 12:03 P.M., documented by the Wound Care Nurse, showed the following: -Wound Assessment, measurements obtained on 12/30/24; -Resident lay in bed with his/her bilateral heels floating on a pillow; -Assessment completed to bilateral heels with no open areas noted to left heel with tissue being pink-blanchable and non-tender to touch; -The right heel open area measured 1 cm in length, 1.8 cm in width, with wound bed being 100% soft, dark-black eschar, with periwound being white in coloration (unstageable), tender to touch; -Goal will be to continue to relieve site of pressure with floating heels when in bed; -Resident has not been wearing his/her shoes to ambulate, instead, slip socks worn due to his/her shoes causing him/her discomfort and rubbing at site; -Treatment remains appropriate, slight improvement noted. Review of the resident's Nurses Progress Notes, dated 01/08/25 at 4:42 P.M., documented by the Wound Care Nurse, showed the following: -Wound Assessment: Resident lay in bed with bilateral heels floating on a pillow; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Area to right heel measures 1.2 cm in length, and 1.7 cm in width with wound margins well defined and attached to wound bed; -Resident yelled ouch upon the slightest touch; -No depth present; wound bed is 100% black eschar (unstageable; obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar); -Peri wound is dry, no longer macerated to surrounding site; -Continuing all pressure relieving interventions which are heels floating when in bed, feather tic mattress in place; -Resident no longer wearing his/her shoes as the back was rubbing, causing resident to have sore feet; the resident prefers slip socks at this time; -Treatment remains appropriate as improvement was noted; -(The assessment showed a new finding of the left heel being soft and boggy.) Review of the resident's Nurses Progress Notes, dated 01/15/25 at 3:30 P.M., documented by the Wound Care Nurse, showed the following: -Wound Assessment: resident lay in bed with bilateral heels floating on a pillow; -Right heel has an area that measures 2.5 cm in length, and 2.3 cm in width, the tissue is dry with all aspects of wound margins lifting; -Resident denies tenderness; -Surrounding tissue pink, healthy and blanches upon touch. -(The assessment showed an increase in the size of the right heel wound, and no documentation to evaluate what caused the increase in dimensions.) Review of the resident's annual MDS, dated [DATE], showed the following: -Required supervision/touching assistance from staff members to roll left and right; -Required substantial/maximal assistance from staff for tub/shower transfer, (worsening activities of daily living (ADL)'s); -New, as needed pain medication and non-pharmacological interventions for pain; -Vocal complaints of pain, one to two days in the last five days; -New pressure ulcer, unstageable and new pressure ulcer care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/23/25 at 2:05 P.M., showed the following: -The Wound Care Nurse entered the resident's room; -The resident lay in his/her bed; -When the Wound Care Nurse pulled the resident's covers back, the resident's heels were pressed against a pillow and not floated on the pillow as the Nurses Progress Notes, dated 12/23/24, directed (pressing against the pillow would cause increased pressure); -The resident's bed did not have a pressure reducing mattress or the feather tic mattress as documented on the resident's updated, 03/01/24, care plan as being added; -The resident grimaced and moaned in pain when the Wound Care Nurse moved his/her leg; -The resident said his/her heels really hurt bad; -The Wound Care Nurse measured the area to the resident's right heel as 1.2 cm in length, 1.5 cm in width total area of the skin alteration; -The eschar dark area measured 0.5 cm in length, and 0.8 cm in depth, without being able to visualize if any depth was present, obscured view because eschar intact; -The resident's wound was not stained with Betadine; the resident's surrounding wound was normal skin color and no area had discoloration or the color of Betadine painting was present. 2. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses of Alzheimer's disease, dementia and anxiety disorder; -Lower extremity impairment on both sides; -Always incontinent of bowel and bladder; -Two Stage I pressure ulcers; -Application of ointments/medications other than to feet. Review of the resident's care plan, revised 11/14/24, showed the following: -Resident has periods of confusion/forgetfulness, which causes him/her to have difficulty thinking and making decisions; -Potential for skin breakdown related to decreased mobility, bowel and bladder incontinence; -Feather tick mattress on bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician's orders, dated January 2025, showed the following: -Left buttocks: apply barrier cream twice daily and upon cares to protect tissue from urinary incontinence; -No treatment order for the right buttocks. Review of the resident's weight record, dated 01/01/25, showed the resident's weight was 159 pounds (72 kilograms). Review of the resident's wound assessment, dated 01/05/25 at 3:11 P.M., showed the following: -No open areas are noted on left buttocks; -Right buttocks at upper aspect of cleft, open area measures 2.4 cm by 1.5 cm with area having a depth of 0. 1 cm with wound margins attached to wound bed (depth now noted - a new finding); -Wound is 100% pink, shiny tissue, with no drainage noted at this time-open area not directly attached to wound as tissue between is pink and healthy measures 0.6 cm by 0.5 cm that is circular in shape with wound bed being 100% pink healthy tissue with wound margins attached to wound bed. Review of the resident's wound assessment, dated 01/06/25 at 11:43 A.M., showed the following: -Areas reported at this time that were not present on yesterdays (01/05/25) assessment to right elbow, outer aspect; -Resident has two open areas proximal (nearer to the center or point of attachment to the body) site measures 1.3 cm by 0.8 cm that has no depth-wound bed is pink, shiny and moist with wound margins attached at the wound bed-distal area measures 0.4 cm by 0.5 cm with no depth, circular in shape and wound margins attached to wound bed-wound bed is 100% pink, shiny tissue; -Resident lays on a feather tick mattress with lamb's wool between arms; -Intervention: feather tick mattress will be removed from bed and air mattress (an alternating pressure mattress system used for the treatment of developed pressure ulcers as well as prevention of them) will be provided. Review of the resident's care plan showed no documentation regarding the development of open areas on the resident's right outer elbow and right buttock or the discontinuation of the feather tick mattress or the addition of an air mattress. Review of the resident's physician's orders, dated 01/06/25, showed no evidence of an order for an air mattress. Review of the resident's wound assessment, dated 01/16/25 at 7:14 P.M., showed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Inner aspect of left elbow to anterior (front) aspect of the forearm tissue is pink and shiny, measures 6.5 cm by 2.5 cm that has an appearance of superficial tissue loss, surrounding tissue is pink and blanchable; -Posterior aspect of elbow to bony prominence site that is scabbing over, measuring 3.7 cm by 1.5 cm; (a noted worsening in measurements of the elbow areas); -Left buttocks dark pink tissue that blanches slowly to touch measures 8.5 cm by 3 cm and to right buttocks dark pink tissue that blanches slowly measuring 4.8 cm by 5.6 cm; -Open area to right buttocks measures 0.5 cm by 0.5 cm with wound bed being pink shiny epithelial tissue with wound margins attached to wound bed; -Noted that upon touch, wound bed is 100% firm with surrounding tissue being firm to touch-tender to touch; -All interventions will remain in place as resident has an air mattress in place and wedge pillow in place for positioning. Observation on 01/21/25 at 12:23 P.M., in the resident's room, showed the following: -The resident lay in bed on his/her back with his/her eyes closed; -A lowaire loss mattress was present on the resident's bed; -The mattress was set at 110-130 kg (242-286 pounds) (over inflated and too firm for the resident's weight). Review of the resident's weight record, dated 01/22/25, showed the resident's weight was 147 pounds (67 kg). Observation on 01/22/25 at 8:46 A.M., in the resident's room, showed the following: -The resident lay on his/her left side in bed with his/her eyes closed; -A low air loss mattress was present on the resident's bed; -The mattress was set at 110-130 kg (242-286 pounds) and overinflated Observation on 01/22/25 at 12:04 P.M., in the resident's room, showed the following: -The resident lay on his/her back in bed; -The resident was awake; -A low air loss mattress was present on the resident's bed; -The mattress was set at 110-130 kg (242-286 pounds) and over inflated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Nursing Home	1260 North Johnson Street Kahoka, MO 63445

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/23/25 at 12:26 P.M., in the resident's room, showed the following: -The resident lay in bed; -Staff provided pericare and changed the resident's gown; -A low air loss mattress was present on the resident's bed; -The mattress was set at 110-130 kg (242-286 pounds) and over inflated. Review of the resident's wound assessment, dated 01/24/25 at 9:58 A.M., showed the following: -Right great toe at distal end with a small blackened circular area that has appearance of a blood blister, measurements are 0.5 cm by 0.8 cm with peri wound being pink and blanchable and non-tender; -Wound bed is 100% soft, not boggy, black eschar with wound margins well defined and area being circular in shape; -Left elbow tissue overall is dry. Medially (towards the middle) is a scabbed area that measures 0.5 cm by 0. 5 cm that is circular in shape and firm to touch. Wound bed is 100%, dull, rust coloration with peri-wound being pink and blanchable surrounding the site-no warmth noted, non-tender; -Right buttocks tissue does blanch, measures 4.4 cm by 5.0 cm and left buttocks is pink, blanchable tissue that measured 5.0 cm by 3.0 cm. During an interview on 01/23/25 at 8:40 A.M., Certified Nurse Aide (CNA) P said the following: -He/She did not know who monitored the settings on the low air loss mattresses; -CNA staff do not adjust the settings on the low air loss mattresses. During an interview on 01/23/25 at 3:12 P.M., the Wound Care Nurse said low air loss mattresses were set when first placed on the resident's bed. During an interview on 01/23/25 at 12:26 P.M. and 3:15 P.M., the DON said the following: -The resident weighs approximately 140 pounds; -The low air loss mattress was set too high for the resident's weight; -Staff should set the mattress by the resident's weight. During an interview on 01/23/25 at 2:20 P.M. the Wound Care Nurse said the following: -She oversees wound care, quality measures and various other areas; -If a resident has a pink area, she will add interventions, then place the resident on her list to monitor; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She notifies the MDS Coordinator, so the MDS Coordinator can update the care plan with all the interventions that added; -She implements a feather tick mattress if the resident needs one; -If a resident had chronic wounds, or many wounds, the resident will get a low air loss mattress; -She expected the CNAs or nursing staff to do the interventions that have been added; -Resident #42's heels were against the pillow during the observed assessment on 01/23/25; -She thought she had asked for a feather tic mattress for Resident #42, but she may have missed asking them to put one on; -If the feather tic mattress was on Resident #42's bed, and staff removed it, staff are expected put it back on; -She expects staff to let her know if they took off an intervention for any reason; -If a resident is getting a betadine paint to a wound, the skin was usually yellow, and Resident #42's was not; -Resident #42 should have had a feather tick mattress and his/her heels floated, not against the pillow. During an interview on 01/23/24 at 3:15 P.M. and 01/28/24, at 3:33 P.M., the Director of Nursing said the following: -Any resident with a pressure ulcer should have a feather tic mattress; she did not have information on the brand or where they purchased the feather tic mattress overlays; -She expected low are loss mattresses to be set to a resident's weight; -She expected staff to ensure a resident's heels do not have direct pressure with a pillow under the heels; the heels should be off the pillow and mattress if heels are to be floated. 50189

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to provide restorative nursing services to assist one resident (Resident #28), in a review of 22 sampled residents to attain or maintain his/her their highest level of functioning. The resident admitted to the facility free of contractures and had no limits in range of motion. The facility did not have a system to identify residents at risk for a decrease in range of motion or prevent development of contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). The facility failed to develop restorative nursing plans with goals to prevent the development of contractures, improve or maintain functional range of motion, or direction to staff to meet the resident's needs. Resident #28 had a decrease in her range of motion abilities. The facility census was 59. During an interview on 01/24/25, the Director of Nursing (DON) said the facility does not have a policy for range of motion, contractures, or prevention/improvement of contractures. Review of the list of resident's on a restorative nursing program in the facility did not include Resident #28. Review of Resident #28's admission Minimum Data Set (MDS's), federally mandated assessment instruments to be completed by facility staff, from 10/22/18 (first admission to facility) to 03/18/24, showed the facility assessed the resident with no limits in range of motion. Review of the resident's Nurses Progress Notes, dated 03/07/24, at 7:05 P.M., showed the resident was found on the floor leaning towards his/her left side. Staff assisted the resident to a partial standing stance (due to contracted knees). Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included heart dysrhythmia (abnormal heart beat), and diabetes mellitus (inability to control blood sugar); -Independent with eating, oral hygiene, toilet hygiene, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, sit to stand, chair/bed to chair transfer, and toilet transfer; -Set up or clean up assistance from staff for upper and lower body dressing; -Required partial/moderate assistance from staff for tub/shower transfer; -Required substantial/maximal assistance from staff for shower/bathe; -Used a wheelchair independently; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Two or more no injury falls and one injury fall; -No limitation in functional range of motion (ROM); -Restorative range of motion and walking one day. Review of the resident's Nurses Progress Notes, dated 3/25/24, at 4:00 P.M. showed the resident had a lack of safety awareness and still believed at times he/she can walk. Resident's knees were contracted, but was still able to transfer self. Review of the resident's significant change in status MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included new dementia, and contractures of the right knee and left knees; -No behavior or rejection of care; -Independent with roll left and right, sit to lying, lying to sitting; -New limited ROM to both lower extremities; -Requires substantial/maximal assistance from staff for toilet hygiene, lower body dressing, putting on/taking off footwear; -Dependent on staff for sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, and wheelchair mobility; -Two or more non injury falls; -No therapy or restorative nursing services; -Bed alarm and chair alarm used daily. Review of the resident's Physician's Orders, dated 12/24/23 to 01/24/25, showed the resident did not have an order for physical therapy to evaluate or treat. Review of the resident's quarterly MDS, dated [DATE], showed limited range of motion both lower extremities. Review of the resident's MDS's showed he/she admitted without contractures at the facility. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Independent with wheelchair mobility; -Limited ROM in both lower extremities; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required partial/moderate assistance from staff for roll left and right -Dependent on staff for toilet hygiene, shower/bathe, lower body dressing, putting on/taking off footwear, -New pain medication and non pharmacological interventions for pain. Observation on 01/22/25, at 10:23 A.M., showed the following: -The resident lay in a low bed; -The resident wore no pants and was partially covered with a sheet; -The resident's legs were drawn up in a fetal position with his/her head leaning to the right side; -The resident had contractures at the knee and hip; -Staff came into the resident's room and assisted him/her to move, the resident was unable to straighten his/her legs. During an interview on 01/23/25, at 8:00 A.M., Certified Nurse Assistant (CNA)/Certified Medication Technician (CMT) M said the resident was contracted at the knees and hips. During an interview on 01/24/25, at 12:08 P.M., the Director of Nursing (DON) said the following: -The facility does not have a policy for range of motion, contractures or prevention/improvement of contractures; -She ensured residents who have a restorative program are appropriate, re-evaluated their programs and oversees the restorative aide; -Therapy can refer residents to restorative when they discontinue therapy services; -Residents get some range of motion with daily cares, getting dressed and taking showers; -The facility did not put residents on a restorative program because of limits with range of motion; -There was nospecific care program for residents with or at risk for contractures; -Resident #28 was not on a restorative program and had contractures. 50189

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to propel three residents (Resident 28, #17, and #11), in wheelchairs equipped with foot pedals, in a review of 22 sampled residents. The facility census was 59. 1. Review of Resident #28's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/14/24, showed the following: -Severe cognitive impairment; -Diagnoses included new dementia and contractures (muscle tightening restricting range of motion due to non use) right knee and left knee, -Dependent on wheelchair mobility; -Two or more non injury falls. Review of the resident's Social Services progress note, dated 12/03/2024, at 8:24 A.M., shoed the Social Services Director documented when up in his/her wheelchair, the resident will at times propel himself/herself. Observation on 01/23/25, 6:30 A.M., showed Certified Nurse Assistant (CNA)/Certified Medication Technician M propelled the resident in his/her wheelchair from his/her bedside, out of his/her room and approximately 20 feet down the hall. The resident's feet slid on the floor, making a sliding sound. The resident did not have foot pedals on his/her wheelchair. The staff did not apply foot pedals, cue the resident, or ensure the resident's feet were safe when there was audible sliding sounds while CNA/CMT M propelled the resident. During an interview on 01/23/25, at 8:05 A.M., CNA/CMT M said staff have been instructed to always make sure residents in wheelchairs have foot pedals before propelling their wheelchairs. Propelling a resident without foot pedals could cause injury to the resident's feet, or if the resident puts his/her feet down while the chair was moving it could eject them from their wheelchair. 2. Review of Resident #17's Care Plan, dated 06/08/23, showed the following: -Resident has potential for falls related to weakness, decreased mobility, poor safety judgment, and history of falls; -Resident uses wheelchair for long distances propelled by the resident. Review of the resident's, quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderate cognitive impairment; -Dependent on staff for putting on/taking off footwear, to wheel his/her wheelchair 50 feet and make two turns, and dependent on staff to wheel his//her wheelchair 150 feet. The resident's care plan did not show evidence staff identified the resident required staff to propel his/her wheelchair long distances as reflected on his/her MDS 11/18/24. Observation on 01/22/25, at 09:45 A.M., showed the resident sat in his/her wheelchair. The wheelchair did not have foot pedals. Observation on 01/23/25, at 11:58 A.M., showed CMT N propelled Resident #17 from his/her room down the hall and into the dining room. The resident tried to hold his/her feet up. His/Her feet were barely off of the ground. Two times the resident could not hold his/her feet up and the wheelchair stopped when the resident's feet hit the floor. CMT N asked the resident to hold up his/her feet and continued down the hall. Observation on 01/23/25, at 03:19 P.M., showed the following: -The Wound Nurse and CNA/CMT M assisted the resident to the bathroom with a wheeled walker; -While in the bathroom the resident became unsteady; -CNA/CMT M assisted the resident to his/her wheelchair while in the bathroom; -CNA/CMT M propelled the resident from the bathroom back to his/her bed with no foot pedals on the wheelchair. The resident's feet touched the floor while CNA/CMT M pushed the resident's wheelchair. During an interview on 01/25/25, at 1:35 P.M., CMT N said he/she propelled residents without foot pedals in their wheelchair slowly while she walked behind the wheelchair. All residents have foot pedals for their wheelchairs, and staff should use foot pedals when propelling residents in the wheelchair to prevent injuries. Staff get busy and do not get the wheelchair foot pedals. 3. Review of Resident #11's face sheet showed the resident had a diagnosis of rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood and can cause muscle weakness and muscle aches). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Used a wheelchair for mobility; -Independently with wheelchair mobility. Review of the resident's care plan, revised 11/18/24, showed the following: -Potential for falls related to weakness, decreased mobility, poor safety judgment and history of falls; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Propels self in wheelchair. Will ask for assistance as needed. Observation on 01/22/25, at 12:09 P.M., showed the Social Services Director (SSD) pushed the resident from his/her room down the hallway, approximately the distance of ten rooms. The resident did not have foot pedals on his/her wheelchair. The resident's right foot was crossed over his/her left foot and drug the floor approximately half the distance as staff pushed the resident in the chair During an interview on 1/24/25 at 4:14 P.M., the Social Services Director said the following: -If a resident was able to self-propel in a wheelchair, staff do not put foot pedals on the wheelchair; -Resident #11 typically self-propelled himself/herself in the wheelchair; -On 1/22/25, he/she thought the resident held his/her feet up and did not realize the resident's foot dragged on the floor. 4. During an interview on 01/28/25, at 3:29 P.M., the Director of Nursing (DON) said the following: -If staff pushed a resident a short distance in a wheelchair, staff could tell the resident to hold up their feet and staff could safely push them; -If staff pushed a resident in a wheelchair a long distance, the wheelchair should have foot pedals; -If staff pushed a resident and the resident's feet dragged on the floor, staff should no longer push the resident to avoid injury. During an interview on 01/28/25, at 4:45 P.M., the Administrator said the following: -Staff should not propel the residents in a wheelchair without foot pedals on the chair; -At times, it can be hard for staff to determine who should have foot pedals because some residents can propel themselves; -There were bags on the wheelchairs for the foot pedals. 42592

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to have a system in place to ensure residents, including one resident (Resident #13), with diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event, either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), were assessed and received trauma informed care to mitigate or eliminate triggers that may cause retraumatization of the resident. The facility's census was 59. Review of email communication, dated 02/05/25 at 4:52 P.M., showed the Director of Nursing (DON) wrote the facility did not have a policy for trauma informed care or care for residents with PTSD. 1. Review of the resident's face sheet showed the following: -Current admitted [DATE]; -Diagnoses of PTSD and major depressive disorder. Review of the resident's care plan, updated 08/15/23, showed the following: -Resident has verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others); -Resident will not threaten, scream at, or curse at other residents, visitors, and/or staff; -Avoid power struggles with resident. Leave the room. Do not argue with resident; -Inform the Charge Nurse and Management of resident's behaviors. Set expectations and limits for resident; -Investigate the reasoning for the behavior; -Maintain a calm environment and approach to the resident. Review of the resident's care plan, last reviewed/updated 11/6/24, did not include information about the resident's PTSD triggers or interventions to prevent the resident from experiencing further re-traumatization related to his/her diagnosis of PTSD. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/26/24, showed the following: -Moderate cognitive impairment; -Diagnosis of PTSD, anxiety, and depression; -The resident did not have a PASARR screening completed; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No difficulties hearing; -No behaviors or rejection of care; -Very important to the resident to have activities involving pets and keeping up with the news; -Somewhat important to the resident to have activities and to go outside when the weather was nice. Review of the resident's medical record, including physician notes and social service notes, showed no documentation regarding the resident's PTSD. The resident's record contained no trauma informed care assessment, and did not address how to care for the resident related to the resident's PTSD. Review of the resident's electronic medical record, under the document tab labeled social services, a document was saved as the DA124C (the states Level I screening form), when the document opened it showed a face sheet and hand written at the top of the face sheet a staff member wrote not needed a VA resident. During an interview on 01/21/25 at 1:43 P.M. and 01/24/25 at 2:00 P.M., the resident said the following: -He/She was in the military during the war and laid on the battle field for four hours with 14 holes in him/her from shrapnel. The shrapnel hit the artery behind his/her knee and he/she thought he/she was would die. The resident shared how much this experience had affected him/her. His/Her spouse was a retired nurse and had helped him/her deal with the PTSD. The resident said he/she did not receive counseling at the facility, his/her spouse was a retired nurse and helped him/her deal with the PTSD; -He/She cannot take the commotion in the dining room, just stays in his/her room and eats all meals in his/her room. If there was too much going on, he/she felt overwhelmed. He/She did not want to go to group activities and the facility did not offer any in room activities so he/she watched television with his/her spouse. Observations throughout survey, from 01/21/25 to 01/24/25, showed the resident did not leave his/her room for activities or meals. During an interview on 01/28/25 at 12:59 P.M., the MDS Coordinator said the following: -The resident did not have a Level I screening that she could find; -She was not sure if the resident had triggers with his/her PTSD; -The care plan should include any special care needs for behaviors or triggers for PTSD for staff to follow; -She was not sure if the care plan included those behavioral issues or if the resident's PTSD was included in the resident's care plans. During an interview on 01/28/25 at 3:33 P.M., the DON said the following: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There were no specific interventions related to residents with PTSD: -Triggers that might cause the resident to remember or have flash backs of their trauma were probably not in the care plan, but staff knew these by word of mouth; -Staff were still learning some of the residents' triggers; -The facility only knew what a resident's triggers were when family shared these with facility staff; -Once staff knew the residents, this would be added to information on the report sheet; -New staff would be told by current staff; -Triggers and behaviors would be good to have on the care plan, but they may not be on the care plan; -The facility did not monitor triggers or specific behaviors as much as the staff were monitoring for side effects of medications. During an interview on 01/28/25 at 3:33 P.M., the Administrator said the facility took care of veterans. Every resident was treated as if they had PTSD.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to complete a side rail assessment for one resident, (Resident #17) or assess three residents' (Resident #17, #54 and #18) risk for entrapment prior to use of side rails, in a review of 22 sampled residents. The facility failed to obtain consent from one resident (Resident #54) or his/her family for use of the side rails prior to use. The facility census was 59. Review of the undated facility policy, Quarter Side Rail Policy, showed the following: -The purpose is to ensure the appropriate use of quarter bed rails and to ensure the safety for a resident who requests quarter bed rails. -Any resident who is admitted to the facility, that has a history of using bed rails, fall risks and compromised mobility, shall be reassessed for appropriate use; -Bed rails are used for: transferring, enhancing mobility, assisting with turning/reposition, and emotion support per request after nursing assessment and agreement by the Quality Assurance (QA) committee; -A resident who uses bed rails shall be screened or assessed monthly according to the monthly assessment scheduled; -The care plan shall reflect the use of bed rails; -A resident who requests to have bed rails shall be educated on risks and benefits; -The QA committee shall assess and decide for the continuity of use; -The procedure is to assess the residents mobility level, assess the residents emotional comfort, send the communication regarding this to the QA committee, QA committee meets briefly in the morning to discuss and approve side rail use after assessment, explain risk for use to resident and family members, obtain signed consent, monitor for entrapment, risk of injury, footboards and headboards, and documentation for risk assessment and evaluation monthly and as needed (especially with change of condition, mobility levels and fall risks). 1. Review of Resident #17's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 11/18/24, showed the following: -Severe cognitive impairment; -Independent when rolling left and right; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required partial to moderate assistance to move from sitting on the side of the bed to lying flat on the bed; -Required partial to moderate assistance lying on his/her back to sitting on the side of the bed with feet flat on the floor; -Required partial to moderate assistance to stand from a sitting position on the bed. Review of the resident's Care Plan, last reviewed 11/21/24, showed the following: -The resident had the potential for falls related to weakness, decrease mobility, poor safety judgement, and history of falls; -On 12/4/24, the resident slid out of bed; -On 12/19/24, the resident rolled out of bed. Staff provided safety awareness education about being aware of where he/she is in bed; -Transfer with assist of one staff at times. He/She transferred himself/herself between the chair and bed; -On 1/3/25, the resident liked side rails up on his/her bed so he/she was able to reposition himself/herself while in bed. Review of the resident's Physician's Orders, dated 12/23/24 through 1/23/25, showed the following: -The resident's diagnoses included history of repeated falls, altered mental status, muscle weakness, need for assistance with personal care, and lack of coordination; -An order dated 1/3/25 for one-fourth side rails for assistance with bed positioning. Review of the resident's medical record showed no documentation staff completed a side rail assessment or assessed the resident's risk for entrapment prior to use of the side rails on 1/3/25. Observation on 01/22/25 at 3:51 P.M., showed the resident lay in bed. The resident had a one-fourth side rail in the raised position on the left side of his/her bed. During interview on 01/23/25 at 1:05 P.M., the Director of Nursing (DON) said she completed a side rail assessment for the resident, but did not fill out a form with the assessment. She made a mental note to complete the assessment form at the end of the month. 2. Review of Resident #54's Side Rails Monthly Assessment, dated 12/5/23, showed the following: -Type of side rails: One-fourth side rails up times two; -Reason for side rail usage: Assist with bed mobility (turning side to side) and boundary limitations; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The side rail was an enabler; -The resident was alert and oriented and requests (side rails); -Risks and benefits were explained to the resident/family. Review of the resident's medical record showed no evidence staff assessed the resident's risk for entrapment prior to use of the bed rails. Review showed no evidence staff obtained consent from the resident/family for use of the side rails. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Required substantial/maximal assistance to roll left and right in bed, to change position from sitting to lying in bed and from lying to sitting on the side of the bed, and to stand from a sitting position on the bed. Review of the resident's Care Plan, last reviewed 11/26/24, showed the following: -The resident required maximum assistance to dependent on staff of cares. He/She used one to two staff assist with Sara Steady (a transfer aide used to assist an individual from a sitting to a standing position) for transfers; -The resident was alert with moments of confusion. He/She had episodes of hallucinations at times. He/She required orientation to his/her surroundings. -The resident liked to have bed rails so he/she was able to reposition himself/herself while in bed. Review of the resident's Physician's Orders, dated 12/23/24 through 01/23/24, showed the following: -The resident's diagnoses included Parkinson's disease, dementia with behavioral disturbances, hallucinations, and muscle weakness; -One-fourth side rails for positioning. Observation on 01/21/25 at 2:15 P.M., showed the resident lay in bed. The right side of the resident's bed was against the wall. The resident had a one-fourth side rail in the raised position on the left side of his/her bed. During interview on 01/23/25 at 1:10 P.M., the DON said the following: -She could not find a side rail consent form for the resident; -The resident used the side rail to know where the edges of the bed were located and to sit on the side of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #18's undated Face Sheet showed the following: -Diagnoses of history of falls, muscle weakness, hypertension (elevated blood pressure), gout (a form of arthritis that causes pain and swelling of the joints), chronic fatigue (tiredness), pain, osteoarthritis, and macular degeneration (a progress eye disease that causes vision loss); -Did not identify a responsible party, power of attorney, or health care proxy. Review of the resident's Resident Quarter Bed Rail Consent Form, dated 7/6/23, showed the resident's family member signed and gave consent for side rails on 7/6/23. Review of the resident's medical record showed no documentation staff assessed the resident's risk for entrapment prior to use of the side rails. Review of the resident's Physician Orders, dated 7/1/24 through 1/23/25 showed an order dated 7/11/23 for one-fourth side rail for positioning. Review of resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Impairment of bilateral lower extremities; -Independent in rolling left to right in bed; -Required partial to moderate assistance to move from sitting on the side of the bed to lying flat on the bed; -Required partial to moderate assistance to move from lying on his/her back to sitting on the side of the bed; -Required substantial to maximum assistance to move from sitting on the side of the bed to standing. Review of the resident's care plan, last reviewed 10/25/24, showed the following: -The resident required limited to extensive assist with activities of daily living (ADLs); -The resident transferred with one or two assist but did not always remember to ask for help; -The resident had the potential for falls related to weakness, decreased mobility, poor safety judgement and history of falls; -One-fourth side rails applied to the resident's bed for assistance and to help the resident determine the edge of the bed (implemented on 7/6/23); -The resident liked to have side rails up so he/she was able to reposition self while in bed (implemented 7/7/23). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Side Rails Monthly Assessment, dated 12/30/24, showed the following: -Type of side rails: one-fourth side rails up times two; -Reason for side rail usage: boundary limitations; -The side rail was an enabler; -The resident was alert and oriented and requests side rails; -The risks and benefits were explained to the resident/family on 7/6/23; -There was no change in condition; -Appropriate and continue use of side rails. Review of the resident's medical record showed no evidence staff assessed the resident's risk for entrapment from the bed rails. Observation on 1/22/25 at 8:49 A.M. showed quarter side rails in the raised position on both sides of the resident's bed. Observation on 1/24/25 at 1:07 P.M. showed quarter side rails in the raised position on both sides of the resident's bed. During an interview on 1/24/25 at 1:07 P.M., the resident said he/she used the side rails to roll over and get up out of bed. During interview on 01/23/25 at 1:10 P.M., the DON said the following: -Staff should obtain consent prior to initiating the bed rails; -She was responsible for completing the bed rail assessments. The assessments should be completed prior to using the side rails. 50189 51988

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42592 Based on observation and interview, the facility failed to ensure insulin (a medication used to treat diabetes) vials/pens for two residents (Residents #2 and #58), were dated when opened or discarded within the designated time frame after opening. The facility failed to secure a schedule IV controlled substance (a medication subject to abuse) in a separately locked compartment, failed to timely destroy expired medications, and failed to destroy one expired resident's (Resident #300's) medications. The facility census was 59. 1. Review of the Drugs.com showed the following: -Use Humalog (a rapid acting injectable insulin used to treat diabetes) within 28 days of opening; -Use Basaglar (a long-acting injectable insulin used to treat diabetes) within 28 days of opening. Observation of the east hall medication room and east hall nurse's medication and treatment cart on 01/23/25 at 5:16 A.M., showed the following: -One bottle containing 29 milliliters (ml) of liquid Ativan (a medication used to treat anxiety), labeled for Resident #1, was located in the unlocked refrigerator in the medication room; -One Basaglar Kwikpen, in use and labeled for Resident #2, was 1/2 full and was not labeled with an open date; -One vial of Humalog insulin, in use and labeled for Resident #58, was 3/4 full and was dated as opened 12/01/24 (opened 54 days, the medication was not discarded within 28 days after opening); -One card containing ten tablets of Xanax (a medication used to treat anxiety) 0.25 milligrams was in the locked emergency narcotic box and had an expiration date of 12/20/24. 2. Observation of the west medication room on 01/23/25 at 10:41 A.M., showed the following: -Two unopened boxes of albuterol sulfate (medication used to treat wheezing and shortness of breath) inhalation solution 0.5 mg/3 mg per 3 ml labeled with Resident #300's name. (Resident #300 expired on 10/20/24); -One opened bottle of nystatin topical powder (antifungal medication) expired 02/24; -One opened box of albuterol sulfate inhalation solution 0.083% 2.5 mg/3 ml expired 09/24. During an interview on 01/23/25 at 10:50 A.M., the Infection Preventionist/MDS Coordinator said certified medication technicians (CMTs) were to notify a nurse as soon as possible after a resident expired so the medication could be destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on 01/23/25, at 5:41 A.M., Licensed Practical Nurse (LPN) F said the following: -He/She was usually responsible for checking the medication rooms and carts for expired medications when he/she had time; -Ultimately, every nurse and certified medication technician (CMT), was responsible to check the medication room and carts for expired medications; -Staff should date insulin vials and pens when opened; -Insulin was good for 28 days once opened; -Two nurses should destroy expired medications; -Resident #1's Ativan was stored in the refrigerator in the medication room, and the refrigerator did not lock. During an interview on 01/28/25, at 3:29 P.M., the Director of Nursing (DON) said the following: -All licensed nursing staff had access to the medication rooms and carts and should check for expired medications; -The pharmacist also checked for expired medications on their monthly reviews; -Staff should check the emergency kits for expired medications; -Liquid Ativan should be stored in the refrigerator. The refrigerator did not lock; -Liquid Ativan should be under double lock.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44610 Based on observation, interview, and record review, the facility failed to label food items, discard food that was past the expiration/remove by date in dry storage, and discard prepared food after the labeled use by date in the walk-in cooler. The facility also failed to ensure food service equipment and surfaces were appropriately cleaned and maintained. The facility census was 59. Review of the facility's policy, Food Storage (Dry, Refrigerated, and Frozen), dated 2020, showed the following: -Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety; -Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration; -Date marking for dry storage food items - once a case is opened, the individual food items from the case are dated with the date the item was received into the facility and placed in/on the proper storage unit utilizing the first in-first out method of rotation. Expiration dates on commercially prepared, dry storage food items will be followed; -Date marking for refrigerated storage food items - once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturer's expiration date; -Prepared food or opened food items should be discarded when the food item does not have a specific manufacturer expiration date and has been refrigerated for seven days, the food item is leftover for more than 72 hours, or the food item was older than the expiration date. 1. Observations on [DATE] between 10:30 A.M. and 5:00 P.M., in the dry food storage room showed the following: -An opened/resealed plastic bag of cornflakes unlabeled with an opened date and did not have an expiration date; -An opened/resealed 11.3-ounce package of pork gravy mix unlabeled with opened date and did not have an expiration date; -An opened/resealed 24-ounce package of cheddar cheese sauce mix, unlabeled with opened date and did not have an expiration date. Observations on [DATE] between 10:30 A.M. and 5:00 P.M., in the walk-in cooler, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An approximate 10-inch by 8-inch stainless steel container of egg salad labeled 'Saturday supper, use by , d+[DATE]'; -An approximate 6-inch by 6-inch glass container of tomato sauce labeled 'Saturday supper, use by , d+[DATE]'. During an interview on [DATE] at 9:15 A.M., the Dietary Manager said the following: -Dietary staff should ensure food items were labeled correctly and removed when required from the walk-in cooler/freezer and the dry food storage room; -Dietary staff should monitor the walk-in cooler/freezer and dry food storage room daily to identify products to ensure they were labeled and not expired; -She expected food items to be labeled correctly and to be removed after the use by/expiration dates. During an interview on [DATE] at 11:00 A.M., the Dietary Supervisor said the following: -All dietary staff were responsible for ensuring food items were labeled properly and any outdated items were removed from the dry storage and walk-in cooler/freezer areas. -She expected dietary staff to monitor the food items in the dry storage and walk-in cooler/freezer daily correct labeling, rotation of stock and removal of products past the use by/expiration dates. During an interview on [DATE] at 3:00 P.M., the Administrator said the following: -All dietary staff and the dietary supervisor were responsible in making sure food items were labeled correctly in the dry storage room and walk-in cooler and freezer; -Staff should monitor these areas on an ongoing basis; -She expected staff to label the food items when opened. Any items with past use by dates were to be removed. 2. Observations on [DATE] between 10:30 A.M. and 5:00 P.M., of the ice machine in the kitchen, showed the following: -An approximate 4-foot long by 0.25-inch-wide white scaly material on the outside of the machine at the top front and around both corners above the door; -White scaly and rust-colored run marks on both left and right sides of the front corners; -A buildup of a white, scaly material was on the inside of the machine at the right side of the stainless-steel panel to the ice dump; -A crack around the circumference of the plastic underside of the door; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The crack was filled with a sealant, and the sealant was separating from the repaired area. Observations on [DATE] between 10:30 A.M. and 5:00 P.M., of the dishwasher in the kitchen, showed the following: -A buildup of debris on the top surface of the dishwasher and around the temperature box area; -A buildup of debris behind the temperature box area and the piping below; -A buildup of debris located below the power/motor switches and wash/rinse temperature gauge area; -A buildup of a blackened material located below the dirty dish entrance side (right side of dishwasher), plastic piping, and baseboard. During an interview on [DATE] at 9:15 A.M., the Dietary Manager said the following: -Dietary staff were responsible for cleaning the ice machine, the dish washing machine and the areas around them; -She was not sure how often staff cleaned the machines; -She expected staff to clean the outside surfaces of the ice machine weekly and to clean inside the machine monthly; -She expected staff to clean the surfaces of the dishwasher daily. During an interview on [DATE] at 11:00 A.M., the Dietary Supervisor said the following: -The dietary department was responsible for cleaning the outside surface of the ice machine daily, and the maintenance department was responsible for cleaning inside the ice machine; -Dietary staff were responsible for cleaning the surfaces of the dishwasher daily and should clean the piping weekly; -She expected the outside/inside areas of the ice machine and the dishwasher surfaces, piping, and area to be clean and sanitized. During an interview on [DATE] at 12:20 P.M., the Maintenance Technician said the maintenance department was responsible for cleaning inside the ice machine. He was not aware of the white scaly material inside the machine. Maintenance cleaned the ice machine bi-annually, and it was due to be cleaned this month. During an interview on [DATE] at 3:00 P.M., the Administrator said the following: -The dietary department was responsible for cleaning the outside surfaces of the ice machine and the dishwasher weekly; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The maintenance department was responsible for cleaning/deep cleaning the interior of the ice machine and the dishwasher monthly; -She expected the ice machine, dishwasher, and equipment areas to be cleaned and sanitized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 42592 Based on observation, interview, and record review, the facility failed to follow current infection control standards for three residents (Residents #25, #17, and #21), in a review of 22 sampled residents, and for two additional residents (Resident #20 and #55). The facility failed to follow infection control practices while performing blood glucose monitoring (a procedure where a drop of blood is obtained to test the amount of sugar in the blood) for three residents (Resident #25, #20, and #17) when staff failed to appropriately sanitize the glucometer (a machine that tests a drop of blood for the amount of sugar it contains) after use and use a barrier to protect against contamination. The facility failed to store oxygen tubing and nebulizer equipment (equipment used to give aerosol breathing treatments) when not in use in a way to prevent potential contamination for three residents (Resident #25, #21 and #55). The facility failed to develop a policy to address Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease (a bacterial disease commonly associated with water-based aerosols) in persons at risk) control that included specific control parameters based on Center for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) standards, and failed to complete a facility water assessment to identify potential sources of Legionella growth. The facility's policy did not include a water management team, a water flow map, parameters for findings related to water monitoring, and did not include how staff were to monitor residents for Legionnaire's Disease. The facility census was 59. Review of the Centers for Disease Control (CDC), Considerations for Blood Glucose Monitoring, showed the following: -Assign blood glucose meters to a person unless the device is designed for use in professional settings and is cleaned and disinfected after every use; -Clean and disinfect blood glucose meters after every use per the manufacturer's instructions, to prevent the spread of blood and infectious agents. Review of the Easy Touch Glucose Monitoring System User Manual, revised 12/2011, showed the following: -When cleaning meter, gently wipe the exterior surface using a damp soft cloth; -For healthcare professionals using this system on multiple residents, please be aware that all items that come in contact with human blood should be handled as potential biohazards. Users should follow the guidelines for prevention of blood-borne transmittable diseases in a healthcare setting for potentially infectious human blood specimens as recommended in the National Committee for Clinical Laboratory Standards, Protection of Laboratory Workers from Instrument Biohazards and Infectious Disease Transmitted by Blood, Body Fluids and Tissue: Approved Guideline. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the National Committee for Clinical Laboratory Standards, Protection of Laboratory Workers from Instrument Biohazards and Infectious Disease Transmitted by Blood, Body Fluids and Tissue: Approved Guideline website, that provides guidance on how to protect workers from bloodborne infections, instructs for safety, appropriate disinfectants should be used. Review of the website for Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes (green top) showed the following: -Wipe surface until completely wet; -30 seconds to 1 minute contact times on most bacteria and viruses. -The product protects against hepatitis B (virus commonly spread by exposure to infected bodily fluids), hepatitis C (virus that is spread by contact with contaminated blood) and human immunodeficiency virus (HIV) (virus that is transmitted by contact with infected blood. Review of the National Heart, Lung, and Blood Institute, National Institute of Health: How to Use a Nebulizer, dated October 2021, showed the following: -After each treatment wash the medicine cup and mouthpiece or mask with warm water and mild soap, rinse well and shake off excess water, air dry parts on a paper towel; -Between uses store nebulizer parts in a dry, clean plastic storage bag. 1. Review of Resident #25's undated Face Sheet, showed the resident's diagnoses included chronic obstructive pulmonary disease (COPD; a lung disease that blocks airflow and makes it difficult to breath), chronic respiratory failure with hypoxia (a long-term condition that occurs when there is not enough oxygen in the blood), dependence on supplemental oxygen, asthma, and diabetes mellitus with diabetic chronic kidney disease (too much sugar in the blood stream and affects the ability of the kidney's for function correctly). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 11/15/24, showed the following: -Cognitively intact; -Received oxygen therapy. Review of the resident's Care Plan, revised 11/15/24, showed the following: -The resident had a potential for impaired air exchange related to COPD and chronic respiratory failure; -Administer oxygen as ordered; -The resident used oxygen at 2 liters via nasal cannula (a medical device that provides supplemental oxygen to a patient through their nose) as needed. The resident will remove oxygen for shower, activities, and meals. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Nursing Home	1260 North Johnson Street Kahoka, MO 63445

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's Physician Orders, dated 12/23/24 through 1/23/24, showed orders for the following: -Continuous oxygen at 2 to 4 liter via nasal cannula. May be off for meals, activities, shower, and transportation; -Blood glucose (level of sugar in the blood stream) checks for times a day as needed for signs and symptoms of hyperglycemia (high blood sugar); -Fasting blood sugar check weekly on Mondays. Observation on 1/21/25 at 1:25 P.M. showed the resident lay in bed. The resident received oxygen via nasal cannula. The oxygen tubing was dated 12/2/24. There was no bag in the resident's room for the oxygen nasal cannula and tubing when not in use. During an interview on 1/21/25 at 1:25 P.M., the resident said the following: -He/She wore continuous oxygen and only took it off when he/she was out of bed or left the room; -When he/she took off the oxygen, he/she laid the oxygen tubing on his/her bed and did not put it in a bag; -The staff did not change the tubing very often, maybe a couple times each year. Observation on 1/22/25 at 9:00 A.M. showed the resident lay in bed and received oxygen via nasal cannula. The oxygen tubing was dated 1/21/25. Observation on 1/22/25 at 11:03 A.M. showed the resident was not in his/her room. The resident's oxygen nasal cannula and tubing lay on the resident's bed and was not stored in a bag. There was no storage bag for the oxygen tubing available in the resident's room. Observation on 1/23/25 at 6:31 A.M. and 2:49 P.M. showed the resident was not in his/her room. The resident's oxygen nasal cannula and tubing lay on the bed and was not stored in a bag. There was no storage bag for the oxygen tubing available in the resident's room. Observation on 01/23/24 at 8:25 A.M., showed the following: -Registered Nurse (RN) B prepared to obtain a blood sugar sample for the resident; -A container of Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes (green top) sat on top of the treatment cart, available for use (an approved disinfectant wipe); -RN B took an Easy Touch glucometer (used for multiple residents) out of the treatment cart and placed it directly on top of the treatment cart without a barrier; -RN B went into the resident's room and placed the glucometer directly on the resident's bedside table without a barrier; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/28/25 at 03:33 P.M., the Director of Nurses (DON) said the following: -Staff should clean the glucometers using the manufacturer's directions; - 70% alcohol is not recommended for multi-use glucometers; -There was some discrepancy with the information that was given from the manufacturer when they called; -She educated staff on how to clean glucometers using Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant wipes. During an interview on 01/28/25 at 4:45 P.M., the Administrator said the manufacturer said to clean the glucometers with alcohol. 3. Review of Resident #21's undated Face Sheet showed he/she had a diagnoses of COPD. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -No rejection of cares; -Received oxygen therapy. Review of the resident's Care Plan, revised 11/04/24, showed the following: -The resident had the potential for impaired air exchange related to COPD and chronic respiratory failure; -Monitor the resident's oxygen saturations due to him/her removing his/her oxygen. He/She removes the oxygen and throws it on the floor at times; -Administer oxygen as ordered by the physician. Review of the resident's January 2025 POS showed the following: -An order for continuous oxygen at 2 to 5 liters per nasal cannula. May be off for meals, activities, showers and transporting between; -An order for ipratropium-albuterol (an inhaled solution administered by nebulizer for treatment of COPD symptoms) 0.5 milligrams (mg) -3 mg/3 milliters (ml) 1 vial by inhalation three times a day between 6:00 A.M. to 10:00 A.M., 11:00 A.M. to 2:00 P.M. and 4:00 P.M. to 7:30 P.M. Observation on 1/21/25 at 11:55 A.M., showed the following: -An oxygen concentrator was against the wall in the dining room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Undated oxygen tubing was connected to the concentrator. The oxygen tubing and the nasal cannula lay on the floor; -There was no storage bag attached to the concentrator; -Certified Nursing Assistant (CNA) E pushed the resident into the dining room and sat him/her at the table closest to the oxygen concentrator; -CNA E placed the nasal cannula, that had been on the floor, inside the resident's nares and turned on the oxygen at 2 liters. Observation on 01/21/25 at 12:40 P.M. showed CNA E removed the nasal cannula from the resident's nares, gathered the oxygen tubing and tucked it in the handle of the oxygen concentrator and took the resident from the dining room. CNA E did not store the oxygen tubing in a bag. During an interview on 01/24/25 at 1:35 P.M., CNA E said the following: -Oxygen tubing should be stored in the blue bag when not in use; -Oxygen tubing that touched the floor should never be used for a resident; -He/She was unaware on 01/21/25 that the oxygen tubing for the resident touched the floor prior to him/her putting it on the resident. Observation on 01/21/25 at 2:12 P.M. showed a nebulizer (a machine used to administer inhaled breathing treatments) machine was at the resident's bedside. The nebulizer tubing was connected and uncovered. A nebulizer set-up (the mechanism to administer the breathing treatment) was disassembled and sat on a washcloth by the handwashing sink. The set-up was uncovered and no storage bag was present in the room. Observation on 01/22/25 at 10:22 A.M., showed a nebulizer machine was at the resident's bedside. The nebulizer tubing was connected and uncovered. The nebulizer set-up was disassembled and sat on a paper towel turned upside down by the handwashing sink. The nebulizer set-up was uncovered and no storage bag was present in the room. Observation on 01/23/25 at 6:05 A.M., showed a nebulizer machine was at the resident's bedside. The nebulizer set-up was connected to the machine and lay uncovered on the resident's bedside table. Observation on 01/23/25 at 6:25 A.M., showed Certified Medication Technician (CMT) C removed the nebulizer treatment mask from the resident's face after administering a breathing treatment. He/She rinsed the nebulizer set up and placed it open side down on a clean washcloth on the counter by the handwashing sink. CMT C did not cover the set up with a drape or towel and did not place the set-up in a bag. Observation on 01/23/25 at 10:43 A.M. showed the resident's nebulizer treatment equipment was dry and continued to sit open side down on a clean washcloth on the counter by the handwashing sink. The equipment sat uncovered and was not placed in the equipment bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 1/21/25 at 1:39 P.M. showed the resident sat in a chair in his/her room. The resident's oxygen nasal cannula and tubing lay on the floor and were not stored in a bag. A storage bag hung on the oxygen concentrator. The oxygen tubing was labeled with the date 12/2/24. During an interview on 1/21/25 at 1:39 P.M., the resident said he/she only wore oxygen at night and not during the day. Observation on 1/22/25 at 8:47 A.M. showed the resident sat in a chair in his/her room. The resident's oxygen nasal cannula and tubing lay on the floor and were not stored in a bag. A clear bag hung on the oxygen concentrator in the room. The oxygen tubing was labeled with the date 1/21/25. Observation on 1/23/25 at 7:39 A.M. and 2:42 P.M. showed the resident sat in a chair in his/her room. The resident's oxygen nasal cannula and tubing lay on the floor and were not stored in a bag. Observation on 1/24/25 at 1:09 P.M. showed the resident sat in a chair in his/her room. The resident's oxygen nasal cannula and tubing lay on the floor and were not stored in a bag. 5. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following: -The bacterium Legionella can cause a serious type of pneumonia called Legionnaires' Disease (LD) (a bacterial disease commonly associated with water-based aerosols and often a result of poorly maintained air conditioning cooling towers and potable water systems) in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The log did not include cold water temperatures or any actions taken for low hot water temperatures. Review of the facility's water temperature log, dated 12/02/24, showed the following: -East shower room, 108.9 degrees F; -East spa, 108.7 degrees F; -room [ROOM NUMBER], 108.3 degrees F; -The specific location that the water temperature was taken from was not specified; -The log did not include cold water temperatures or any actions taken for low hot water temperatures. Review of the facility's water temperature log, dated 12/23/24, showed the following: -East spa, 106.8 degrees F; -The specific location that the water temperature was taken from was not specified; -The log did not include cold water temperatures or any actions taken for low hot water temperatures. Review of the facility's water temperature log, dated 12/31/24, showed the following: -room [ROOM NUMBER], 108.9 degrees F; -West spa/shower, 109.6 degrees F; -400 hall shower, 106.7 degrees F; -room [ROOM NUMBER], 108.7 degrees F; -The specific location that the water temperature was taken from was not specified; -The log did not include cold water temperatures or any actions taken for low hot water temperatures. The facility did not provide water temperature logs from 01/01/25 to 01/24/25. During an interview on 01/24/25 at 11:02 A.M. and 12:28 P.M., the Environmental Services Supervisor, said the following: -The facility does not test for legionella; -Every open or closed loop was moving; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265485	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark County Nursing Home	1260 North Johnson Street Kahoka, MO 63445

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility did not have stagnant water; -He flushed empty rooms by turning on the water for a couple minutes once a month, sometimes every two weeks; -The facility has not completed a CDC tool kit that he knew of and he had not heard of the ASHRAE guidelines; -He made sure there were no breaks in the water lines; -The facility tested for hard water but does not test for legionella; -The facility does not have a water flow map; -The facility does not have a water management team; -He monitored hot water temperatures weekly to make sure they were above 120 degrees Fahrenheit. If they were below, he turned the water heater temperature up; -He does not monitor cold water temperatures, chlorine levels, water sediment or biofilm; -The hard water test has a pH (measure of alkalinity/acidity) component but they do not have any actions or specifications of what the pH needed to be so they do not do anything with that value. During an interview on 01/24/25 at 11:02 A.M., the Infection Preventionist (IP), said the following: -She does not serve on a water management committee or any committee that discussed water or Legionella; -The facility does chest x-rays for people with pneumonia; -She does not screen anyone for legionella, she thought the hospital would have to do that if the resident was sick enough to go to the hospital; -She does not know the signs or symptoms of legionella, or Legionnaire's disease or how to check for legionella. During an interview on 01/23/25 at 1:45 P.M., the Administrator said the following: -The facility tests the water for legionella; -She did not have documentation of a facility water assessment; -She did not know what a water flow map was; -The Maintenance Director monitored water temperatures and can get the water management program and any testing completed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The Maintenance Director was expected to follow the policy and guidelines for monitoring water; -The facility did not have a water management team. 50189 51988