STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265498	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluffs, The	3105 Bluff Creek Drive Columbia, MO 65201

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43327 Based on interview and record review, facility staff failed to notify one resident (Resident #119) of one sampled resident's physician and representative in a timely manner when the resident had a fall with major injury. The facility census was 117. 1. Review of the facility's Notification of Family Members, Physician and Residents policy, dated 09/05/08, showed: -The purpose is to maintain communication and ensure that family members, physicians and residents are provided the opportunity to participate in the planning of medical care; -The resident's responsible party must be notified when there is a significant change of condition to include falls and injury; -The resident's physician and the facility administrator must be notified for significant changes of condition to include falls and injury; -The nurse on duty at the time the significant change occurs is responsible for making every attempt to contact the resident's family as soon as possible as well as the residents' physician if indicated and document the contact attempts in the resident's nurse notes. 2. Review of Resident #119's Admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/12/21, showed staff assessed the resident as follows: -Dependent for transfers, toileting, and hygiene. -Diagnosis of Alzheimer Disease, dementia with psychosis, anxiety, insomnia, and peripheral vertigo (dizziness that occurs in the inner ear that controls balance). Review of the resident's Nurse Notes, dated 09/07/24 at 11:22 P.M., showed Licensed Practical Nurse (LPN) C documented the family took the resident to the hospital emergency room for an evaluation and was diagnosed with a broken right hip. The physician and leadership notified. (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: 265498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nurse Notes, dated 09/09/24 at 8:00 A.M., showed LPN B documented the resident had a fall on 09/07/24 at 1:00 A.M. LPN B documented the resident refused to allow him/her to assess and/or voiced no complaints of hip pain. He/She returned to the room and administered Tylenol 650 mg for sleep. LPN B did not document the resident's responsible party, physician, or the facility administrator was notified at the time of the fall. During an interview on 10/28/24 at 12:09 P.M., the resident's family said he/she took the resident to the hospital on 09/07/24 because he/she was having a lot of pain in his/her leg. The family said he/she was not notified of the resident's fall until after they took the resident to the hospital and was admitted with a broken hip. He/She visited daily and would expect staff to alert him/her of any changes in condition to include falls. During an interview on 10/29/24 at 3:23 P.M., Registered Nurse (RN) D said he/she was not informed of the resident's fall by LPN B. He/She said staff are to report falls to the family, physician, and leadership as soon as possible after falls and document it. During an interview on 11/01/24 at 12:30 P.M., the Director of Nursing (DON) said LPN B informed him/her that he/she did not document the fall or notification of the family the night the incident occurred. The DON said staff are educated to document falls and fall notifications and this responsibility is discussed all the time with the nursing staff. The staff who discovered the fall should notify the physician, family and management immediately after a fall. MO00243654

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 43327 Based on observation, interview, and record review, the facility staff failed to provide a clean, homelike and comfortable environment when staff failed to maintain resident rooms in clean and good repair. The facility census was 117. 1. Review of the facility's Work Order Policy, dated 01/10/24, showed when staff noticed maintenance or repair needs, they should report this to their immediate supervisor, the charge nurse, or a member of the leadership team. 2. Observation on 10/28/24 at 11:40 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom floor with a ripped area at the shower stall. Stained floor trim that was pulled away from the wall by the shower.i Observation on 10/28/24 at 2:31 P.M., showed resident occupied room [ROOM NUMBER]'s wall behind the bed with multiple areas of gouged and chipped paint. Observation on 10/29/24 at 10:20 A.M., showed resident occupied room [ROOM NUMBER]'s wall with scuff marks next to the bed and behind the recliner. Observation on 10/29/24 at 10:25 A.M., showed resident occupied room [ROOM NUMBER] wall with multiple areas of missing drywall. Observation on 10/29/24 at 10:30 A.M.,showed resident occupied room [ROOM NUMBER]'s bathroom with a black substance on the grout around the toilet. Observation on 10/29/24 at 10:35 A.M.,showed resident occupied room [ROOM NUMBER]'s bathroom with a black substance on the grout around the toilet. Observation on 10/29/24 at 10:45 A.M.,showed resident occupied room [ROOM NUMBER]'s wall behind recliner with gouges and scratched up. 3. During an interview on 11/01/24 at 10:20 A.M., Housekeeper H said staff are to report maintenance issues to their supervisor who makes a work order for maintenance. He/She is not aware of any current issues, but would report gouged walls, chipped paint, and anything broken or needing repaired. During an interview on 11/01/24 at 10:26 A.M., Maintenance aide I said if he/she is informed of an issue, he/she would get approval to fix it as soon as possible from his/her supervisor. He/She said staff should complete a work order so maintenance knows what needs fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 at 10:32 A.M., Certified Nurse Aide J said if he/she finds something that is broken or looks bad like chipped paint or holes in the walls, he/she reports to his/her charge nurse. He/She said some things are constant issues like the walls behind the bed get scarred from the movement of the beds. During an interview on 11/01/24 at 10:36 A.M., Registered Nurse E said if staff tell him/her of an issue, he/she fills out an email to the maintenance department who takes it from there. During an interview on 11/01/24 at 10:49 A.M., the Maintenance Director said he receives work orders from the nurses or department heads and then puts repairs in motion. He/She said gouges, chipped paint and broken things are some of the things he/she would expect staff to report. He/She did not know room [ROOM NUMBER] needed repair and would need to check his/her log for the other issues. During an interview on 11/01/24 at 12:30 P.M., the Director of Nursing (DON) said staff training includes the work order policy. Staff are directed to report issues to the nurses who then send an email to maintenance and copy it to the administrator and DON or unit manager to make them aware of the issues.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35558 42484 Based on interview and record review, facility staff failed to provide written notice to residents or the resident's representatives regarding resident transfers to the hospital for four of four sampled residents (Resident #19, #48, #69, and #115). The facility census was 117. 1. Review of the facility's policies showed staff did not provide a policy for transfers to the hospital. 2. Review of Resident #19's medical record showed the following: -Transferred to the hospital on 05/25/24; -Returned to the facility on [DATE]; -Transferred to the hospital on 07/29/24; -Returned to the facility on [DATE]; -Staff did not document they notified the resident or resident representative of the transfer in writing. 3. Review of Resident #48's medical record showed the following: -Transferred to Emergency Department on 10/9/24 with return anticipated; -Staff did not document they notified the resident or resident representative of the transfer in writing. 4. Review of Resident #69's medical record showed the following: -Transferred to the hospital on 06/05/24; -Returned to the facility on [DATE]; -Staff did not document they notified the resident or resident representative of the transfer in writing. During an interview on 10/29/24 at 3:09 P.M., the resident said no paperwork was issued regarding a notice of transfer when he/she was transferred to the hospital. 5. Review of Resident #115's medical record showed the following: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Transferred to the hospital on 09/11/24; -Returned to the facility on [DATE]; -Transferred to the hospital on 09/20/24; -Returned to the facility on [DATE]; -Staff did not document they notified the resident or resident representative of the transfer in writing. 6. During an interview on 10/30/24 at 2:50 P.M., the administrative assistant said there is no process for written notification of discharges to the resident or resident representatives. During an interview on 10/30/24 at 2:50 P.M., the Regional Nurse Consultant said when a resident is transferred to the hospital, the process should include giving the resident a copy of the notice of transfer and to have the resident sign it before leaving the building. These documents should be scanned and placed in the miscellaneous section of the resident's electronic medical record. If the nursing staff speaks with the resident representative on the phone, two nurses should talk to the family and document this on the form as well. In addition, nurses should document the notification in the progress notes and in the discharge note. During an interview on 11/01/24 at 12:33 P.M., the Director of Nursing said planned discharge paperwork such as home health are handled by Social Services, and nursing information such as medication lists are handled by the nursing staff. The administrative staff has realized there is no policy for written notifications when residents are transferred to the hospital. 50432

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of their bed hold policy at the time of transfer to the hospital for two (Resident #19 and #69) of three sampled residents. The facility census was 117. 1. Review of the facility's policies showed staff did not provide a policy for transfers to the hospital. 2. Review of Resident #19's medical record showed staff documented the resident: -Transferred to the hospital on 05/25/24 and returned to the facility on [DATE]; -Transferred to the hospital on 07/29/24 and returned to the facility on [DATE]; -Staff did not document they notified the resident or the resident representative of the bed hold policy in writing. 3. Review of Resident #69's medical record showed staff documented the resident transferred to the hospital on 06/05/24 and returned to the facility on [DATE]. Staff did not document they notified the resident or the resident representative of the bed hold policy in writing. During an interview on 10/29/24 at 3:09 P.M., the resident said no paperwork was issued regarding a bed hold when he/she was transferred to the hospital. 4. During an interview on 10/30/24 at 2:50 P.M., the administrative assistant said there is not a process for written notification of the bed hold policy for the resident or resident representatives when a resident is transferred to the hospital. During an interview on 10/30/24 at 2:50 P.M., the Regional Nurse Consultant said when a resident is transferred to the hospital, the process should include giving the resident a copy of the bed hold policy and to have the resident sign it before leaving the building. This document should be scanned and placed in the miscellaneous section of the resident's electronic medical record. If the nursing staff speaks with the resident representative on the phone, two nurses should talk to the family and document this on the form as well. Nurses should document the notification in the progress notes and in the discharge note. During an interview on 11/01/24 at 10:18 A.M., Registered Nurse E said when a resident is transferred to the hospital, the charge nurse prepares the paperwork to go with the resident. RN E said he/she did not know of any written bed hold paperwork required for the transfer. During an interview on 11/01/24 at 12:33 P.M., the Director of Nursing said planned discharge paperwork such as home health are handled by social services, and nursing information such as medication lists are handled by the nursing staff. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 1:38 P.M., the administrator said a new process for hospital transfers will be implemented almost immediately. 50432

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview, and record review, the facility staff failed to develop comprehensive care plans with resident-specific interventions to meet the resident's preferences and goals, and to address the resident's medical, physical, and psychosocial needs for five residents (Residents #45, #49, #56, #108, and #111) out of twelve sampled residents. The census was 117. 1. Review of the facility's policies showed the facility did not provide a policy for care plans. 2. Review of Resident #45's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/16/24, showed staff assessed the resident as: -Cognitively impaired; -Had inattentive and disorganized thinking that fluctuated; -No behaviors or wandering; -Diagnosis of dementia. Review of the resident's nurse notes, dated 08/28/24 through 10/28/24 showed staff documented: -On 08/28/24 at 2:38 P.M., intermittent behaviors; -On 09/16/24 at 12:41 P.M., resident began to get angry and yell at staff while taking resident to the bathroom; -09/18/24 at 3:47 P.M., resident being rude to staff and other residents. Refused skin assessment, called staff names and tried to hit; -09/23/24 at 5:53 P.M., resident calling staff names, not wanting to cooperate going to bed; -10/06/24 at 12:51 P.M., became very upset after lunch accusing everyone of taking his/her root beer, did not calm down until removed peers from area; -10/17/24 at 12:08 P.M., aggressive and agitated with staff trying to hit them, allowed to calm down; -10/28/24 at 5:22 P.M., agitated and verbally aggressive and yelling shut up, attempted getting out of the unit door multiple times, redirected. Review of the resident's Point of Care history, dated 09/01/24 through 11/01/24, showed on 10/24/24 staff documented verbal and physical behavior directed toward others not easily redirected. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 09/23/24, showed the care plan did not contain direction for the resident's verbal and physical behaviors or attempts/to leave the secured unit. During an interview on 10/31/24 at 10:09 A.M., Certified Nurse Aide (CNA) F said the resident can become agitated around dinner time. The resident has the past of getting physical with other residents before and will try to get out of the secured unit. Staff tries to walk with him/her when they are agitated, but it isn't always successful. When left alone, the resident will calm down after about an hour but in the meantime, staff need to keep other residents away from him/her. He/She is not sure what the care plan says regarding this resident behaviors or interventions. 3. Review of Resident #49's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Severely impaired vision; -Did not take medication for pain on a schedule or as needed; -Required moderate/partial assistance for bed mobility and transfers; -Very important to have books, newspapers, and magazines to read but could not do or had no choice. Review of the resident's care plan, dated 10/08/24, showed staff assessed the resident had pain in the back and legs due to arthritis, is blind. The care plan did not address the resident's positioning in the recliner. Observation on 10/29/24 at 9:36 A.M., showed the resident in his/her recliner flat on his/her back, with only his/her head propped with the backrest, eating breakfast. Observation on 10/30/24 at 2:07 P.M., showed the resident in his/her recliner flat on his/her back, with only his/her head propped up with the backrest. Observation on 10/31/24 at 9:30 A.M., showed the resident in his/her recliner flat on his/her back, with only his/her head propped up with the backrest. During an interview on 10/31/24 at 11:55 A.M, the resident said he/she positions himself/herself in the recliner almost flat because he/she has back pain and has difficulty sitting up because of pain. 4. Review of Resident #56's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Required partial/moderate assistance for bed mobility; -Required supervision or touch assistance for transfers and walking; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Impaired functional limitation of range of motion in one leg. Review of the resident's care plan, dated 08/27/24, showed the care plan did not contain direction for the use of bed rails. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed an order for the use of bed rails. Observations on 10/29/24 at 10:16 A.M, showed the resident's bed with rails on both sides of the bed. Observation on 10/30/24 at 9:01 A.M., showed the resident's bed with rails on both sides of the bed. Observation on 10/31/24 at 9:14 A.M., showed the resident's bed with rails on both sides of the bed. During an interview on 10/29/24 at 10:16 A.M., the resident said he/she used the bed rails to help with mobility on the bed. 5. Review of Resident #108's Quarterly MDS dated [DATE] showed: -Moderate cognitive impairment; -Diagnosis' of Alzheimer's disease, dementia and heart failure; -Hospice care. Review of hospice contract signed by resident representative, dated 05/22/24 showed the resident started hospice services . Review of the resident's care plan, revised 3/21/24, showed the care plan did not contain direction for hospice services. During an interview on 11/1/24 at 9:30 A.M., Licensed Practical Nurse Q said normally the MDS Coordinator updates care plans, but charge nurses can update if a resident's status changes. He/she said a change to hospice care should be care planned and was not aware this resident's care plan had not been updated to include it. During an interview on 11/1/24 at 9:49 A.M., MDS/Registered Nurse (RN) A said he/she is responsible for updating care plans. He/She said they are updated quarterly or with a significant change. Hospice care should be care planned and he/she only recently became aware it was not for this resident. During an interview on 11/1/24 at 11:06 A.M., Social Services said care plans are reviewed at daily clinical meetings and every 92 days in a care planning meeting. He/She said she does hospice referrals when he/she receives an order, the leadership team is then notified by a group email, which triggers an MDS update. He/She does not know why this resident's care plan does not address hospice care, but the MDS Coordinator should do that part. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #111's Admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -No behaviors or wandering; -Diagnosis of dementia with psychosis. Review of the resident's nurse notes, dated 09/01/24 through 11/01/24, showed on: -09/25/24 at 3:17 P.M., appears quite confused, makes eye contact but unable to state his/her name or follow simple commands during assessment and likes to fidget with his/her shoelaces; -09/25/24 at 5:55 P.M., per family resident likes to walk, fidget and be active. He/She might wake up at night and walk around; Review of the resident's care plan, dated 10/09/24, showed: -The resident gets overstimulated and confused; -Behavior needs will be evaluated for improved quality of life, safety, safety of others and a behavior monitoring plan will be addressed if needed with the resident/representative, physician and/or Interdisciplinary Team (IDT); -The care plan did not contain direction for activity preferences. 7. During an interview on 10/31/24 at 10:09 A.M., CNA F said he/she is notified of resident care needs by verbal report from the nurse or the off-going shift. He/She said there is also care plans in the point of care charting but mostly gets the information from the staff. The CNA said it would be nice if specific resident interventions were in the care plan, especially on the secured unit so other staff can know what works and doesn't. During an interview on 11/01/24 at 9:38 A.M., Certified Medication Technician (CMT) AA said care plans should include the likes and the dislikes of the resident, and all of the care that needs to be done. CMT AA said care plans give details on how to best care for the resident. During an interview on 11/01/24 at 10:18 A.M., RN E said the care plan defines how staff should care for the resident, and every resident has a care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 at 9:48 A.M., the MDS Coordinator said it is his/her responsibility along with another coordinator to keep care plans up to date. He/She said care plans should be updated at least quarterly and with any significant change. Care plans should include anything that describes the resident to include, hospice, declines that are not correcting itself, activity of daily living needs/preferences, advanced directives, behaviors and specific interventions and anything that triggers on the MDS assessment. He/She said the secured unit has not been a part of the care plan before and is not sure if it should be or not. There are report sheets that also include basic care needs for the direct care staff that will reflect the care plans. He/She said he/she was by him/herself for a while until recently and now trying to get caught up and make the care plans more resident specific. During an interview on 11/01/24 at 12:30 P.M., the DON said care plans should include use of wander guards, secured unit, specific behavior needs and paint a clear picture of the resident needs. He/She said the staff have access to a care sheet that comes from the care plan data to use as a guide to care for the residents. He/She said the MDS nurse is overall responsible for the accuracy and completeness of the care plans. He/She did not know the care plans were missing information. 42484 43327 50432

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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** 42484 Based on observation, interview and record review, staff failed to document neurological checks after a fall for one (Resident #119) per facility policy, failed to document the removal of medication patches and the location of the new patch for one resident (Resident #48) who received Exelon Patches (to treat Alzheimer's disease) per facility policy and failed to document an indication for use on medications for seven (Resident #31, #45, #72, #87, #99, #111, and #324) of seven sampled residents. The facility census was 117. 1. Review of the facility's fall policy, dated October 2021, showed a fall is defined as an unintended change in position coming to rest on the ground or onto the succeeding lower surface and can occur while walking, standing, lying in bed and sitting. When a resident falls or is found on the floor, the licensed nurse will complete the appropriate fall documentation to include, fall observation and neurological checks on all residents who experienced unwitnessed falls or witnessed falls in which the resident was noted to hit their head. Review of Resident #119's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/04/24, showed staff assessed the resident as: -Cognitively impaired; -History of falls; -Diagnosis of dementia. Review of the nurse notes late entry, dated 09/09/24 at 8:00 A.M., showed Licensed Practical Nurse (LPN) B documented the resident on the floor on 09/07/24 at 1:00 A.M. The nurse notes did not contain documentation of an assessment or the implementation of neurological checks of the resident were completed. Review of the facility's investigation, dated 09/09/24, showed staff documented LPN B did not document a neurological exam at the time the resident was observed on the floor. During an interview on 11/01/24 at 9:19 A.M., Registered Nurse (RN) E said staff are expected and trained to assess the resident, document all falls and initiate neurological exams after a fall with known or unknown head involvement. During an interview on 11/01/24 at 12:30 P.M., the Director of Nursing (DON) said LPN B informed him/her that he/she did not document due to being responsible for two halls. 2. Review of facility's Medication Administration Policy, revised 9/9/22, directed staff to: -Monitor response to all medications. This includes medication related problems and adverse effects; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Medication Patches: initial, date and time patches at the time of application. In addition, document the site of patch placement; -Document removal of the old patch in Matrix on the Medication Administration record (MAR); -Discard the used patch by folding over onto itself and place in the sharps container; -Report medication erros including near miss and close calls on the medication error form report and to the Supervisory Clinical Nurse; -The Supervisory Clinical Nurse or charge nurse shall orient nurses to medication administration policies and practices. Review of Resident #48's Quarterly MDS, dated [DATE], showed: -diagnosed with Alzheimer's disease and Parkinson's disease; -Moderate cognitive impairment; -Received antidepressant and antianxiety medications. Review of the resident's physician orders, dated 8/15/24, showed the physician directed staff to administer Exelon patch every 24 hour 4.6 mg/24 hour; amt: 1; transdermal. Special instructions: alternate patch placement between right and left deltoid only. Once a day, 0630-1030 A.M. Review of the resident's MAR, dated 9/11/24 to 10/9/24, showed the record did not contain documentation staff removed the existing patch or the location of the new patch. Review of RN N's written statement, dated 10/11/24, showed on 10/9/24 at approximately 2:00 P.M., Certified Medication Technician (CMT) R reported finding four patches on the resident on 10/05/24. The resident was checked immediately and only one patch was found on his/her neck. Certified Nursing Aide (CNA) S reported finding two additional patches on the resident the morning of 10/5/24 during his/her shower. During an interview on 10/30/24 at 3:00 P.M., RN D said he/she works three weekends per month as the charge nurse. He/She said no one reported multiple patches on the resident. He/She said he/she always removed old patches before applying new one. Occasionally there was not a patch on to remove. He/She reported being totally surprised the incident occurred and atypical symptoms were never reported to him/her. During an interview on 10/30/24 at 3:41 P.M., CMT R said he/she gives showers to the resident and sees more than one patch on his/her back or neck pretty often. Patches have not been found on the upper arms. He/She said he/she would remove one and tell the charge nurse, RN D. He/She did not know what RN D did after being notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/24 at 5:10 P.M., the DON said his/her understanding of the events is nurses and CMTs did not look at the resident's body for patches. He/She said CMT W, placed patches behind the resident's ear for two days in the week prior, which is not where staff would expect to find them. He/She said misplacement of the patches had apparently been going on for quite awhile before he/she was made aware. He/She assumed they were doing their jobs right and was not aware of reports of multiple patches on the resident or atypical symptoms. During an interview on 11/1/24 at 1:38 P.M. the Administrator said the nursing and CMT staff did not follow policy and standards of practice administering Exelon patches to the resident. He/She said it is the Supervisor and DON's responsibility to monitor compliance with policy and medication administration standards of practice. He/She said the medication alert does display on the medication administration record each time the medication is administered. 3. Review of the facility's Medication Administration policy, dated 09/09/22, showed: -Medication order components shall include the name of the medication and indication; -The nurse shall write all verbal and telephone orders and shall read the order back to the ordering physician or authorized practitioner for confirmation of accuracy; -Confirmation includes the required information to include indication for use and that the information is clear, accurate and appropriate; -Prior to medication administration, resolve any concerns about the medication with the provider, prescriber and/or staff involved with the resident's care. 4. Review of Resident #31's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -No behaviors; -Diagnosis of stroke, heart disease, hypertension, and respiratory failure. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed physician orders as followed: -On 03/03/22, Aspirin 81 milligram (mg) tablet daily; -On 05/24/22, Calcium-vitamin D, 315 mg/5mg tablet, two tablets daily; -On 03/03/22, Carvedilol (treats hypertention) 25 mg, one tablet twice a day; -On 05/21/23, Keppra (treats seizures) 750 mg, twice a day; -On 09/11/23, Lansoprazole (treats stomach ulcers and acid) 30 mg, one time a day; -On 08/05/22, Lorartan (treats blood pressure and kidney disease) 100 mg daily; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/21/23, Vitamin D3, 2000 units one time a day; -The POS did not contain an indication and/or diagnosis for the medication use. 5. Review of Resident #45's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Diagnosis of heart failure and dementia. Review of the resident's POS, dated October 2024, showed physician orders as followed: -On 08/06/23, Amiodipine (treats blood pressure and chest pain) 5 mg, daily; -On 05/29/23, Vitamin B12, 500 microgram (mcg) daily; -On 10/26/24, Lasix (treats fluid retention and swelling) 20 mg daily; -On 08/06/24, Levothyroxine (treats an enlarged thyroid or thyroid cancer) 50 mcg, daily; -On 10/25/24, Potassium Chloride (treats low potassium) 10 milliequivalent (mEq), daily; -On 10/25/24, Protonix Delayed Release (treats stomach acid) 20 mg, daily; -On 10/25/24, Tylenol 325 mg, two tablets twice a day; -On 10/25/24, Tylenol 325 mg, two tablets twice a day as needed; -On 09/12/24, Vitamin D3 1000 units daily; -The POS did not contain an indication and/or diagnosis for the medication use. 6. Review of Resident #72's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Diagnosis of neurogenic bladder, Alzheimer dementia, anxiety and dementia. Review of the resident's POS, dated October 2024, showed physician orders as followed: -On 06/15/21, Bisacodyl (treats constipation)10 mg suppository daily as needed; -On 09/15/22, Levothyroxine 50 mcg, daily; -On 06/05/24, Levsin (antispasmodic and anti-tremor) 0.125 mg every four hours as needed; -On 07/14/21, Melatonin 5 mg as needed, may give if wakes up during the night; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 04/29/22, Metoprolol (treats blood pressure, chest pain and heart failure) 12.5 mg twice a day; -On 06/15/21, Milk of Magnesia 2400 mg/10 mL, give 30 mL daily as needed; -On 01/16/23, Miralax 17 grams, daily every other day as needed; -On 02/03/22, Potassium 10 mEq daily; -The POS did not contain an indication or diagnosis for the medication use. 7. Review of Resident #87's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Diagnosis of anemia, hypertension and dementia. Review of the resident's POS, dated October 2024, showed physician orders as followed: -On 05/20/24, Acidophilus (probiotic) capsule daily; -On 12/06/23, Miralax 17 gm daily as needed; -On 11/10/22, Pantoprazole (treats damaged esophagus and elevated stomach acid) 40 mg delayed release daily; -On 11/10/22, Docusate Sodium-Sennosides (treats constipation) 8.6/50 mg, one tablet daily; -The POS did not contain an indication or diagnosis for the medication use. 8. Review of Resident #99's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Diagnosis of hypertension, diabetes, anxiety, depression and dementia. Review of the resident's POS, dated October 2024, showed physician orders as followed: -On 08/15/24, Acetaminophen 500 mg, two tablets three times a day; -On 06/05/24, Actos (treats diabetes) 15 mg daily; -On 07/20/23, Amlodipine 5 mg daily; -On 08/16/24, Buspirone (treats anxiety) 15 mg, twice a day; -On 04/15/24, Metformin (treats diabetes) 1000 mg twice a day; -On 05/25/24, Myrbetriq (treats overactive bladder) 50 mg extended release daily; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/21/24, Vitamin D2, 1250 mcg weekly on Friday; -On 08/16/24, Xanax (treats anxiety) 0.5 mg daily at bedtime; -The POS did not contain an indication and/or diagnosis for the medication use. 9. Review of Resident #111's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Diagnosis of anemia, enlarged prostate, diabetes, anxiety and dementia. Review of the resident's POS, dated October 2024, showed physician orders as followed: -On 09/25/24, Divalproex (treats seizures, bipolar depression and migraine headaches) 125 mg, three tablets daily; -On 09/25/24, Miralax 17 grams daily; -On 09/25/24, Tamsulosin (treats enlarged prostate) 0.4 mg daily; -On 09/30/24, Trazodone (treats depression) 50 mg, two and one-half tablet daily at bedtime; -On 09/25/24, Tylenol 325 mg, two tablets as needed; -The POS did not contain an indication and/or diagnosis for the medication use. 10. Review of Resident #324's Entry MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's POS, dated October 2024, showed physician orders as followed: -On 10/16/24, Atorvastatin (treats elevated cholesterol and triglycerides (fat used for energy)) 20 mg daily at bedtime; -On 10/16/24, B12 500 mcg daily; -On 10/16/24, Seroquel (treats Schizophrenia, Bipolar depression and depression) 50 mg daily at bedtime; -On 10/16/24, Tamsulosin 0.4 mg daily; -The orders did not contain an indication or diagnosis for use. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. During an interview on 11/01/24 at 9:19 A.M., RN E said all medications should have a diagnosis for use so staff know why the medication is administered and what to watch for if there is an issue with the medication. He/She said the receiving nurse is responsible to ensure there is a diagnosis that corresponds to the medication, if not, he/she is expected to clarify the order with the physician. He/She works part time so would have to look up each residents medications to see if a diagnosis is with each medication. RN E is not aware of any residents that do not have a diagnosis to correspond with it. During an interview on 11/01/24 at 12:30 P.M., the DON said all medications should have an indication for use due to some medications having a possible alternate use than the typical diagnosis. The physician and nurse practitioners should give the diagnosis and the receiving nurse should clarify any discrepancies with the orders. He/She said the DON, Unit Managers and pharmacy consultant review the resident orders as a joint effort and is aware there is issues with missing diagnosis/indications. MO00243398 43327

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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** 40424 Based on observation, interview, and record review, facility staff failed to transfer two residents (Residents #26 and #81) of three sampled residents by mechanical lift in a manner to prevent accidents. Facility staff failed to safely propel two residents (Resident #50 and #24) in a wheelchair and failed to properly secure medication in two treatment carts on the secured unit and the 500 hall. The facility census was 117. 1. Review of the facility's Use of Lift Machine policy, dated 12/06/19, showed: -Portable lift should be used by two nursing assistants to perform procedure; -Assist resident in guiding his/her legs; -Always keep the resident centered over the base and facing the caregiver operating the lift; -The policy did not contain direction for position of the base legs during the transfer. Review of Resident #26's 5-Day Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/29/24, showed staff assessed the resident as: -Cognitively impaired; -Used a mechanical lift; -Impaired movement on one side; -Dependent on staff for transfers; -Diagnosis of hemiplegia (paralysis of one side of body). Observation on 10/28/24 at 2:09 P.M., showed Certified Nurse Aide (CNA) L and CNA M attached Resident #26's sling to the mechanical lift. CNA L raised the resident from the bed using the mechanical lift, pulled the resident from the bed suspended in the sling and staff did not guide the resident. CNA M positioned the wheelchair. The resident was lowered to the wheelchair. During an interview on 10/28/24 at 02:15 P.M., CNA M said the second person in the lift procedure should guide the resident to make sure nothing happens during the moving of the resident. He/She should have held Resident #26, but wanted to make sure the chair was positioned good. Review of Resident #81's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Moderately cognitively impaired; -Used a mechanical lift; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for transfers; -Diagnosis of a stroke and dementia. Observation on 10/29/24 at 11:11 A.M., showed CNA CC and CNA DD attached Resident #81's sling to the mechanical lift. CNA DD raised the resident from the bed in the sling using the mechanical lift with the legs in the closed position. CNA CC reached across the bed to steady the resident, leaving him/her suspended in the sling without stable staff support as the lift was moved from the middle of the bed to the foot of the bed. CNA DD pulled the lift away from the bed with the legs closed and pushed the lift to the resident's wheelchair and widened the legs to accommodate the wheelchair and lowered the resident. During an interview on 10/29/24 at 11:27 A.M., CNA DD said he/she had watched videos on lifts, and the legs of the lift should be out wide as possible, but it was hard in the small rooms. CNA DD said he/she makes sure the legs are wide open when he/she transfers heavy people. During an interview on 11/01/24 at 12:30 P.M., the Director of Nursing (DON) said there should be two staff for mechanical lift transfers, one to operate the lift and the other to guide the resident. Staff should widen the base of the mechanical lift and hold on to the resident while in the air or something could happen such as the battery could die, the resident may not be in the sling solid, and to not hit the resident on something while in the air. 2. Review of the facility's policies showed staff did not provide a wheelchair safety policy. Review of Resident #50's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: - Mild cognitive impairment; - Independent wheelchair; - Diagnosis of coronary artery disease, stroke, anxiety, and depression. Observation on 10/28/24 at 12:28 P.M., showed Dietary Aid (DA) Z propelled Resident #50's from the dining area of 300 hall to the doorway of the resident's room without footrests. The resident's left foot bounced up and down on the floor. During an interview on 10/28/24 at 12:30 P.M., DA Z said he/she has been educated that you should not push a resident in a wheelchair without footrests, because it could case an injury. He/She said they were in a hurry and did not put the footrests on the wheelchair first. Review of Resident #24's Annual MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively impaired; -Dependent wheelchair; -Diagnosis of heart failure, hemiplegia, and respiratory failure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/29/24 at 8:30 A.M., showed Resident Staff Assistant Y propelled Resident #24 in a wheelchair from the hall of 400 to the dining room without footrests on the wheelchair. The resident picked up their feet but then put them down while being propelled. During an interview on 10/29/24 at 8:35 A.M., Resident Staff Assistant Y said he/she should have gone and got the resident's footrests before pushing the resident into the dining room. He/She said it is unsafe to push a resident without foot rests because they may fall or become injured. During an interview on 11/01/24 at 9:59 A.M., Registered Nurse (RN) V said pushing a resident without foot rests on the wheelchair could cause a fall or other injury. During an interview on 11/01/24 at 12:42 P.M., the DON said footrests should be on the wheelchair. Staff are not allowed to push a resident without them because it could cause injury to the resident. Staff have been educated on this. During an interview on 11/01/24 at 1:40 P.M., The Administrator said staff are educated to never push a resident without footrests because it could cause injury and is an unsafe practice. 3.Review of the facility's Medication Administration policy, dated 09/09/22, showed medication must be secured at all times. When not in use, medication cart drawers should be locked. Medications shall not be left unattended on counters or at workstations. Observation on 10/29/24 at 8:04 A.M., Certified Medication Technician (CMT) G left three insulin pens and box containing artificial tears on top of the medication cart unsecured and unattended when he/she passed medications on the secured unit. Residents sat in close proximity of the cart. Observation on 10/29/24 at 8:14 A.M., CMT G left three insulin pens and box containing artificial tears on top of the medication cart unsecured and unattended when he/she passed medications on the secured unit. Residents sat in close proximity of the cart. Observation on 10/29/24 at 8:27 A.M., CMT G left a bottle of eye drops on top of the Maple medication cart unsecured and unattended on the secured unit. During an interview on 10/30/31 at 11:44 A.M., CMT G said he/she was the last one in the treatment cart and should have locked it when finished. He/She said it must have been an oversight. Medication should not be stored on top of the carts and locked because residents could get it and get hurt. He/She said he/she was planning on giving the insulin and eye drops pretty quickly and didn't put them away like he/she should have. Observation on 10/31/24 at 2:40 P.M., showed the 500 hall treatment cart unlocked and unattended in the dining area. During an interview on 10/31/24 a 2:45 P.M., RN V said the treatment cart should never be left unlocked and unattended due to the risk to residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 at 12:30 A.M., the DON said medication and treatments should be kept under lock and key. Medications should never be stored on top of carts for resident safety. Staff are provided education that includes locking the carts, storage of meds and pass medication using the rights of administration. 42484 43327

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40424 Based on observation, interview, and record review, facility staff failed to properly maintain the temperature of hot food at or above 120 Degrees Fahrenheit (F) for four residents (Resident #6, #49, #68, and #69) at the time of meal service and failed to implement a system to monitor food temperatures at the time of service. Failure to maintain foods at the proper temperature has the potential to affect all residents who received room trays. The facility census was 117. Review of the facility's policy Nutrition, dated 9/10/23, showed the facility strives to enhance the health and quality of likes of all residents through nutritious and appetizing meals. 1. Observation on 10/31/24 at 8:44 A.M., showed facility staff delivered a hall tray to Resident #6's room. The scrambled eggs were 82 F and the oatmeal was 92 F when checked with a calibrated stem-type thermometer by Department of Health and Senior Services (DHSS) staff. During an interview on 10/31/24 at 8:46 A.M., Resident #6 said the food is often cold, and especially breakfast. He/She said, I don't enjoy my food as much when it is cold like this. 2. Observation on 10/30/24 at 9:50 A.M., showed facility staff delivered a hall tray to Resident #49's room. The Cream of Wheat was 80 F when checked with a calibrated stem-type thermometer by DHSS staff. During an interview on 10/31/24 at 9:50 A.M., Resident #49 said the food is almost always served cold and cold food is unappetizing. Observation on 10/31/24 at 12:40 P.M., showed facility staff delivered a hall tray to Resident #49's room. The tomato soup was 84 F when checked with a calibrated stem-type thermometer by DHSS staff. 3. Observation on 10/29/24 at 8:16 A.M., showed facility staff delivered a hall tray to Resident #68's room. The scrambled eggs were 85 F when checked with a calibrated stem-type thermometer by DHSS staff. Observation on 11/01/24 at 8:05 A.M., showed facility staff delivered a hall tray to Resident #68's room. The scrambled eggs were 82 F when checked with a calibrated stem-type thermometer by DHSS staff. During an interview on 11/01/24 at 8:15 A.M., the resident said the food is often cold, especially breakfast. He/She said it's almost to the point of not being edible. 4. Observation on 10/30/24 at 9:49 A.M., showed facility staff delivered a hall tray to Resident #69's room. The scrambled eggs were 80 F when checked with a calibrated stem-type thermometer by DHSS staff. Observation on 10/31/24 at 1:02 P.M., showed facility staff delivered a hall tray to the resident's room. The pulled pork was 76 F, the corn was 82 F, and the rice was 84 F when checked with a calibrated stem-type thermometer by DHSS staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Bluffs, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 3105 Bluff Creek Drive Columbia, MO 65201	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/24 at 9:49 A.M., the resident said the food is almost always served cold and it just made it not taste as good. 5. During an interview on 11/01/24 at 9:31 A.M., Certified Nurse Aide (CNA) T said a resident's food should be above 130 degrees at the time of service. The CNA said if the meal was not, it should be reheated. He/She said aids do not temp the hall trays. During an interview on 11/01/24 at 9:38 A.M., Dietary Aide U said food temps should be around 160 degrees. The DA said if it's not hot it won't taste good and could be a health risk to a resident. During an interview on 11/01/24 at 9:40 A.M., the Dietary Manager said staff monitor the temperature of foods during cooking and at serving lines. The temperature should be at 140 degrees. The Dietary Manager said once a hall tray cart leaves the aides are responsible to check the temperatures. He/She said if food is cold at service, it could cause a food borne illness. During an interview on 11/01/24 at 9:55 A.M., Registered Nurse (RN) V said food should be 165 degrees to prevent bacteria and resident illness. During an interview on 11/01/24 at 9:38 A.M., Certified Medication Technician AA said when meals are brought to the floor, the residents who sit at tables are served first, and then the hall trays are distributed. He/She said residents complain about the length of time it takes to get their tray all the time, and that could possibly be why the food is cold. During an interview on 11/01/24 at 10:10 A.M., Resident Services Assistant BB said room meals are served in the order the trays are stacked in the cart, from the top to the bottom. He/She said residents do complaint about cold food, and the food can be microwaved but residents usually don't want it to be reheated that way. During an interview on 11/01/24 at 10:18 A.M., RN E said residents are served first in the dining room then hall trays sit while the dining room is taken care of. RN E said residents complain frequently about how late the meals are served, and this may be related to the food being cold. During an interview on 11/01/24 at 12:33 P.M., the Director of Nursing (DON) said food should be warm when delivered to the resident. It is unsafe to serve food cold that has been cooked. The DON said nursing staff are responsible for the hall trays and ultimately he/she was responsible for the nursing staff. During an interview on 11/01/24 at 1:38 P.M., the administrator said residents should not be given cold food, no one should. The administrator said the Dietary Manager is responsible for food service but ultimately he/she is responsible. MO00244159 42484 50753

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview and record review, facility staff failed to follow standard universal infection control precautions when staff used one insulin pen on three residents (Resident #7, #10, and #41), possibly creating a risk of bloodborne and bacterial pathogen transmission. The facility failed to use appropriate hand hygiene infection control practices during perineal and wound care for four (# 41, #43, #47, #105) of four sampled residents, and failed to follow Enhanced Barrier Precautions (EBP), the wearing of gown and gloves during high contact patient care activities to prevent the spread of multi-resistant organisms, for three (#7, #19, and #105) of four sampled residents. The facility census was 117. The administrator was notified on 10/31/24 at 8:00 A.M., of an Immediate Jeopardy (IJ) which began on 10/28/24. The IJ was removed on 10/30/24, as confirmed by surveyor onsite verification. 1. Review of the facility's policy showed staff did not provide an Insulin Administration policy. Review of the Glargine insulin pen manufacture safety information, showed to never share a pre-filled pen, insulin syringe, or needle between patients. Review of the Centers for Disease Control (CDC), Insulin Pen handout, undated showed: Insulin Pens: Recommendations For Safe Use Protecting your patients from infection is a basic standard of care. Reusing insulin pens and other injection equipment for more than one person can spread infections to your patients. -Insulin pens and other injection equipment are meant to be used on one person only. -Insulin pens should never be used for more than one person, even when the needle is changed or when there is leftover medicine. Although invisible to the eye, back flow of blood into the insulin pen can happen during an injection. This creates a risk of bloodborne and bacterial pathogen transmission to patients if the pen is used for more than one person, even when the needle is changed. Review of the facility investigation, dated 10/28/24, showed the administrator was made aware the medication cart keys were locked in the medication cart on 10/27/24. Review showed Licensed Practical Nurse (LPN) A unable to unlock the cart to administer insulin to Resident #7, #10, and #41. LPN A used one emergency medication kit Glargine insulin pen for three residents. Review showed the LPN said he/she used the same insulin pen, but changed the needles between residents. Review of Resident #7's quarterly Minimum Date Set (MDS),a federally mandated assessment, dated 09/11/24 showed staff assessed the resident as follows: -Cognitive; (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnosis of Diabetes; -Received insulin injection seven out of seven days. Review of Resident #7's Physician Order Sheet, dated 05/24/24, showed an order for: -Insulin Glargine 100 unit/milliliters (mL) (3 mL) 25 units subcutaneous twice a day between 6:00 A.M. and 10:00 A.M., and 7:00 P.M. and 10:00 P.M. Review of Resident #7's medication administration record (MAR), dated 10/27/24, showed: -An order for Insulin Glargine; -LPN A documented he/she administered the resident's insulin on 10/27/24 at 10:56 P.M. Review of Resident #10's significant change MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitive; -Diagnosis of Diabetes; -Received insulin injection seven out of seven days. Review of Resident #10's Physician Order Sheet, dated 08/26/24, showed an order for Insulin Glargine 100 unit/mL (3 mL) 5 units subcutaneous between 7:00 P.M. and 10:00 P.M. Review of Resident #10's MAR, dated 10/27/24, showed: -An order for Insulin Glargine; -LPN A documented he/she administered the resident's insulin on 10/27/24 between 7:00 P.M. and 10:00 P.M. Review of Resident #41's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitive; -Diagnosis of Diabetes; -Received insulin injection seven out of seven days. Review of Resident #41's Physician Order Sheet, dated 04/11/24, showed an order for Insulin Glargine 100 unit/mL (3 mL) 17 units subcutaneous between 7:00 P.M. and 10:00 P.M. Review of Resident #41's MAR, dated 10/27/24, showed: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order for Insulin Glargine; -LPN A documented he/she administered the resident's insulin on 10/27/24 at 10:52 P.M. During an interview on 10/28/24 at 3:30 P.M., LPN P said he/she was informed on 10/27/24 by LPN A the key to the treatment cart had been locked inside and LPN A gave Resident #7, #10 and #41 their insulin with the same insulin pen due to not being able to get into the locked cart. LPN P said there is multiple phone numbers to call overnight if there is an issue like this. During an interview on 10/29/24 at 9:00 A.M., LPN C said it would be unsafe to use the same pen on multiple residents. He/She said they called the Maintenance Director to have the cart unlocked prior to leaving their shift on 10/27/24. During an interview on 10/28/24 at 1:45 P.M. the Director of Nursing (DON) said he/she was made aware on 10/28/24, LPN A had administered insulin to Resident #7, #10, and #41 using the same insulin pen with different one time use needles. During an interview on 10/28/24 at 3:30 P.M., the Medical Director said changing the needle decreased the risk, but not to zero. During an interview on 10/29/24 at 4:00 P.M., the DON said the facility does not have a specific insulin administration policy, the facility instead follows manufactures recommendation on how to safely administer insulin. He/She was made aware on 10/28/24 by the charge nurse on duty the cart keys were missing. The DON said he/she was not aware of the insulin administration from one insulin pen until the following morning. During an interview on 10/29/24 at 2:00 P.M., the administrator said he/she was made aware of the insulin being administered incorrectly the next day. The cart being locked and keys missing was the only issue he/she was made aware of during the overnight shift. He/She did not know there were no extra keys available. 2. Review of the facility's Hand Hygiene policy, revised 10/30/2018, showed staff are to wash their hands: -Before and after direct resident contact or after handling resident's personal belongings; -Before and after performing any invasive procedures; -Before and after handling peripheral vascular catheters and other invasive devices; -Before and after removing gloves or aprons. Review of Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/24, showed the CDC guidelines are to perform hand hygiene, either by handwashing with soap and water or antiseptic hand rub: -Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Before moving from work on a soiled body site to a clean body site on the same patient; -After touching a patient or patient's surroundings; -After contact with blood, body fluids, or contaminated surfaces; -Immediately after glove removal. Observation on 10/29/24 at 9:09 A.M. showed LPN Q and Certified Nurse Assistant (CNA) EE applied gloves and transferred Resident #43 to bed by mechanical lift. LPN Q provided care to the resident and with the same gloves put a clean brief on the resident. LPN Q and CNA EE removed their gloves and did not perform hand hygiene before they assisted with the resident's clothing, bedding and left the room. During an interview on 10/29/24 at 9:20 A.M., CNA EE said glove changes and hygiene should be done when going from a dirty to a clean area. He/She did not know why he/she didn't do it this time. During an interview on 10/29/24 at 9:22 A.M., LPN Q said gloves should be changed and hand washing done after wiping someone's bottom. He/She said it was not done because he/she did not want to leave the resident, afraid he/she would roll out of bed. Observation on 10/29/24 at 1:45 P.M., showed CNA GG and NA FF entered Resident #41's room to perform perineal care and applied gloves. CNA GG removed bowel movement and with the same gloves he/she touched the bottle of spray cleaner, applied cream to the resident's skin, and applied a clean brief and clothing. CNA GG removed his/her gloves and did not perform hand hygiene before he/she left the resident's room. CNA GG did not perform hand hygiene before he/she applied gloves to make the resident's bed. During an interview on 10/29/24 at 2:16 P.M., CNA GG said it is appropriate to wash hands or use hand sanitizer after removing gloves and when care is finished. He/She said handwashing and glove change should have been done after cleaning up the bowel movement. Observation on 10/30/24 at 1:50 P.M. showed Registered Nurse (RN) E applied gloves and performed perineal care for Resident #105. RN E did not perform hand hygiene after he/she performed perineal care and removed his/her gloves or before he/she left the resident's room. During an interview on 10/30/24 at 2:06 P.M. RN E said he/she had received training to wash hands before and after caring for a resident. Observation on 10/30/24 at 11:13 A.M. showed the Infection Preventionist (IP) applied gloves and performed wound care for Resident #47 and removed the resident's leg wrap and cleaned the wound. The IP removed his/her gloves, did not perform hand hygiene and put on new gloves. The IP removed scissors from his/her pocket, did not clean the scissors, and cut the medicated gauze. During an interview on 10/30/24 at 11:45 A.M., the IP said hand hygiene should be performed before and after wound care, and when you change gloves. He/She did not realize he/she missed doing hand hygiene when gloves were changed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Review of the facility's Enhanced Barrier Precautions Policy, dated 4/1/24, showed: -EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities; -The facility will have the discretion on how to communicate to staff which residents require use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high contact care activities; -An order for EBPs will be obtained for residents with wounds and /or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Review of the facility's Enhanced Barrier Precaution sign used by the facility, showed staff are instructed as follows: -Everyone must clean their hands, including before entering and when leaving the room; -Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, showering/bathing, transferring, changing linens, providing hygiene, changing briefs of assisting with toileting hygiene, device care or use - central line, urinary catheter, feeding tube, tracheostomy, and wound care - any skin opening requiring a dressing. Review of Resident #7's quarterly MDS, dated [DATE], showed staff assessed the resident with one open ulcer. Review of Resident #7's care plan, dated 08/24/24, showed the resident at risk of infection due to wounds. Observation on 10/30/24 at 11:36 A.M., showed IP entered Resident #7's room to perform wound care. The IP did not wear a gown when he/she performed wound care on the resident. The resident's door frame displayed a EBP sign that indicated instructions for staff during care. Review of Resident #19's significant change MDS, dated [DATE] showed staff assessed the resident used a feeding tube. Observation on 10/30/24 at 1:48 P.M., showed LPN II entered Resident #19's room to administer medications via the resident's feeding tube. LPN II did not wear a gown when he/she administered the resident's medication via the feeding tube. The resident's door frame displayed a EBP sign that indicated instructions for staff during care. Review of Resident #105's quarterly MDS, dated [DATE], showed staff assessed the resident with an indwelling catheter. Observation on 10/30/24 at 1:50 P.M. showed RN E entered Resident #105's room to perform catheter care. RN E did not wear a gown when he/she performed catheter care. The resident's door frame displayed a EBP sign that indicated instructions for staff during care. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/30/24 at 2:06 P.M., RN E said he/she had received training on EBP and that it was about washing hands before and after caring for a resident. He/She said gowns are only used when the resident has an MDRO or infectious organism. This would be communicated to staff in morning huddle and a personal protective equipment cart would be placed outside the room. During an interview on 11/01/24 at 10:18 A.M., RN E said if a resident has EBPs, a gown, gloves and a mask should be put on before providing care. The precautions are for resistant infections or residents more prone to infections in order to prevent any other infections in the resident. During an interview on 11/01/24 at 9:00 A.M., LPN P said EBP differs from standard precautions because wounds and catheters use more personal protective equipment. He/she said regarding gowns, he/she would be cautious and tell staff to put them on for extra protection. He/She did not recall receiving EBP training because there have been so many inservices lately. During an interview on 11/01/24 at 9:30 A.M., LPN Q said the premise of EBP is if there is a catheter, for example, you wear gloves. He/She said a gown would be worn if you expect to be splashed or if they have some kind of infection, or emptying a catheter; you never know if it will splash. During an interview on 11/1/24 at 1:00 P.M., DON said EBP is implemented for residents who have wounds, catheters, or tubes that can be susceptible to infection. Gown and gloves are required when working with these residents. Staff have been inserviced on EBP. He/She said the IP/RN is responsible for putting signage on the doors and monitoring compliance. Hand sanitizer is readily available in each bathroom and outside each room. He/She said poor hand washing is the number one cause of transmission of disease and inservice has been provided two or three times this year. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote the facility has complied with State law (Section 198.026.1 RSMo.) requiring prompt remedial action to be taken to address Class I violation(s). MO00244239 42484 50432