STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265504	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Current River Nursing Center, Inc	1015 North Grand Avenue Doniphan, MO 63935

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46521 Based on interview and record review, the facility failed to consistently document a code status for one resident (Resident #12) out of 12 sampled residents. The facility census was 40. The facility did not provide a policy regarding a resident's code status. 1. Review of Resident #12's medical record showed: - An admitted [DATE]; - The revised care plan, dated [DATE], showed a Do Not Resuscitate (A DNR instructs providers not to do CPR (cardiopulmonary resuscitation) if a patient's breathing stops or if the patient's heart stops beating). - The face sheet, undated, showed a DNR status; - The Physician's Order Sheet (POS), dated [DATE], showed a full code (if a person's heart stopped beating and/or they stopped breathing, CPR procedures would be provided) status; - A DNR form signed by the resident on [DATE], and signed by the physician on [DATE]; - The resident's Medication Administration Record (MAR) showed a red DNR code sheet. During an interview on [DATE] at 9:34 A.M., Resident #12 said he/she had discussed a code status change with his/her family a few months ago and they had decided together on the DNR status. During an interview on [DATE] at 9:30 A.M., Certified Medication Technician (CMT) F said he/she would look at the orders to check a resident's code status. The MAR had red or green paperwork that indicated a code status for a quick reference and a nurse could be asked. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:05 A.M., the Assistant Director of Nursing said there was a red or green sheet that indicated the code status in the charts, red meant DNR and green was full code. There were also purple sheets that showed a code status either way, and there were usually several kept in the chart, so it was easy to grab if a resident transferred out of the facility. The staff could also look at the code status in the physician's order sheet. The orders should match the color-coded sheets in the MAR and show the correct code status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37575 Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, homelike environment, and failed to clean and/or repair/replace wheelchairs for one sampled resident (Resident #22) and three residents (Resident #6, #9, and #20) outside the sample. The facility's census was 40. Review of the facility's policy titled, Orientation Manual Guidelines, dated May 2006, showed the maintenance manager responsibilities will be: - Supervise the day-to-day activities of the maintenance department in accordance with current federal, state, and local standards, guidelines and regulations governing the facility, and as may be directed by the environmental manager or the Administrator; - Assure the facility will be maintained in a safe and comfortable manner; - To repair and install drywall including mudding, taping and sanding; - Paint walls; - Assist in setting maintenance standards as well as establishing a preventative maintenance program; - Perform general rough and finish carpentry as well as rough and finish concrete work; - Sweep, mop, and buff floors; - Clean, disinfect and sanitize bathrooms, kitchens and bedrooms; - The maintenance manager will perform preventive and routine maintenance of the facility. Observation on 07/11/24 at 10:15 A.M., of the 500 Hall shower room showed: - The tiled shower base foundation was elevated three and one half inches above the floor, creating a step up into the shower; - The caulking bead with a brown substance in the corner where the wall and floor met on each of the three walls of the shower stall floor. Observations on 07/15/24 at 12:49 P.M., of the 300 Hall shower room showed: - The left side shower end wall section without three 6 in. ceramic tile baseboard pieces and a 16 in. unpainted section above the floor surface; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The fiberglass shower unit with the left end panel unattached and separated 8 in. from the shower unit near the top; - Corner wall base section below the shelf and towel rack missing one 4 in. section of ceramic tile base. During an interview on 07/15/24 at 1:05 P.M., Housekeeper F said damage in the shower rooms should be reported to maintenance staff. There was a maintenance log and some of the current issues like wall damage, missing paint and tiles had been reported a long time ago. Housekeeping staff were supposed to enter issues in the log but sometimes they were reported verbally to maintenance. The fiberglass shower unit on the 300 Hall had not worked since he/she was hired and the left side panel had always been separated but he/she had not reported it to maintenance. He/she hadn't noticed the caulk bead being discolored in the 500 Hall shower but it should be cleaned or replaced. During an interview on 07/15/24 at 1:20 P.M., the Maintenance Director said he/she was not aware of plans to repair the damage in the shower rooms and he/she inspected the showers at least once a week. The fiberglass shower unit on the 300 Hall had not worked in the two years he/she had been here and removing and/or repairing it had not been discussed. The side panel was separated from the fiberglass shower but since that shower unit didn't work there were no plans to make a repair. He/She was aware of the damaged shower wall section and missing paint and ceramic tiles in the 300 Hall shower room stall, but was not planning to replace the tiles or paint currently but it might be done eventually. The shower stall was currently used by the residents. The discolored caulk should be cleaned or replaced in the 500 Hall shower but it wasn't reported. Observations of Resident #22's wheelchair showed: - On 07/09/24 at 9:42 A.M., the resident sat in his/her wheelchair in the room with the wheelchair arms wrapped with Coban (a self-adherent wrap) stained, dirty, pilled up, and the seat cushion hung over the front edge by four inches (in.), and the wheelchair dirty with food and debris; - On 07/09/24 at 12:18 P.M., wheelchair in the hall with the wheelchair arms wrapped with Coban stained, dirty, pilled up, and the seat cushion hung over the front edge by four inches (in.), and the wheelchair dirty with food and debris; - On 07/10/24 at 2:36 P.M., the resident lay in bed with his/her wheelchair in the room with the wheelchair arms wrapped with Coban stained, dirty, pilled up, and the seat cushion hung over the front edge by four inches (in.), and the wheelchair dirty with food and debris. Observations of Resident #20's wheelchair showed: - On 07/09/24 at 9:43 A.M., the resident lay in bed with his/her wheelchair at the bedside, the back of wheelchair cover with cracks all across the back, both corners split 1.5 in. down toward the seat with filler showing, both arm rests with cracks all down the outside edge and around the back edge, the seat cushion dirty with food and debris; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 07/10/24 at 12:55 P.M., the resident sat in his/her wheelchair with the back of wheelchair cover with cracks all across the back, both corners split 1.5 in. down toward the seat with filler showing, both arm rests with cracks all down the outside edge and around the back edge, the seat cushion dirty with food and debris. Observations of Resident #9's wheelchair showed: - On 07/09/24 at 9:45 A.M., the resident sat in his/her wheelchair without an arm rest on the right arm and propelled him/herself down the hall; - On 07/10/24 at 12:58 P.M., the resident sat in the dining room in his/her wheelchair without an arm rest on the right arm. Observations of Resident #6's wheelchair showed: - On 07/11/24 at 5:42 P.M., the resident sat in his/her wheelchair the covering missing and foam fill exposed on both arm rests and propelled him/herself down the hall; - On 07/12/24 3:22 P.M., the resident sat in his/her wheelchair the covering missing and foam fill exposed on both arm rests. During an interview on 07/10/24 at 5:42 P.M., Resident #6 said his/her wheelchair had been like that for a very long time and the wheel made a noise but no one had fixed it. He/She needed a new one. Review of the Maintenance Director repair logs dated 11/21/23 through 7/15/24, showed: - No documentation of the 300 and 500 Hall shower room repair concerns; - No documentation of residents' wheelchairs repair concerns; During an interview on 07/11/24 at 7:53 A.M., Nurse Aide (NA) B said he/she hadn't been at the facility long and was unsure about when the wheelchairs should be cleaned or what to do about equipment that needed repaired or replaced. During an interview on 07/11/24 at 7:55 A.M., CNA D said he/she did not know about the wheelchair cleaning/maintenance. During an interview on 07/11/24 at 7:57 A.M., Licensed Practical Nurse (LPN) M said as far as he/she knew, the wheelchairs should be cleaned by the night shift CNAs and should be done nightly. During an interview on 07/11/24 at 5:29 P.M., CNA G, said the wheelchairs that need cleaned, should be cleaned by night shift, and if he/she wasn't busy. During an interview on 07/12/24 at 11:22 A.M., the Maintenance Director said needed wheelchair repair was usually just verbally reported. No wheelchair repairs had been reported to him/her recently. Wheelchairs that were all cracked up should be taken out of use and replaced, but didn't remember any new wheelchairs ever being bought. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/24 at 3:46 P.M., the Administrator said she wished there were funds to get new wheelchairs. They should be cleaned, repaired or replaced. The wheelchairs should be cleaned weekly and night shift CNAs were responsible. There is no documentation to show when they are cleaned. During an interview on 07/11/24 at 4:40 P.M., the Corporate Quality Assurance (QA) Registered Nurse (RN) said the facility had available funds for resident wheelchairs and an order just had to be submitted. 45693

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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. 46521 Based on observation, interview and record review, the facility failed to assess the use of a bed and chair alarm (devices that contain sensors that trigger an alarm when they detect a change in pressure) to determine if utilized as restraints and to complete on-going evaluations for the continued need for one resident (Residents #24) out of three sampled residents. The facility census was 40. Review of the facility's policy titled, Nursing Guidelines Manual, undated, showed bed and chair alarm documentation should include: Date and time bed and chair alarm ordered and name and title of person ordering the restraint; Type of restraint; Reason or reasons for the use of the bed and chair alarm and the resident's response; All pertinent observations; Signature and title of person recording the data. 1. Review of Resident #24's medical record showed: - Diagnoses of Alzheimer's Disease (progressive mental deterioration), altered mental status, and osteoporosis (a condition causing loss of bone mass, predisposing a person to fractures); - Required assistance of one staff for toileting; - No documentation of a physician's order for the bed and chair alarms; - No documentation of a bed and chair alarm assessment. Review of the facility's fall records showed: - On 06/11/24 at 3:00 P.M., the resident had an unwitnessed fall with no injuries; - On 06/25/24 at 6:58 P.M., the resident was found sitting on the fall mat in front of his/her bed with no injuries; - On 06/28/24 at 8:09 A.M., the resident had a witnessed fall on the fall mat; - On 07/05/24 at 1:58 P.M., the resident had an unwitnessed fall; - On 07/09/24 at 9:50 P.M., the resident had an unwitnessed fall. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 04/15/24, showed: - Cognition severely impaired; - Dependent for most activities of daily living (ADL's); - Wheelchair used for mobility; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bed and chair alarms not used. Review of the resident's care plan, revised 05/23/24, showed: - The resident requires supervision with ADL's and one person assist with bathing; - The resident at risk for falls; - Bed and chair alarms used as a fall intervention; - Resident fell out of bed on 6/11/24; - Multiple interventions to prevent falls attempted. Observations of the resident on 07/09/24 at 10:49 A.M. and 3:14 P. M., and 07/15/12/24 at 8:37 A.M., showed: -The resident lay in bed with a bed alarm attached to a pressure pad under his/her back; -The resident was unable to remove the bed alarm. Observations of the resident on 07/09/24 at 12:37 P.M., 07/12/24 at 12:35 P.M. and 2:42 P.M., and 07/15/12/24 at 1:08 P.M., showed: - The resident sat in a wheelchair with a chair alarm attached to the back of the wheelchair and a pressure pad under the resident's thighs and buttocks; - The resident was unable to remove the chair alarm. During an interview on 07/12/24 at 1:30 P.M., the MDS Coordinator said chair and bed alarms were not assessed in the facility, but should have been. The bed and chair alarm monitoring were not documented but should be to ensure they were working properly. They were used as a fall intervention. During an interview on 07/15/24 at 4:00 P.M., the Administrator and Assistant Director of Nursing (ADON) said they expect monitoring and assessments for bed and chair alarms to be completed. Assessments should be done every three months. During a phone interview on 07/26/24 at 1:24 P.M., the Administrator she is not sure why there was not a physician's order in place for the bed and chair alarms but there should have been orders.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37575 Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the the resident's responsible party and to the representative of the Office of Long-Term Care (LTC) Ombudsman for six residents (Resident #3, #8, #12, #23, #34 and #36) out of six sampled residents. The facility census was 40. The facility did not provide a transfer or discharge policy. 1. Review of Resident #3's medical record showed: - The resident transferred to the hospital on 04/22/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative or the Office of the LTC Ombudsman. 2. Review of Resident #8's medical record showed: - The resident transferred to the hospital on 06/10/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative or the Office of the LTC Ombudsman. 3. Review of Resident #12's medical record showed: - The resident transferred to the hospital on 05/26/24; - The resident transferred to the hospital on 06/07/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party for the 05/06/24 and 06/07/24 transfers; - No documentation of the written transfer/discharge notification provided to the representative or the Office of the LTC Ombudsman for the 05/06/24 and 06/07/24 transfers. 4. Review of Resident #23's medical record showed: - The resident transferred to the hospital on 06/19/24; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative or the Office of the LTC Ombudsman. 5. Review of Resident #34's medical record showed: - The resident transferred to the hospital on 04/28/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative or the Office of the LTC Ombudsman. 6. Review of Resident #36's medical record showed: - The resident transferred to the hospital on 05/04/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative or the Office of the LTC Ombudsman. During an interview on 07/09/24 at 9:30 A.M., the Ombudsman said he/she had not received transfer logs from the facility since April 2024. During an interview on 07/10/24 at 3:53 P.M., the Administrator said it was her responsibility to send the transfer/discharge logs to the ombudsman monthly at the end of the month. During an interview on 06/15/24 at 4:00 P.M., the Assistant Director of Nursing (ADON) and the Administrator said they would expect transfer and discharge notices to be given for each hospital transfer/discharge. The charge nurse that was transferring/discharging the resident was responsible. Management should receive them under the office doors and then check back on them. It was not just one person's responsibility to check and make sure they were done. 45693 46521

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46521 Based on interview and record review, the facility failed to provide written notification of the bed-hold policy to the resident and/or their representatives at the time of transfer for six residents (Resident #3, #8, #12, #23, #34 and #36) out of six sampled residents. The facility census was 40. The facility did not provide a bed hold policy. 1. Review of Resident 3's medical record showed: - The resident transferred to the hospital on 04/22/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer. 2. Review of Resident 8's medical record showed: - The resident transferred to the hospital on 06/10/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer. 3. Review of Resident 12's medical record showed: - The resident transferred to the hospital on 05/26/24; - The resident transferred to the hospital on 06/07/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfers on 05/26/24 and 06/07/24. 4. Review of Resident 23's medical record showed: - The resident transferred to the hospital on 06/19/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer. 5. Review of Resident 34's medical record showed: - The resident transferred to the hospital on 04/28/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of Resident 36's medical record showed: - The resident transferred to the hospital on 05/04/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer. During an interview on 06/15/24 at 4:00 P.M., the Assistant Director of Nursing (ADON) and the Administrator said they would expect bed-hold policies to be given for each hospital transfer/discharge. The charge nurse that was transferring/discharging the resident was responsible. Management should receive the bed-hold policies under the office doors and then check back on them. It was not just one person's responsibility to check and make sure they were done.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility failed to update and revise care plans with specific interventions tailored to meet individual needs for one resident (Resident #22) out of 12 sampled residents. The facility census was 40. Review of the facility's policy titled, Care Plan, Comprehensive, undated, showed: - Assessment of each resident is an ongoing process and the care plan will be revised as changes occur in the resident's condition; - A well developed care plan will be oriented to managing risk factors to the extent possible or indicating the limits of such interventions; - Addressing ways to try and preserve and build upon resident strengths; - Evaluating treatment of measurable goals, timetables and outcomes of care; - Use appropriate interdisciplinary approach to care plan development to improve the residents functional abilities; Involve direct care staff with the care planning process relating to the resident's expected outcomes; - The interdisciplinary care plan team is responsible for periodic review and updating of care plans; - When a significant change in the resident's condition has occurred; - At least quarterly; - When changes occur that impact the resident's care, (i.e., change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment). 1. Review of Resident #22's medical record showed: - admitted [DATE]; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), dysuria (discomfort when urinating), muscle weakness, repeated falls, and urinary tract infection (UTI). Review of the resident's Nurses Notes showed: (continued on next page)

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Current River Nursing Center, Inc	1015 North Grand Avenue Doniphan, MO 63935

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/19/24 at 8:28 A.M., the resident fell at 3:00 A.M. He/She was trying to put something into the ashtray in the floor. The resident was put on neuro checks due to an unwitnessed fall as well as hitting the right side of his/her forehead on the bedroom floor. The resident continued to move his fall mat thinking he/she thought there was an ashtray under the mat in the floor. Received orders to collect urinalysis (UA - a test to check urine for infection) with culture and sensitivity (C&S - a test to find the the germs that cause an infection and find the type of medicine that will treat the infection); - On 04/06/24 at 5:17 A.M., the resident's cushion slid out of the wheelchair, caused the resident to slide, and witnessed by a Certified Nurse Assistant (CNA). The resident had a small skin tear to the right forearm; - On 04/17/24 at 2:40 P.M., the resident fell out of wheelchair in the hallway and witnessed by staff. The resident denied pain and hitting head; - On 05/08/24 at 10:29 A.M., urine was collected on 05/07/24 and sent to lab this morning. Notified by lab the urine specimen was kicked back to due to the wrong date on the specimen and another specimen would need to be sent in; - On 05/07/24 at 1:38 P.M., resident complaining of dysuria, stating: it's burning hot when it comes out, resident is confused and agitated today. His/Her urine is milky and tan. Physician aware, with new orders to obtain UA with C&S and encourage fluids. Order processed. Will attempt to collect urine this shift; - On 05/17/24 at 12:00 P.M., the resident was found on the floor of his/her room on his/her back/right side and on top of a blanket. Resident with a small bleeding laceration to his/her right forehead and a small laceration to the upper right cheek; - On 06/01/24 at 7:38 A.M., the resident's spouse reported he/she helped him/her to the bathroom several times, almost every hour, due to the urgency to urinate. The resident had blood in his/her urine. The physician was notified and received new orders to collect the UA; - On 06/04/24 at 12:12 A.M., the resident had an unwitnessed fall at approximately 9:40 P.M. The resident reportedly hit his/her head. No injuries; - On 06/20/24 at 3:48 A.M., at approximately 2:40 A.M., the resident was found on floor by staff with a 1.5 centimeter (cm) X 0.1 cm laceration to the right forehead and a 1.8 cm X 04. cm skin tear to the right outer forearm; - On 06/23/24 at 8:45 P.M., the resident was found on the floor in front of the far exit door. The resident had a laceration to the left side of the forehead; - On 06/27/24 at 12:23 A.M., the resident fell out of the wheelchair onto the floor in the hall. Staff witnessed the fall from the other end of the hallway but was not able to make it to the resident in time. The resident had a laceration to the right forehead which was bleeding heavily; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 07/06/24 at 2:32 A.M., at approximately 09:40 P.M., the resident was found in his/her room on the floor lying on his/her back holding a walker in one hand. The resident had socks on and had a 1.5 cm X 0.8 cm skin tear to the bridge of the nose; - On 07/10/24 at 4:07 A.M., at approximately 9:50 P.M., the resident was found on floor next to the recliner with skin tears to the top left hand, left elbow, and left knee. There was blood in the floor in front of the air conditioner and on the corner of the recliner cushion; - On 07/14/24 at 3:45 A.M., the resident had an unwitnessed fall and was sent to the emergency department for evaluation; - On 07/14/24 at 4:00 P.M., the resident returned from the emergency department evaluation to the facility. The resident was diagnosed with a UTI. Received a new order for Keflex (an antibiotic) 500 milligram (mg) by mouth one capsule three times a day for seven days. Review of the resident's care plan, dated 05/23/24, showed: - Resident at risk for falls, dated of 11/09/23; - No new interventions added since 11/09/23, that addressed the recurrent frequent falls; - Did not address nonskid footwear, the wheelchair cushion, assessments for UTI with frequent urination, increased confusion/agitation and falls, and follow up on orders for the UA; - The facility failed to update the resident's care plan. Observations of the resident showed: - On 07/09/24 at 9:42 A. M., the resident sat in his/her room in a wheelchair and the seat cushion hung over the edge of the seat four inches (in.) in the front. The resident had a dressing to the right forehead and the nose; - On 07/09/24 at 12:18 P.M., the resident sat in the hall in a wheelchair and the seat cushion hung over the front edge of the seat four in in the front.; - On 07/11/24 at 12:51 P.M., the resident sat in the dining room in a wheelchair and the seat cushion hung over the edge of the seat four in. in the front. Observations on 07/11/24 at 10:32 A.M., showed the clean linen cart on the 500 Hall showed no nonskid footwear. During an interview on 07/15/24 at 2:40 P.M., the Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) Coordinator said the resident care plan should be updated with falls, new interventions put in place, and recurrent UTI's. During an interview on 07/15/24 at 4:40 P.M., the Assistant Director of Nursing (ADON) said she would expect the care plan to be updated with falls. Interventions were discussed in the morning meetings and the MDS Coordinator was responsible for updating the care plans.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37575 Based on observation, interview, and record review, the facility failed to follow physician's orders for three residents (Residents #5, #34, and #40) out of 12 sampled residents. The facility census was 40. Review of the facility's policy titled, Physician's Orders, undated, showed: - Current lists of orders must be maintained in the clinical record of each resident to avoid conflict and errors; - Orders must be written and maintained in chronological order; - Physician orders must be reviewed and renewed. Review of the facility's policy titled, Skin Assessments, undated, showed residents at risk will have preventative measures implemented to include: weekly documented skin audits by a licensed nurse and treatments as ordered by the physician if skin breakdown occurs. 1. Review of Resident #5's medical record showed: - Diagnoses of schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), cellulitis (a bacterial infection of the skin), high blood pressure, hypokalemia (decreased blood level of potassium), venous insufficiency (a condition in which veins have problems moving blood back to the heart), atrial fibrillation (irregular heart beat), and bipolar disorder (a mental disorder that causes unusual shifts in mood); - An order for consulting wound care clinic to evaluate and treat for cellulitis, dated 11/07/23; - An order for weekly skin assessments completed and documented once a day on Thursdays, dated 12/28/23; - An order to monitor resident's shower/bath, chart, and fill out shower sheet if with any new skin issues once a day on Mondays, Thursdays, Saturdays, dated 02/22/24; - From 04/01/24 - 07/10/24, no documentation of weekly skin assessments completed for 04/04/24, 04/11/24, 04/18/24, 05/02/24, 05/09/24, 05/16/24, 06/06/24, 06/13/24, and 07/04/24, with nine out of 14 opportunities missed. Review of the resident's Treatment Administration Record (TAR), dated April 2024, showed: - An order to cleanse/lightly scrub bilateral (right and left) lower extremities (BLE) with warm water and ketoconazole (an antifungal) 2 percent (%) shampoo, rinse, pat dry, apply generous amount of triamcinolone (a topical steroid) cream to the BLE twice daily for venous insufficiency, dated 11/14/23, and discontinued on 04/23/24, with 20 out of 60 opportunities missed; (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	- An order to cleanse the BLE with Dakin's wound cleanser (DWC), measure, cut and apply tubigrips (tubular bandages for tissue support) daily for cellulitis, dated 01/30/24, and discontinued on 04/23/24, with 14 out of 22 opportunities missed. Review of the resident's Medication Administration Record (MAR), dated July 2024, showed: - An order for ammonium lactate (used to hydrate the skin) lotion 12%, administer topically at bedtime for cellulitis, dated 07/12/24, with three out of three opportunities missed; - An order to cleanse BLE with soap and water, pat dry, apply ammonium lactate lotion, wrap with an ace wrap daily, undated, with two out of three opportunities missed. Review of the resident's care plan, last reviewed on 06/24/24, showed: - Cellulitis with interventions not addressed; - Venous insufficiency with interventions not addressed. Observations of the resident showed: - On 07/09/24 at 10:07 A.M., 07/10/24 at 8:51 A.M., the resident sat in a recliner in the room with a tan compression sock on halfway up the left lower leg. At the top of the compression sock, the visible skin was red, dry, and swollen with scattered scabs. The right lower extremity (RLE) had a tan compression sock on up to the ankle area, the visible skin at top of the sock was red, dry and swollen with scattered scabs and open areas; - On 07/10/24 at 4:23 P.M., the resident sat in a recliner in the room with a tan compression sock on halfway up the left lower leg. At the top of the compression sock, the visible skin was red, dry, and swollen with scattered scabs. The right lower extremity (RLE) with a tan compression sock on up to the ankle area with the visible skin at top of the sock to the was red, dry and swollen with scattered scabs, open areas, and blisters; - On 07/10/24 at 4:45 P.M. Licensed Practical Nurse (LPN) P entered the resident's room and removed the resident's compression socks. The inside of the resident's RLE had blisters with drainage and multiple open areas noted. LPN P asked the resident where the compression socks came from because they were too small. The resident said he/she didn't know where they came from. LPN P informed the resident he/she would call the physician to see what to do and they should have been assessed by staff before now. The resident agreed with LPN P. LPN P notified the physician and received new orders to send the resident to the hospital; - On 07/15/24 at 8:35 A.M., the resident sat in a recliner in the room with no ace wraps on his/her lower extremities as ordered and yellow non-slip socks on his/her bilateral feet. BLE were red, dry, and swollen with dried skin flakes; - On 07/15/24 at 4:05 P.M., the resident sat in a chair in the common area near the entrance with no ace wraps to his/her BLE as ordered. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/09/24 at 10:07 A.M., Resident #5 said he/she had an infection to his/her right leg that was slow to heal and had been on antibiotics, but not any longer. He/She said the staff used to come in and treat his/her legs but not in a while. During an interview on 07/11/24 at 11:35 A.M., the Assistant Director of Nursing (ADON) said if a resident refused skin assessments and care the staff should give the resident a little bit of time, go back in and try again. She expected nursing staff to document on the resident's skin assessment sheets/shower sheet and in the nurse's notes, what was done, what was tried, what another person tried. If there was a skin concern, the resident should get a shower sheet completed too. If a resident refused a shower or skin assessment, the staff should sign it, a witness should sign it, and the resident should sign it if able, and then it should be turned into her. She was not aware the last skin assessment for Resident #5 was completed in May 2024, and she was not aware it was not getting done. Registered Nurse (RN) E moved to the day shift in June 2024, to make sure the skin assessments were getting done. The charge nurse was responsible for doing the skin assessments, and RN E audited them and made sure they were done. Resident #5 didn't like someone in the shower with him/her so the staff stood outside of the shower curtain and he/she would take a shower. The resident would refuse medications and skin assessments, but she would expect staff to go in and try again later, try another staff member, or a different time for medications, and even another day for assessments and showers. She said they had to get social services involved a lot. The resident's legs should had been found before 07/10/24. There should have been two sets of eyes on the skin assessments, and it should have been caught. During an interview on 07/11/24 at 2:25 P.M., RN E said Resident #5 would complain about pain to his/her legs and would take Tylenol. The resident complained the Tylenol wouldn't do anything, but he/she didn't complain of any pain after it was taken. During an interview on 07/11/24 at 3:19 P.M., Certified Nursing Assistant (CNA) N said every once in awhile the Resident #5's legs were red. The resident was mostly independent with his/her activities of daily living (ADLs) so didn't see his/her legs a lot. He/She can't remember the last time he/she saw the resident's legs. During an interview on 07/11/24 at 3:25 P.M., RN E said the night shift charge nurse was in charge of completing skin assessments. He/She didn't know who was in charge of auditing the skin assessments to ensure they were completed. He/She had not done any skin assessments since moving to the day shift last month. Resident #5 had been aggressive toward him/her when trying to do the skin assessments. He/She hadn't seen Resident #5's legs in over a month and a half. During an interview on 07/11/24 at 3:30 P.M., the Social Services Designee (SSD) said Resident #5 used to listen to him/her but stopped about four - five months ago. He/she was verbally aggressive but not generally physical. He/She had not seen the resident's legs in a very long time and the resident hadn't mentioned them. During an interview on 07/11/24 at 3:35 P.M., the ADON said she had not seen Resident #5's legs since she discontinued the treatment back in April 2024. She discontinued that treatment because the resident only had a penny sized scabbed area. The resident did end up needing oral antibiotics within six days for cellulitis after that. The resident had not complained about pain in the last couple of months. The resident's legs should have been seen prior to them getting to the point of having to go to the hospital. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/11/24 at 4:15 P.M., the Corporate QA RN said the resident could refuse care up until it's started causing harm and then the facility staff would need to step in and figure out some way to provide the care the resident required. The resident couldn't go two months without a shower. The resident shouldn't go more than two weeks since he/she was non-compliant, and no staff saw his/her legs. Physician orders should be followed to include the skin assessments and showers. The resident's legs should have been caught before the point they were at. During an interview on 07/11/24 at 4:15 P.M., the Administrator said they couldn't do skin assessments or showers on Resident #5 because he/she refused everything. The resident even refused care and medications. She had not seen his/her legs. During an interview on 07/11/24 at 10:44 A.M., the Physician said if an order was given, he/she expected it be followed. Resident #5 had a lot of medical conditions. He/She refused to take baths and medications. He/She was not aware of the condition of the resident's skin on his/her legs until last night when the nurse called. That was the first he/she had heard of it. The resident's legs had some chronic conditions, and could have some fungus growing in the wounds. The resident received intravenous (IV) antibiotics while at the hospital. The facility staff should document when the resident refused care. During an interview on 07/11/24 at 4:19 P.M., the Physician said it could have just taken days for Resident #5's legs to get to this point they were before he/she went to the hospital because of him/her living in such a high microbial environment, the resident picked at his/her skin, and refused care. Review of the facility's policy titled, Lab Reporting Guidelines, undated, showed it did not address what to do when lab orders were not completed. 2. Review of Resident #34's medical record showed: - Diagnoses of congestive heart failure (CHF - an inability of the heart to pump sufficient blood flow to meet the body's needs), high blood pressure, hip fracture, and pressure ulcer (damage to the skin and/or underlying tissue as a result of pressure) Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle); - Care plan, last revised on 04/24/24, the resident with a wound to the coccyx (the small triangular bone below the spine). The wound will be followed by the consulting wound clinic and treatment orders followed; - An order to lightly wet plain packing strip with Vashe (wound cleanser), apply collagen (helps promote tissue growth) to strip and pack wound with collagen strip once a day, dated 06/19/24; - An order to soak the wound to the coccyx with Vashe before the treatment, dated 06/19/24; - An order to cut Polymem (a dressing that will constantly cleanse the wound bed, while also managing drainage) to size and place over the wound tissue and cover with bordered gauze daily, dated 06/27/24; - An order for weekly skin assessments completed and documented on Mondays, dated 02/26/24. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	-Review of the the resident's TAR, dated June 2024, showed an order for weekly skin assessments to be completed and documented on Mondays, with a start date of 02/26/24. Three out of the four Mondays in June 2024 had no skin assessments documented. Review the resident's TAR, dated 07/01/24 through 07/10/24, showed: - An order for weekly skin assessments to be completed and documented on Mondays, with a start date of 02/26/24. No documentation the for the assessment on 07/01/24 (Monday). - An order, dated 06/19/24, to lightly wet plain packing strip with Vashe, apply collagen to strip and pack wound with collagen strip once a day, with two out of 10 opportunities missed; - An order dated 06/19/24, to soak the wound to the coccyx with Vashe before the treatment, with two out of 10 opportunities missed; - An order dated 06/27/24, to cut Polymem to size and place over the wound tissue and cover with bordered gauze daily, with two out of 10 opportunities missed. Observation on 07/10/24 at 1:00 P.M., of the resident's wound care showed: - LPN P soaked the packing strip with Vashe wound cleanser and applied Santyl (a wound debridement) to the packing strip; - LPN P used Santyl instead of collagen as ordered. During an interview on 07/10/24 at 1:30 P.M., LPN P said Santyl and collagen were the same medication. During an interview on 07/11/24 at 10:30 A.M., the ADON said in a resident's medical record, if the TAR has an order for a treatment, and there is no corresponding initial to indicate the treatment was completed, then there is no proof the treatment was completed. Santyl and collagen were not the same treatments and the physician's order for collagen should have been followed. During an interview on 07/11/24 at 1:00 P.M., the consulting wound care clinic nurse said there was a difference between Santyl and collagen powder. Collagen powder was what was ordered for Resident #34's wound. Santyl broke down bad tissue and collagen built up new tissue. The collagen was ordered on 06/18/24. The use of Santyl could cause negative effects like maceration (when a wound experiences excessive moisture, leading to the softening and breaking down of the surrounding skin) of the tissue which would stall the improvement of the wound and create a more wet environment. It wouldn't destroy the healthy tissue but the tissue would be too wet of an environment for tissue growth. During an interview on 07/11/24 at 3:00 P.M., RN E said he/she used collagen powder for Resident #34's wound care. Santyl was an old order and not the same thing as the collagen powder. Santyl shouldn't be used for the resident's wound. During an interview on 07/11/24 at 3:10 P.M., the ADON said physician orders should be followed. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/11/24 at 4:15 P.M., the Corporate QA RN said collagen powder and Santyl were not the same thing. Physician orders should be followed. During an interview on 07/11/24 at 4:17 P.M., the Administrator said physician orders should be followed. 3. Review of Resident #40's medical record showed: - A diagnosis of Alzheimer's disease; - An order for weekly weights for four weeks, dated 06/11/24; - On 06/11/24, the resident weighed 106.9 pounds (lbs); - No documented weight for the week of 06/18/24; - No documented weight for the week of 06/25/24; - On 07/02/24, the resident weighed 101.8 lbs, with a 4.77% weight loss in three weeks; - The facility failed to weigh the resident weekly for four weeks as ordered with two out of four opportunities missed. During an interview on 07/10/24 at 10:42 A.M., the Administrator said the ADON was responsible for making the weekly weight list and monitoring. During an interview on 07/10/24 at 02:53 P.M., the Physician said if weekly weights were ordered, he/she would expect them to be completed as ordered. During an interview on 07/12/24 at 8:09 A.M., CNA L said the resident did not have weekly weights. The resident was not on the weekly weight list. During an interview on 07/12/24 at 8:16 A.M., the ADON said the resident was not on the weekly weight list. She didn't know why the resident wasn't added and didn't get weekly weights. 45693 46521 47445

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 37575 Based on interview and record review, the facility failed to provide a safe transfer for one resident (Resident #23) in a manner to prevent accidents, when staff did not utilize two staff for transfers as directed on the resident's care plan and the resident sustained a hip fracture. Also, the facility failed to safely transfer one additional resident (Resident #8) outside of the sample. The facility census was 40. Review of the facility's policy titled, Gait Belt (a device used for assistance with transfers and walking) Transfers, undated, showed: - Assist resident to a sitting position; - Apply belt to the resident's waist and tighten to fit snugly with the buckle at the side; - Face the resident; - Bend your knees and place your hands around the gait belt on each side of the resident's waist; - Bring the resident to a standing position while straightening your knees; - After the resident is standing, the belt provides assistance stabilizing the turning of the resident. 1. Review of Resident #23's medical record showed diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following a stroke, pneumonia, muscle weakness, COPD, difficulty in walking, fracture of the neck of the left femur (thigh bone), pain to the left hip, bipolar disorder (a mental disorder that causes unusual shifts in mood), and anxiety disorder. Review of the resident's quarterly MDS, dated [DATE], showed: - Cognitively intact; - Substantial/maximal assistance of staff for dressing, personal hygiene, transfers, toilet use, and bathing. Review of the resident's care plan, last revised 05/23/24, showed: - The resident required assist of staff with ADL's, incontinent care and transfers; - Required a minimum of two staff to transfer. Review of the nurse's notes showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Current River Nursing Center, Inc	1015 North Grand Avenue Doniphan, MO 63935

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- On 06/19/24 at 3:47 P.M., the resident requested to be transferred from the wheelchair to the recliner. The resident was assisted to stand with a gait belt by Registered Nurse (RN) E. While pivoting, the resident began leaning to the left. RN E attempted to correct the resident's position and the resident leaned further due to his/her left sided weakness. The resident was lowered to the floor by RN E and he/she complained of left hip pain. RN E and a second nurse assisted the resident to a sitting position and transferred the resident into the recliner. The resident had a small skin tear to his/her left hand. The physician was notified and received an order for an x-ray of the left hip; - On 06/19/24 at 7:30 P.M., the left hip x-ray was obtained; - On 06/19/24 at 9:46 P.M., the resident continued to complain of increased pain to the left hip. The resident requested to be sent to emergency department (ED). The physician was notified and received an order to send the resident to the ED. - On 06/20/24, the ED staff notified the facility of the resident being admitted to the hospital for a fractured left hip with possible surgery; - On 06/24/24, the resident returned to the facility from the hospital and the resident's left hip with a small incision with seven sutures in place. Review of RN E's Employee Counseling Notice, dated 06/20/24, showed: - Employee failed to follow the resident's care plan; - Employee transferred a two person assist resident by his/herself resulting in an injury to the resident. During an interview on 07/10/24 at 2:53 P.M., the Physician said staff should transfer residents as indicated. During an interview on 07/11/24 at 11:00 A.M., RN E said the resident started yelling he/she wanted to be transferred. There was no one readily available to assist and he/she thought the resident would be able to assist. The resident was usually a two person assist. The resident did help stand but while pivoting, the resident started leaning over to one side. RN E tried to correct the resident's leaning, but they both started to fall. The resident lifted his/her right leg, which was the strong one, to try to help but when that happened, RN E and the resident fell . He/She tried to control the resident's fall, but it was hard due to falling him/herself. The resident did complain of hip pain immediately. Another nurse came to help assess the resident and they got him/her up out of the floor because of difficulty breathing. They gave the resident pain medication and ordered an x-ray. Later that night, the resident complained of increased pain while the facility still was waiting for results from the x-ray. They sent the resident out to the hospital and he/she did have a fractured femur. During an interview on 07/11/24 at 10:10 A.M., the Administrator was aware of the incident and interviewed RN E. RN E said she transferred the resident as a one person assist but used a gait belt. The staff were in-serviced. She did not complete an official investigation which showed documentation of the incident. She didn't have any monitoring of staff transfers since the incident occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Review of Resident #8's medical record showed diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), pneumonia (an infection that inflames the air sacs in one or both lungs), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), diabetes mellitus (a disease that results in too much sugar in the blood), fracture of left clavicle (bone that connects arm to body), anxiety disorder (persistent worry and fear about everyday situations), and chronic heart failure (CHF - a serious condition that occurs when the heart is unable to pump blood efficiently). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by the facility staff), dated 06/05/24, showed: - Cognition severely impaired; - Dependent on staff for activities of daily living (ADL's); - Mechanical lift not indicated; - Impairment to one side of upper and lower extremity; - Sit to standing and all transfers to be substantial/maximal assist where helper does more than half the work. Review of the resident's CNA Care Card, undated, showed the resident required assist of two for mechanical lift transfers. Observation on 07/11/24 at 10:10 A.M., of the resident showed: - CNA D and Nursing Assistant (NA) B transferred the resident from the bed to the wheelchair by a Hoyer Lift (a mechanical lift to move residents); - CNA D and NA B pushed the resident across the hall to the shower room in the wheelchair where Hospice Aide (HA) Q waited to assist the resident with a shower; - CNA D and NA B transferred the resident from the wheelchair to the shower chair by a Hoyer lift; - NA B left the shower room; - While the resident sat in the shower chair, HA Q placed his/her right arm under the resident's left axillary (arm pit area), CNA D placed his/her left arm under the resident's right axillary area, HA Q and CNA D lifted the resident and removed the brief. The resident's feet did not touch the floor to bear weight and no gait belt was used by HA Q and CNA D; - NA B returned to the shower room and the resident sat in the shower room outside of the shower. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/11/24 at 2:45 P.M., CNA D said the resident should be transferred with a Hoyer lift. When the resident was lifted from the shower chair to remove his/her brief a gait belt should've been used, but he/she was just following the lead of HA Q because he/she acted more experienced. CNA D said he/she just started a few weeks ago, was still learning, and hadn't received any training or education on transfers at this facility. During an interview on 07/11/24 at 2:47 P.M., CNA L, said the facility staff verbally tell hospice staff how the residents needed to be transferred. During an interview on 07/11/24 at 2:50 P.M., NA B said lifting the shower chair with the resident in it was the only way to get the resident into the shower when the resident required a Hoyer lift. There was no other way. The facility had a policy that a resident couldn't be taken down the hall in a shower chair, so he/she couldn't be taken to a different hall in the shower chair. He/She hadn't received any recent in-services/education on transfers. Hospice usually did the resident showers for the residents on hospice. During an interview on 07/11/24 at 3:35 P.M., the Assistant Director of Nursing (ADON) said it was not safe transferring a resident without a gait belt or with a gait belt if the resident can't bear weight, a Hoyer lift should be used for a resident that bears no weight. Hospice staff was communicated with verbally and there were CNA care cards for each resident that were available for review. During an interview on 07/11/24 at 4:15 P.M., the Corporate Quality Assurance (QA) Registered Nurse (RN) said staff should not lift residents by placing their arm/hands under the resident's arms at all. If a resident does not bear weight during a transfer, she would expect a Hoyer lift be used for safety. During an interview on 07/11/24 at 4:15 P.M., the Administrator said would expect the resident to be lifted by a gait belt, not under their arms. Complaint #MO237896 45693 46521

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to obtain timely urine specimens when a resident had symptoms of a urinary tract infection and failed to notify the physician the urine specimen was not collected, which resulted in an emergency room visit for one resident (Resident #22) out of 12 sampled residents. The facility census was 40. Review of the facility's policy titled, Lab Reporting Guidelines, undated, showed it did not address what to do when lab orders were not completed. 1. Review of Resident #22's medical record showed: - An admitted [DATE]; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), dysuria (discomfort when urinating), muscle weakness, repeated falls, and urinary tract infection (UTI); - Nurses notes showed new orders for a urine analysis (UA - a test to check urine for infection) with culture and sensitivity (C&S - a test to find the the germs that cause an infection and find the type of medicine that will treat the infection), dated 03/19/24, 05/07/24 and 06/01/24; - No documentation of completed UA lab results ordered on 03/19/24, 05/07/24, and 06/01/24; - No documentation of the completed UA results and no notification to the the physician of the uncompleted UA orders. Review of the resident's Nurses Notes showed: - On 03/19/24 at 8:28 A.M., the resident fell at 3:00 A.M. He/She was trying to put something in the ashtray in the floor. The resident was put on neuro checks due to an unwitnessed fall as well as hitting the right side of his/her forehead on the bedroom floor. The resident continued to move his/her fall mat thinking he/she thought there was an ashtray under the mat in the floor. Received orders to collect urinalysis UA with C&S; - On 05/07/24 at 1:38 P.M., resident complained of dysuria and said the urine burns hot when it came out. The resident was confused and agitated today. His/Her urine was milky and tan. The physician was aware and received new orders to obtain a UA with C&S and to encourage fluids. New orders processed and will attempt to collect urine this shift; - On 05/08/24 at 10:29 A.M., urine was collected on 05/07/24, and sent to lab this morning. Notified by lab the urine specimen was kicked back to due to the wrong date on the specimen and another specimen would need to be sent in; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 06/01/24 at 7:38 A.M., the resident's spouse reported he/she helped him/her to the bathroom several times, almost every hour, due to the urgency to urinate. The resident had blood in his/her urine. The physician was notified and received new orders to collect the UA. The UA was not collected; - On 07/14/24 at 3:45 A.M., the resident had an unwitnessed fall and was sent to the emergency department for evaluation; - On 07/14/24 at 4:00 P.M., the resident returned from the emergency department evaluation to the facility. The resident was diagnosed with a UTI. Received a new order for Keflex (an antibiotic) 500 milligram (mg) by mouth one capsule three times a day for seven days. Review of the resident's Physician Order Sheet (POS) showed for March 2024 and June 2024, no orders for a UA with C&S. During an interview on 07/09/24 at 3:05 P.M., the Administrator said she would expect orders to be followed and was not sure what happened with the UAs. During an interview on 07/10/24 at 8:57 A.M., the Assistant Director of Nursing (ADON) said the UA ordered on 05/07/24, was kicked back due to the specimen not having a correct time on it, and she was unsure about what happened with the others. Since the specimen was kicked back on 05/07/24, another specimen should have been obtained and sent to the lab. Lab orders should be completed as ordered and followed up on. There was no documentation located that showed the additional specimens were collected and sent to the lab or that the physician was notified. During an interview on 07/10/24 at 2:53 P.M., the Physician said he/she would expect the facility to follow orders as given and to be notified if they weren't followed. During an interview on 07/15/24 at 9:34 A.M., RN E said if unable to collect a specimen for a UA, it should be passed on to the next shift. It should be reported to the physician if the specimen was not collected. During an interview on 07/15/24 at 11:50 A.M., the ADON said it was the responsibility of nursing to follow up with labs and it was her responsibility to check physician's orders and results. Resident #22's UA specimens just didn't get done.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45693 Based on observation, interview, and record review, the facility failed to ensure a physician's order for oxygen was followed for three residents (Resident #6, #36, and #245) and failed to ensure oxygen tubing was dated when changed for two residents (Resident #195, and #245) out of five sampled residents. The facility census was 40. Review of the facility's policy titled, Oxygen Administration, undated showed: - The purpose is to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues; - Prefilled disposable humidifiers may be changed when empty; - Set the flow meter to the rate ordered by the physician; - Label humidifier with date and time opened; - Change humidifier and tubing per cleaning guidelines; - At regular intervals, check and clean the oxygen equipment, masks, tubing and cannulas; - At regular intervals, check the liter flow contents of the oxygen cylinder, fluid level in the humidifier and assess the resident's respiration. 1. Review of Resident #6's medical record showed diagnosis of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and lung cancer. Review of the resident's July 2024 Physician Order Sheet (POS) showed an order for oxygen at 3 liters per minute (LPM) per nasal cannula (NC - flexible tubing placed in the nose to administer supplemental oxygen) for shortness of breath, dated 03/29/24. Observations of the resident showed: - On 07/09/24 at 10:45 A.M., the resident lay in bed with oxygen at 5 LPM per NC; - On 07/09/24 at 2:00 P.M., 07/10/24 at 8:30 A.M., and 2:00 P.M., and on 07/12/24 at 3:00 P.M., the resident lay in bed with oxygen at 4 LPM per NC. During an interview on 07/09/24 at 10:45 A.M., Resident #6 said his/her oxygen should be at 3 LPM but when he/she turned it down, it popped back up to 5 LPM. 2. Review of Resident #36's medical record showed diagnosis of pneumonia, COPD, and respiratory failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's July 2024 POS showed: - An order for oxygen 2 LPM per NC continuous, dated 04/10/24; - An order to change oxygen the tubing weekly while in use on Sunday, dated 03/07/24. Observations of the resident showed: - On 07/09/24 at 10:25 A.M., the resident lay in bed with oxygen at 4 LPM per NC; - On 07/10/24 at 8:36 A.M., and 4:00 P.M., 07/11/24 at 9:00 A.M., and 07/12/24 at 2:50 P.M., the resident lay in bed with oxygen at 3.5 LPM per NC. During an interview on 07/09/24 at 10:25 A.M., Resident #36 said his/her oxygen should be at 3 LPM as that's what the physician had ordered months ago. 3. Review of Resident #195's medical record showed diagnoses of pneumonia and atherosclerotic heart disease (a buildup of cholesterol plaque in the walls of the arteries causing obstruction of blood flow). Review of the resident's July 2024 POS showed: - An order for oxygen 2 LPM as needed for shortness of breath, dated 09/21/22; - An order to change oxygen tubing weekly while in use on Sunday, dated 08/02/23. Observations of the resident showed: - On 07/09/24 at 10:19 A.M., the resident lay in bed with oxygen at 3 LPM per NC, with tubing not dated and no humidifier bottle. The portable oxygen tubing, undated, without a sealed container hung from the wheelchair handle and the nasal cannula lay in the floor; - On 07/09/24 at 2:54 P.M., the resident lay in bed with oxygen at 2 LPM per NC, with tubing not dated and disconnected from the concentrator. The portable oxygen tubing, undated, hung from the wheelchair handle outside of the sealed container tubing bag, dated 07/07/24; - On 07/11/24 at 8:33 A.M., the resident lay in bed and the NC lay outside of the sealed container tubing bag, dated 07/07/24, on top of the concentrator; - On 07/12/24 at 8:16 A.M., the resident lay in bed with oxygen at 2 LPM per NC, with tubing not dated. The portable oxygen tubing, undated, hung from the wheelchair handle and lay against the plastic wheelchair wheel, outside of the sealed container tubing bag, dated 07/07/24. During an interview on 07/12/24 at 8:17 A.M., Resident #195 said he/she used the wheelchair for trips around the facility frequently and had been out of the room in the chair this morning while using the attached portable oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #245's medical record showed diagnoses of chronic fatigue, morbid (severe) obesity due to excess calories, orthopnea (shortness of breath that happens when you're lying on your back), COPD, chronic pain, acute and chronic respiratory failure with hypoxia (when you don't have enough oxygen in your blood), nonrheumatic aortic (valve) stenosis with insufficiency, and heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of the resident's July 2024 POS showed: - An order for oxygen 3 LPM per NC, keep oxygen saturation level sat above 90% , twice a day, diagnosis of COPD, dated 10/18/23, discontinued 07/09/24; - An order to change oxygen tubing weekly, change weekly on Sunday, dated 10/17/23; - An order for oxygen 3 LPM per NC continuously to maintain oxygen saturation level above 90%, twice a day, diagnoses of COPD, dated 07/09/24. Review of the resident's Care Plan, last reviewed 07/08/24, showed: - Resident has orthopnea and resident's bed will be elevated to 30 degrees when in bed; - Resident has shortness of breath related to COPD with oxygen 2 LPM per NC and breathing treatments as ordered. Observations of the resident showed: - On 07/09/24 at 10:16 A.M., the resident sat in a wheelchair in his/her room on oxygen 2 LPM per NC. The oxygen tubing, and humidifier undated, no sealed container on the concentrator. The oxygen tubing attached to the portable oxygen tank on the wheelchair, undated; - On 07/10/24 at 8:35 A.M., after providing incontinent care to the resident, Certified Nurse Assistant (CNA) O placed the nasal cannula into the resident's nose with the concentrator turned off. The resident lay flat in his/her bed, the resident didn't receive any oxygen, and CNA O left the room; - On 07/10/24 from 8:35 A.M. to 12:05 P.M., the resident lay flat in his/her bed with the NC in his/her nose and the oxygen concentrator turned off. The resident didn't receive any oxygen; - On 07/10/24 at 12:05 P.M., staff assisted the resident to a wheelchair via a Hoyer (mechanical lift) transfer, the NC attached to the portable oxygen tank on the wheelchair placed in his/her nose, and the oxygen regulator on 2 LPM; - On 07/10/24 01:48 P.M., the resident lay flat in bed with his/her eyes closed with oxygen at 2 LPM per NC; - On 07/11/24 at 1:41 P.M., and 2:35 P.M., and 07/12/24 at 8:05 A.M., the resident sat in a wheelchair his/her room with oxygen at 2 LPM per NC from the portable oxygen tank on the back of the wheelchair; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 07/12/24 at 10:00 A.M., the resident sat in a wheelchair in the therapy room and received occupational therapy with oxygen on at 2 LPM per NC from the portable oxygen tank on the back of the wheelchair. During an interview on 07/09/24 at 10:16 A.M., Resident #245 said he/she usually wore oxygen when he/she needed it, but this morning the staff said he/she had to wear it all the time. He/She got short of breath when he/she lay in bed and sometimes during therapy. During an interview on 07/10/24 at 8:37 A.M. CNA O said Resident #245's NC was kept in place during care if the resident had oxygen on. The oxygen settings were changed by the nurse. If a resident was wearing oxygen while in their wheelchair, they usually had a concentrator in their room and were switched to the concentrator when in bed. 46521 47445

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47445 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled for at least eight consecutive hours per day, seven days a week. The facility also failed to have a Director of Nursing (DON). This deficiency had the potential to affect all residents. The census was 40. The facility did not provide a policy regarding RN and DON coverage. Review of the Facility Assessment, dated 03/07/24, showed: - DON should work five days a week for eight hours; - Licensed Nurses should include a RN eight hours per day when the DON is not available and on weekends. 1. Review of the Facility's Daily Nursing Staffing Sheets, dated 04/06/24 through 07/15/24, showed: - No RN scheduled for 04/11/24 through 04/14/24; - No RN scheduled for 04/18/24, 04/20/24, 04/22/24, 04/25/24, and 04/30/24; - No RN scheduled for 05/03/24, 05/09/24, 05/10/24, 05/12/24, 05/13/24, 05/17/24, 05/19/24, 05/23/24, and 05/30/24; - No RN scheduled for 07/12/24; - No RN scheduled for 19 out of 102 opportunities missed. Review of the facility's staff sheets, dated 07/01/24 through 07/15/24, showed; - RN E worked eight out of 15 days; - Agency RN staff worked five of 15 days; - A total of two out of 15 days with no RN coverage from 07/01/24 to 07/15/24. Review of Staffing Assignment Sheets, dated 07/01/24 through 07/15/24, showed no documentation a RN was assigned for 07/02/24, 07/05/24 - 07/12/24, with nine out of 15 opportunties missed. Review of the facility's current staff list showed one RN E as the only floor nurse and no DON. Review of RN I's employment record showed RN I hired as the DON on 06/29/22, and a termination date of 05/18/23. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of RN J's employment record showed RN J hired as the DON on 11/08/23, and a termination date of 12/11/23. During an interview on 07/9/24 at 12:02 P.M., the Administrator said the facility didn't currently have a DON, and had not had a DON since November 2023. The Corporate Quality Assurance (QA) RN consults with them. The facility had one RN on day shift as a floor nurse. During an interview on 07/15/24 at 10:30 A.M., RN E said he/she was the only staff floor nurse for the facility. The only other nurses employed by the facility were the Assistant Director of Nursing (ADON) and Minimum Data Set (MDS - a federally required assessment to be completed by facility staff) Coordinator which were Licensed Practical Nurses (LPN). During an interview on 07/15/24 at 4:45 P.M., the Administrator and ADON said there should always be RN coverage for the facility. They used agency staff to try to fill the voids the best they could. They currently did not have a DON.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47445 Based on interview and record review, the facility failed to ensure two Certified Nurse Assistants (CNAs) (CNA G and CNA H) out of two sampled CNAs, received nurse aide performance reviews annually. The facility census was 40. The facility failed to provide a policy regarding annual training. Review of the facility assessment, dated 03/07/24, showed staff competencies and annual training requirements per regulatory authority and/or facility policy to include: Abuse, Neglect, Exploitation and Misappropriation, Care/ Management for persons with dementia, Infection Control, Culture change, Person centered care, Disaster planning, Communication, and Resident rights. 1. Review of CNA G's employee file from 11/08/22 to 11/08/23, showed: - A hire date of 11/08/22; - No documentation of annual performance review. 2. Review of CNA H's employee file from, 09/05/2022 to 09/05/23, showed: - A hire date of 09/05/19; - No documentation of annual performance review. During an interview on 07/15/24 at 5:00 P.M., the Administrator and Assistant Director of Nursing (ADON) said the CNA's should have annual performance reviews, She had not done any since starting as administrator. They do not know if or where previous reviews are.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37575 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for three out of three medication carts. This practice had the potential to affect all residents. The facility census was 40. Review of the facility's policy titled, Schedule II-V Medications, undated, showed: - All schedule II, III, IV, and V medications must be counted (comparing number of pills to disposition record) at every change of shift by two Certified Medication Technicians (CMT) or one CMT and one licensed nursing staff. Both personnel must sign verification of the correct count; - If at any time, the count is incorrect, the CMT must notify licensed nursing staff, who will call the Director of Nursing (DON) or designee for instructions. 1. Review of the 100/200 Hall Nurse Narcotic Count log for the controlled substances showed: - For 04/01/24 - 04/30/24, documentation of the narcotic reconciliation completed by staff with 50 out of 60 opportunities missed; - For 05/01/24 - 05/31/24, no documentation of the narcotic reconciliation completed by staff with 62 out of 62 opportunities missed; - For 06/01/24 - 06/31/24, no documentation of the narcotic reconciliation completed by staff with 62 out of 62 opportunities missed; - For 07/01/24 - 07/10/24, documentation of the narcotic reconciliation completed by staff with four out of 20 opportunities missed. Review of the 300/400 Hall Nurse Narcotic Count log for the controlled substances showed: - For 04/01/24 - 04/30/24, no documentation of the narcotic reconciliation completed by staff with 60 out of 60 opportunities missed; - For 05/01/24 - 05/31/24, no documentation of the narcotic reconciliation completed by staff with 62 out of 62 opportunities missed; - For 06/01/24 - 06/31/24, documentation of the narcotic reconciliation completed by staff with 28 out of 62 opportunities missed; - For 07/01/24 - 07/10/24, documentation of the narcotic reconciliation completed by staff with four out of 20 opportunities missed. Review of the 500 Hall Nurse Narcotic Count log for the controlled substances showed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For 04/01/24 - 04/30/24, no documentation of the narcotic reconciliation completed by staff with 60 out of 60 opportunities missed; - For 05/01/24 - 05/31/24, no documentation of the narcotic reconciliation completed by staff with 62 out of 62 opportunities missed; - For 06/01/24 - 06/31/24, documentation of the narcotic reconciliation completed by staff with 38 out of 62 opportunities missed; - For 07/01/24 - 07/10/24, documentation of the narcotic reconciliation completed by staff with five out of 20 opportunities missed. During an interview on 07/10/24 at 4:56 P.M., CMT A said the off-going and on-coming staff complete the narcotic count and sign the log. If there were issues, the involved staff didn't leave the facility unit it was resolved. The Assistant Director of Nursing (ADON), DON and/or the Administrator would be notified. During an interview on 07/15/24 at 1:27 P.M., the ADON said she would expect the narcotic counts to be completed by the on-coming and off-going staff at the beginning/ending of each shift and any other time there was a change in the involved staff. During an interview on 07/15/24 at 5:05 P.M., the ADON said the the narcotic count sheets should be turned into her at the end of each month.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45693 Based on interview and record review, the facility failed to limit the use of an as needed (PRN) order for psychotropic (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behaviors) medication to 14 days for two residents (Resident #3 and #33) and the facility also failed to ensure an appropriate diagnosis for the use of a psychotropic medication and to attempt a gradual dose reduction (GDR) for three residents (Resident #5, #31 and #33) out of five sampled residents. The facility census was 40. The facility did not provide a policy on PRN, appropriate diagnoses, and GDR's of psychotropic medications. 1. Review of Resident #3's July 2024 Physicians Order Sheet (POS) showed: - Diagnoses of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and hospice services (health care that focuses on the quality of life of a terminally ill person); - An order for lorazepam (an antianxiety medication) 2 milligram per milliliter (mg/ml) administer 0.5 ml orally every hour PRN, related to anxiety disorder, dated 04/06/24, and no stop date; - The facility failed to provide a 14 day stop date order for the lorazepam PRN order. 2. Review of Resident #5's July 2024 POS showed: - Diagnoses of schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations) and bipolar disorder (a mental disorder that causes unusual shifts in mood); - An order for paroxetine (an antidepressant medication) tablet 40 mg orally once a day for bipolar disorder, dated 02/14/22, discontinued on 07/11/24; - An order for trazodone (an antidepressant medication) tablet 150 mg orally once a day for bipolar disorder, dated 02/14/22; - An order for quetiapine (an antipsychotic medication) 400 mg orally at bedtime for schizophrenia, dated 08/22/23. Review of the resident's Pharmacist's Medication Regimen Review (MRR), dated 11/24/23, showed: - Paroxetine 40 mg daily, quetiapine 400 mg hours of sleep, and trazodone 150 mg at bedtime. Last GDR evaluation, dated 12/2022; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diagnoses of bipolar and schizophrenia; No physician response documented. 3. Review of Resident #31's June 2024 POS, showed: - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), and generalized anxiety disorder (persistent worry and fear about everyday situations); - An order for buspirone (an antianxiety medication) tablet 15 mg oral three times a day, for generalized anxiety disorder, dated 06/20/22; - An order for trazodone tablet 50 mg oral at bedtime, for depression, dated 06/17/22; - An order for sertraline (an antidepressant medication) tablet 25 mg oral give one 25 mg tablet by mouth daily with a 50 mg tablet to equal 75 mg daily, for depression, dated 02/23/23; - An order for risperidone (an antipsychotic medication) tablet 0.25 mg oral once a day, for dementia. Review of Pharmacy Consultant progress notes, dated 01/20/23 through 07/23/24, showed: - On 02/18/23, 04/08/23, 07/10/23, 01/23/24, and 03/18/24, a note to see report for recommendation; - No documentation of the recommendations or the results of the recommendations for the notes of 02/18/23, 04/08/23, 07/10/23, 01/23/24, and 03/18/24. No GDR documentation provided by the facility. 4. Review of Resident #33's July 2024 POS showed: - Diagnoses of Alzheimer's disease (progressive mental deterioration) and hospice services; - An order for lorazepam 2 mg/ml administer 0.5 ml orally every hour PRN related to anxiety disorder, dated 06/25/24, and no stop date; - An order for quetiapine tablet 25 mg 1 1/2 tablets orally at bedtime related to anxiety disorder, dated 08/22/23; - The facility failed to provide a 14 day stop date order for the lorazepam PRN order; - The facility failed to provide an appropriate diagnosis for quetiapine; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/15/24 at 8:10 A.M., the ADON said the MDS nurse and herself were responsible for the MRR's received from the pharmacist consultant via email. Whoever received them was who emailed them to the physicians. She was not sure when GDR's should be completed. She said chart audits were completed by the Registered Nurse (RN). During an interview on 07/15/24 at 8:15 A.M., the Administrator said MRRs were received from the pharmacist consult and they emailed them to the physicians. They could email them a dozen times, but the physicians don't always address them. They could only keep sending them to the physicians. During an interview on 07/15/24 at 4:30 P.M., the Administrator said MRR's and GDR's were emailed from the pharmacist consultant, and then they were emailed to the physicians. The ADON and MDS Coordinator emailed them to the physicians. If it was a week or two and no response, she would get them and try her best to get answers. 46521 47445

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37575 Based on interview and record review, the facility failed to properly monitor the refrigerator temperatures for stored medications, including insulin (medication used to treat diabetes). This had the potential to affect all residents. The facility census was 40. Review of the facility's policy titled, Refrigerator Temperature, undated, showed: - All refrigerators being used for resident medication must be checked daily for temperature; - Task should be completed every night by night shift nurse; - Temperatures will be logged in the temperature log binder located at the nurses station; - This is mandatory and regulation; - Temperature should range between 36 - 42 degrees. If it is not correct, please adjust the temperature and recheck it within your shift. Review on 07/12/24 at 2:47 P.M., of the Refrigerator Temperature Logs for the Nurse Medication Room, the Medication Technician #1 room and the Medication Technician #2 room showed: - For 04/01/24 - 04/30/24, no documentation of the refrigerator temperatures for 04/01/24, 04/07/24, 04/13/24, 04/14/24 and 04/28/24, with five out 30 opportunities missed; - For 05/01/24 - 05/31/24, no documentation of the refrigerator temperatures for 05/01/24, 05/04/24, 05/05/24, 05/09/24, 05/11/24, 05/12/24, 05/13/24, 05/23/24, 05/26/24, 05/27/24, 05/28/24, 05/29/24, 05/30/24, 05/31/24, with 14 out of 31 opportunities missed; - For 06/01/24 - 06/30/24, no documentation of the refrigerator temperatures for 06/01/24 - 06/09/24, 06/13/24 - 06/30/24, with 27 out of 30 opportunities missed; - For 07/01/24 through 07/10/24, no documentation of the refrigerator temperatures for 07/05/24, 07/06/24, 07/07/24, with three out of 10 opportunities missed; - For 07/01/24, of the Nurse Medication room, the temperature documented at 44 degrees; - For 07/04/24, the Medication Technician #2 room, the temperature documented at 48 degrees; - The facility failed to monitor and document refrigerator temperatures and to follow up on the out of range temperatures. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/15/24 at 3:52 P.M., the Assistant Director of Nursing (ADON) said the refrigerator temperatures should be checked nightly by the charge nurse. If a temperature was not in range, the setting should be adjusted and rechecked on the same shift. It should be reported if it didn't come within range. She was responsible for monitoring the logs. During an interview on 07/15/24 at 05:07 P.M., the the Administrator said she expected the refrigerator temperatures to be checked nightly, and it was the night charge nurse's responsibility. The ADON was in charge of the refrigerator temperatures.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 45693 Based on interview and record review, the facility failed to ensure written transfer agreements with hospitals were in effect to assure residents of a timely hospital admission when medically appropriate and the necessary information would be exchanged between the providers. This failure had the potential to affect all residents. The facility census was 40. The facility did not provide a policy on transfer agreements. The facility did not provide transfer agreements with any hospitals. During an interview on 07/15/24 at 5:00 P.M., the Administrator and the Assistant Director of Nursing (ADON) said the corporate Quality Assurance Registered Nurse could not find transfer agreements for any hospitals. The Administrator said she had no knowledge of transfer agreements with any hospitals.

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 45693 Based on interview and record review, the facility failed to provide written notice to the State agency responsible for licensing the facility when their Director of Nursing (DON) was no longer employed. This had the potential to affect all resident. The facility census was 40. Review of the Facility Assessment, dated 03/07/24, showed: - DON should work five days a week for eight hours; - Licensed Nurses should include a Registered Nurse (RN) eight hours per day when the Director of Nursing (DON) is not available and on weekends. Review of RN I's employee record showed: - RN I hired as the DON on 06/29/22, and a termination date of 05/18/23. Review of RN J's employee record showed: - RN J hired as the DON on 11/08/23, and a termination date of 12/11/23. Review of the last state agency Change of DON Form, dated 07/07/22, showed RN I started employment as the DON on 06/29/22. Review of the nursing schedules, dated 04/06/24 - 07/15/24, showed: - No documentation of a DON scheduled for 04/06/24 - 07/15/24; - No documentation a DON worked 04/06/24 - 07/15/24, with 107 out of 107 days missed. During an interview on 07/15/24 at 5:00 P.M., the Administrator said the facility did not have a DON. The last DON that worked was back in November 2023.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 45693 Based on interview and record review, the facility failed to establish a written agreement with hospice (health care that focuses on the quality of life of a terminally ill person) for two Residents (Resident #3 and #33) out of eight sampled residents. The facility census was 40. The facility did not provide a policy on hospice services. 1. Review of Resident #3's medical record showed the resident admitted to hospice services on 04/05/24. Review of the resident's hospice care plan, dated 04/05/24, showed the resident admitted to hospice services on 04/05/24. The facility did not provide a hospice agreement with the resident's hospice service provider. 2. Review of Resident #33's medical record showed the resident admitted to hospice services on 03/19/23. Review of the resident's hospice care plan, dated 03/19/23, showed the resident admitted to hospice services on 03/19/23. The facility did not provide a hospice agreement with the resident's hospice service provider. During an interview on 07/15/24 at 5:00 P.M., the Administrator said the facility did one time agreements with hospice providers that weren't the primary company the facility used for hospice services. Both Residents #3 and #33 were using a hospice provider that would require a one time agreement and the facility did not have one time agreements for those two hospice residents. There should have been one time agreements completed upon admitting the residents into the hospice program.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 45693 Based on interview and record review, the facility failed to have a Quality Assurance and Performance Improvement (QAPI - a program to improve the processes for the delivery of health care and quality of life for the residents) program in place with policies and protocols describing how the facility will identify and correct its own quality deficiencies. This deficient practice had the potential to affect all residents in the facility. The facility census was 40. The facility's policy titled, QAPI Plan, dated, September 2022 showed: - The purpose of our facility's QAPI plan is to take a proactive approach to promote excellence in quality of care, quality of life, resident directed care and resident choice incorporating staff, care partners, and family; - The QAPI program will be developed with governance and leadership; - The governing body ensures staff accountability; - Performance indicators for all QAPI-designated goals will be established; - At a minimum, the leadership will report annually on the status of the current QAPI plan as well as the proposed QAPI plan and goals for the coming year; - At a minimum, the QAPI Steering Committee will report the progress on the established QAPI goals, cycles, and current data trends; - On a quarterly basis, data will be collected and reported to the QAPI Sterring Committee. Review of the facility's QAPI binder showed the facility did not follow their QAPI plan that contained the necessary policies and protocols describing how they would identify and correct their quality deficiencies, track and measure performance, and establish goals and thresholds for performance measurement. The last documented QAPI meeting, was dated 02/21/24. During an interview on 07/12/24 at 12:55 P.M., Administrator said the last QAPI meeting had been on 02/21/24, and the facility not held one since. Their QAA meetings were daily with their morning meetings with the department heads. QAPI meetings should be held quarterly and more if needed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45693 Based on interview and record review, the facility failed to ensure the Quality Assurance/Quality Assurance Performance Improvement (QAA/QAPI - a program to improve the processes for the delivery of health care and quality of life for the residents) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies using a Performance Improvement Project (PIP). This had the potential to affect all residents in the facility. The facility census was 40. Review of the facility's policy titled, QAPI Plan, dated September 2022, showed: -The QAPI committee annually prioritizes activities, endorses or re-endorses policies and procedures, and continually monitors for improvement through the use of a QAPI self-assessment; - The QAPI Steering Committee will implement any PIP topics indicated by data analysis; - Quality improvement activities are also developed in collaboration with the support of providers, residents, families, and staff; - PIPs are implemented in accordance with Centers for Medicare and Medicaid (CMS - a government agency) protocols for conducting PIPS. Review of QAPI binder showed no documentation the facility maintained the minimum required documentation for a PIP. During an interview on 07/12/24 at 12:55 P.M., the Administrator said she did not know what a PIP was. She had not done any PIPs since becoming administrator and had no documentation of previous PIPs.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45693 Based on interview and record review, the facility failed to maintain quarterly Quality Assurance and Improvement Program (QAPI - a program to improve the processes for the delivery of health care and quality of life for the residents) committee meetings with the required members. The facility census was 40. Review of the facility's policy titled, Quality Assurance and Improvement Plan (QAPI Plan), dated September 2022,showed it did not address the specific members required for the QAPI committee. Review of the QAPI attendance sheets, dated 02/21/24, showed the Director of Nursing (DON) did not attend the QAPI meeting. During an interview on 07/12/24 at 12:55 P.M., the Administrator said the last QAPI meeting was on 02/21/24. The DON did not attend the QAPI meeting because the facility hasn't had a DON since November 2023. The QAPI committee did require the DON to be a required member.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 The facility failed to provide appropriate documentation of tuberculosis (TB-an infectious bacterial disease that affects the lungs) testing for four residents (Resident #1, #24, #30 and #42) out of five sampled residents. The facility failed to perform hand hygiene and glove changes during wound care for one (Resident #34) out of two residents and incontinent care for one (Resident #245) out of four residents. The facility failed to develop and implement a risk management process specific to Legionella disease (a serious type of pneumonia caused by Legionella bacteria) which had the potential to affect all residents, staff, and the public. The facility also failed to provide an annually reviewed Infection Prevention and Control Program (IPCP - an antibiotic stewardship log that indicated the name of the infectious pathogen or copies of labs/radiology reports.) The facility's census was 40. Review of the facility's policy titled, Surveillance, undated, showed: - The primary purpose of infection control surveillance is the collection of information for action; - All long term care facilities must have infection control policies which are made evident to all new employees at time of orientation; - Long term care facilities should have active, effective infection control programs which include weekly surveillance for nosocomial (acquired in the facility) infections and multiple resistant organisms; - A facility's surveillance policies and procedures should be reviewed and updated on a yearly basis to assure appropriateness and effectiveness in reducing specific body site infections or number of infections with specific organisms; - A facility's surveillance system must include the reporting of infectious diseases as required by the Missouri Department of Health; - A facility's surveillance system should include monitoring for appropriate antibiotic use, a positive culture in a person without clinical symptoms rarely requires treatment with antibiotics; - Long term care facilities should request their laboratory to notify the Director of Nursing (DON) of all positive cultures with a multiple resistant organism or laboratory data indicative of a reportable disease. Tracking these includes keeping records of dates when the resident changes rooms or roommates and also monitoring resident activities or exposures; - It is important to track and follow trends of infection data related to both residents and staff on a monthly basis and presented to the appropriate committee on at least a quarterly basis; - Assessments of all residents for any/all changes in symptoms or conditions which may be indicative of infection should be performed on an ongoing basis; example, clinical observations, house reports, chart review, culture reports; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Indications of infection in the elderly may vary and include presence of delirium (acute confusion state), worsening in function of activities of daily living (ADL's), and falls; - In accordance with Department of Health, all residents new to long term care who do not have documentation of a previous skin test, should have the initial test a purified protein derivative (PPD - a skin test to used to diagnose TB infection two-step test to rule out TB within one month prior to or one week after admission. Thereafter, the resident is only retested following exposure or clinical symptoms. Review of 19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities and State Correctional Centers, revised 01/29/23, showed: - For Long-Term Care Residents: Within one month prior to or one week after admission, all residents new to long-term care are required to have the initial test of a Mantoux PPD two-step tuberculin test. If the initial test is negative, zero to nine millimeters (mm), the second test, which can be given after admission, should be given one to three weeks later. Documentation of a chest X ray evidence ruling out tuberculosis disease within one month prior to admission, along with an evaluation to rule out signs and symptoms compatible with infectious tuberculosis, may be accepted by the facility on an interim basis until the Mantoux PPD two-step test is completed; - All residents of long-term care facilities who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease. Review of the Division of Community and Public Health, Section 2.0 Testing for Latent Tuberculosis Infection, revised May 2020, showed: - Interpretation of Tuberculin Skin Test (TST) reactions should be conducted within 48 to 72 hours after administration by a trained health care professional. If the test is not read within the 48 to 72 hour window, it must be repeated. - Patients or family members should not interpret or read TST results. Review of Guidelines for Screening for Tuberculosis in Long Term Care Facilities, dated, May 2015, showed: - Annual skin tests for residents with documented results less than 10 millimeters are not required. 1. Review of Resident #1's medical record showed: - admitted on [DATE]; - No documentation of annual screenings for 2023 or 2024. Review of Resident #24's medical record showed: - admitted on [DATE]; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Initial TST administered on 07/26/23, and read on 07/26/23; - The facility failed to allow enough time between the administration and the read date for the TST. Review of Resident #32's medical record showed: - admitted on [DATE]; - No documentation of sign and symptoms in 2023. Review of Resident #36's medical records showed: - admitted on [DATE]; - No documentation of two step TST. Review of the facility's policy titled, Gloves, undated, showed: - Wear gloves when it can be reasonably anticipated that hands will be in contact with mucous membranes, nonintact skin, any moist body substances (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, or items/surfaces soiled with these substances) and/or persons with a rash. Gloves must be changed between residents and between contacts with different body sites of the same resident; - Dirty gloves are worse than dirty hands because microorganisms adhere to the surface of a glove easier than to the skin on your hands. Handling medical equipment and devices with contaminated gloves is not acceptable; - Change gloves between contacts (as defined above) with different residents or with different body sites of the same resident. 2. Review of Resident #34's medical record showed: - Care Plan, last revised on 04/24/24, showed the resident with a wound to the coccyx (small triangular bone at the base of the spine). The wound will be followed by the consulting wound care clinic and treatment orders followed; - An order to lightly wet plain packing strip with Vashe (a wound cleanser), apply collagen (helps promote tissue growth) to strip and pack wound with collagen strip once a day, dated 06/19/24; - An order to soak the wound to the coccyx with Vashe before the wound treatment, dated 06/19/24; - An order to cut Polymem (a dressing that will constantly cleanse the wound bed, while also managing drainage) to size and place over the wound tissue and cover with bordered gauze daily, dated 06/27/24. Observation on 07/10/24 at 1:00 P.M., of the resident's wound care showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Licensed Practical Nurse (LPN) P performed hand hygiene and put on gloves; - LPN P removed the resident's wet brief, removed gloves, washed hands, and put on new gloves; - LPN P applied Vashe wound cleanser to gauze and held it to the wound for 30 seconds; - LPN P didn't change gloves or perform hand hygiene, soaked the packing strip with Vashe wound cleanser, and applied Santyl (a wound debridement) to the packing strip; - LPN P opened a cotton applicator, removed the gloves, did not perform hand hygiene, and put on new gloves; - LPN P cleansed the scissors with a disinfectant wipe, LPN failed to change gloves or perform hand hygiene; - LPN P did not change gloves or perform hand hygiene, measured the wound, packed the wound with Vashe soaked packing gauze, and Santyl applied packing; - LPN P did not perform hand hygiene, changed gloves and applied Polymem with non-bordered gauze; - LPN P changed gloves but did not perform hand hygiene, initialed and dated the dressing, and placed a clean brief on the resident; - LPN P failed to change gloves and perform hand hygiene when going from dirty to clean care. During an interview on 07/10/24 at 1:30 P.M., LPN P said he/she didn't change gloves or wash hands like he/she should because the resident was getting tired of standing. He/She had been told it was easier to do the wound treatment with the resident standing up in front of the sink and holding on to it. During an interview on 07/11/24 at 10:30 A.M., the Assistant Director of Nursing (ADON)said gloves and hand hygiene should be done at the start, when going from dirty to clean care, and at the end of wound care. During an interview on 07/11/24 at 4:15 P.M., the Corporate Quality Assurance (QA) Registered Nurse (RN) said gloves should be changed when going from dirty to clean care for wound care. Hands should be sanitized with glove changes. During an interview on 07/11/24 at 4:17 P.M., the Administrator said physician orders should be followed and hand hygiene and glove changes should be done as expected. 3. Observation on 07/10/24 at 8:13 A.M., of Resident #245's incontinent care showed: - Certified Nurse Assistant (CNA) O and CNA N did not perform hand hygiene, put on gloves, and transferred the resident to the bed from the wheelchair via a Hoyer lift (a mechanical lift) to the bed; - CNA N rolled the incontinent pad soaked with urine to the back of the wheelchair seat; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA N removed the gloves, did not perform hand hygiene, left the room to retrieve trash bags, returned to the room, did not perform hand hygiene, placed a trash bag in the trash can, did not perform hand hygiene, left the room to retrieve wipes, returned to the room, did not perform hand hygiene, and put on gloves; - CNA O assisted the resident to roll to the side, removed the Hoyer lift pad soaked with urine, and the resident wore a brief soaked with urine and fecal material; - With the same soiled gloves, CNA O touched the peri wash spray bottle, sprayed the wipes, wiped the resident's groin and front peri area, discarded a wipe soiled with fecal material in the trash, did not change gloves or perform hand hygiene, retrieved a new wipe from the package, and touched the resident's hip to assist the resident to roll to the other side; - CNA N used a wipe to clean fecal material from the resident's buttocks; - With the same soiled gloves CNA N retrieved and opened a clean brief, removed the brief and incontinent pad soiled with urine and fecal material, and placed them in trash bags; - With the same soiled gloves, CNA O touched the package of wipes, removed a wipe, cleaned fecal material from the resident's right leg and buttock area, folded the wipe and wiped from the resident's front peri area to the gluteal cleft; - With the same soiled gloves, CNA N placed a clean brief under the resident; - With the same soiled gloves, CNA O used a clean wipe to clean the resident's front peri area and groin; - With same soiled gloves, CNA N fastened the brief, touched the sheet and blanket to cover the resident, touched the call light, removed the gloves, did not perform hand hygiene, removed the trash bags with soiled linens and trash, touched the inside doorknob, touched the lids of the bins in the hall to open them and place bags inside, and performed hand hygiene; - With same soiled gloves, CNA O touched call light cord and the privacy curtain, removed the gloves, did not perform hand hygiene, picked up the resident's oxygen tubing off of the oxygen concentrator, placed the nasal cannula (NC - flexible plastic tubing that delivers supplemental oxygen) into the resident's nose, and performed hand hygiene. During an interview on 07/10/24 at 8:32 A.M., CNA N said gloves should be put on before providing care. Should change gloves when dirty with fecal material or urine, when moving from dirty to clean care, and when going to different parts of the body. During an interview on 07/10/24 at 8:37 A.M., CNA O, said hands should be sanitized before going into a room or starting care. Gloves should be put on, should wipe front to back during incontinent care, and should clean the resident's front side first, change gloves, roll the resident, and clean the back side. Should change gloves if soiled and change gloves when going from dirty to clean care. Should wash hands when done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. No documentation of a water management program in place to monitor for Legionella bacteria in water provided. During an interview on 07/15/24 at 12:37 P.M., the Maintenance Supervisor said he/she hadn't heard of a water management program, didn't have one, and hadn't heard of Legionella. He/She checked water temperatures in one or two random rooms on each hall once a week and documented them. He/She didn't check empty rooms. During an interview on 07/15/24 at 3:30 P.M., the Administrator said they had a water management program, and knew maintenance checked water temperatures. 5. Review of the IPCP/Antibiotic Stewardship Binder showed: - No annually reviewed IPCP; - An outdated list of reportable communicable diseases reportable dated 2016; - Monthly logs from January 2024 through June 2024, showed the facility failed to identify the pathogen name itself; - The facility failed to provide the name of the antibiotics administered; - No documentation of the lab and radiology no. During an interview on 07/12/24 at 11:00 A.M., the Infection Preventionist (IP) said if the IPCP wasn't located in the binder, then he/she didn't have it because the binder was the only thing he/she was given. He/She used the same papers as the previous IP did and hadn't been told to do anything more or different. During an interview on 07/12/24 at 4:00 P.M., the Corporate QA RN said the facility should have an IPCP. The name of the pathogen should be indicated and results of labs/radiology reports should be part of the binder. 47445

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 45693 Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year for two Certified Nurse Assistants (CNA) (CNA G and CNA H) out of two sampled CNAs. The facility's census was 40. The facility did not provide a policy regarding annual training. Review of the facility assessment, dated 03/07/24, showed staff competencies and annual training requirements per regulatory authority and/or facility policy to include: abuse, neglect, exploitation and misappropriation, care/ management for persons with dementia, infection control, culture change, person centered care, disaster planning, communication, and resident rights. 1. Review of CNA G's employee record, dated November 2022 through November 2023, showed: - Hire date of 11/08/22; - No documentation of any annual in-service trainings provided; - The facility failed to provide CNA G with at least twelve hours of in-service education for November 2022 through November 2023. 2. Review of CNA H's employee record, dated September 2022 through September 2023, showed: - Hire date of 09/05/19; - Documentation of eight topics provided for annual in-service trainings; - No documentation of the length of time for each in-service provided; - The facility failed to provide CNA H with at least twelve hours of in-service education for September 2022 through September 2023. During an interview on 07/15/24 at 5:00 P.M., the Administrator and Assistant Director of Nursing (ADON) said aides should have 12 hours of training annually. The trainings should include abuse and neglect, dementia, and any issues found with the specific CNA. 47445