

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview and record review, the facility failed to ensure five residents (Resident #61, #100, #31, #67 and #91) in a review of 34 sampled residents, and two additional residents (Resident #27 and #40), were treated in a manner to maintain dignity and respect, or honor the right to make choices. The facility census was 116. Review of the facility's policy, Dignity and Respect, revised on 06/29/23, showed the following: -The purpose of the policy is to ensure that every resident is treated with dignity and respect; -Every resident has a right to be treated with dignity and respect; -All staff will speak to and treat all residents with dignity and respect; -Residents have the right to retain and use personal possessions to assist each resident in maintaining their independence, subject to reasonable limitations to protect the health and safety of residents and space limitations. 1. During the group resident council, on 03/06/24, at 1:04 P.M., various residents said the following: -They do not feel like they can file a grievance, or call in a complaint to the abuse hotline without fear of retaliation. They feel like if they call the state hotline they will be discharged ; -All of the night shift has a bad attitude and yell at the residents; -Certified Nurse Aide (CNA) V likes to yell and belittle the residents. 2. Review of Resident #67's face sheet showed he/she had diagnoses that included schizoaffective disorder (mental illness), bipolar disorder (mental illness), anxiety disorder, personality disorder and major depressive disorder. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/9/23, showed the resident had mild cognitive impairment, understands others and has clear comprehension. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, revised 12/22/23, showed staff was to provide positive feedback and reinforcements. During an interview on 3/5/24 at 12:11 P.M., the resident said the following: -Licensed Practical Nurse (LPN) Z and the Director of Nursing can be short, hateful and rude; -Often times he/she feels ignored and like they do not care to help him/her. Observation on 3/7/24 at 12:54 P.M. at the nurses' station showed the following: -The resident asked CNA V if he/she could get extra (extra food after the meal); -CNA V told the resident with a raised voice, I am tired of going back and forth to the kitchen. I've been back and forth four times!; -When CNA V spoke to the resident, the resident dropped his/her eyes and his/her head; -LPN Z intervened and told the resident he/she would go get him/her a sandwich. During an interview on 3/7/24 at 12:55 P.M., the resident said the following: -He/She didn't know CNA V had been up to the kitchen four times; -He/She guessed he/she asked CNA V at the wrong time. It was his/her (the resident's) fault for the way CNA V reacted; -That is the way CNA V normally responded to the residents. During an interview on 3/7/24 at 1:02 P.M., LPN Z said the following: -He/She witnessed how CNA V responded to the resident; -He/She felt like CNA V's response was rude and inappropriate; -CNA V often acted that way; -CNA V should not respond that way to a resident. 3. Review of Resident #27's care plan, dated 10/11/23, showed the following: -The resident has a communication problem related to hearing deficit; -The resident is able to understand verbal communication and is understood. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No behaviors; -Diagnoses of depression, schizophrenia (mental illness) and post traumatic stress disorder (PTSD; a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). During an interview on 3/7/24 at 12:36 P.M., the resident said the following: -CNA V yelled at residents if residents ask for an alternate before all the trays are passed; -He/She doesn't like yelling so he/she walks away and doesn't get extras. 4. Review of Resident #40's care plan, revised 8/31/23, showed the following: -The resident has a history of behavioral challenges that require protective oversight in a secure setting; -The resident has a history of temper outbursts that can lead to property damage. He/She can be verbally and physically aggressive towards others. He/She will hit windows when he/she is upset. He/She has poor impulse control. He/She will ask the same questions repeatedly and does not stop with redirection; -The resident has many childlike behaviors and will have outbursts when he/she doesn't get his/her way; -The resident has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others; -If resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others; Review of the resident's quarterly MDS dated [DATE] showed the following: -Moderately impaired cognition; -Usually understood others. -No behaviors; -Diagnoses of anxiety, depression, manic depression and schizophrenia. During an interview on 3/7/24 at 5:45 P.M., the resident said the following: -He/She didn't get the two juices he/she asked for at supper; -If he/she tells CNA V, CNA V will just yell at him/her; -CNA V yells and curses at us all the time and he/she doesn't like it. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She spoke to CNA V on 3/7/24 about his/her tone of voice and educated him/her on acting with kindness; -She has had residents complain about CNA V being rough/short (verbally) with them before and she has talked with CNA V about this. During interview on 03/13/24, at 2:40 P.M., the administrator said the following: -He would expect staff to treat residents with respect and dignity at all times; -It would not be appropriate for staff to yell or curse in the presence of residents; -Residents should be able to make a grievance or complaint to the hotline without fear of retaliation from staff. MO231300 36219 41412 42592		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41412 Based on observation, interview and record review, the facility failed to protect the residents' right to retain and use personal possessions, including instant coffee, when the facility kept residents' instant coffee locked up in the medication room and controlled the times the residents could access their coffee. This affected three residents (Residents #31, #91 and #106), in a review of 34 sampled residents, and four additional residents (Residents #50, #56, #60, and #75). The facility held coffee for eight residents. The facility census was 116. Review of the facility's policy, Resident's Rights, revised on 07/05/23, showed the following: -The purpose of the policy is to ensure that resident rights are protected; -Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility; -Facility must protect and promote rights of each resident; -Resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Review of a posted sign, titled Personal Coffee Times, on the wall just before the 600 hall showed the following: -1:00 P.M. and 6:30 P.M.; -You can only have up to four spoon fulls of coffee which equals a medicine cup full; -The sign was signed by the administrator (no date). Review of another posted sign, no title, on the wall just before the 600 hall and beside the Personal Coffee Times sign, showed all containers of coffee purchased from activities must go behind the desk until 1:00 P. M. and 6:30 P.M. for personal coffee time. Observation on 3/5/24 at 2:53 P.M. and 3/6/24 at 11:40 A.M. and 10:00 P.M., of the locked medication room on the locked secured unit (Station Two), showed a large tote held individual containers of coffee. The lids of the coffee were marked with residents' names, including Residents #31, #91, #106, #50, #56, #60, and #75. During an interview on 3/6/24 at 11:53 A.M., Licensed Practical Nurse (LPN) Z said the following: -The coffee in the large tote belonged to the specific resident whose name was on the lid; the coffee was purchased by the residents or brought in by their families for them; (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents were not allowed to keep their coffee in their rooms; they can keep other snacks if they have totes to keep food in, but the facility does not allow residents to keep their coffee; -In the past, there was a resident who traded coffee for favors. That resident was no longer at the facility. The residents, who the facility currently held coffee for, had not been involved with any of the trading issues; -He/She was not aware of any physician ordered or guardian restrictions regarding any of the resident's coffee; -At 1:00 P.M. and 6:30 P.M., residents who have purchased their own coffee, can come to the medication room to request a medication cup of instant coffee to make coffee with hot water from their sink. 1. Review of Resident #31's face sheet showed he/she had a guardian. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 8/9/23, showed it was very important to the resident to take care of his/her personal belongings or things. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact and did not have a swallowing disorder. Review of the resident's March 2024 physician order sheets (POS) showed the resident was ordered a regular diet, regular texture with thin/regular consistency. During interviews on 3/6/24 at 12:12 P.M. and 3:30 P.M., the resident said the following: -He/She wished he/she could keep his/her own coffee in his/her own room; -He/She had purchased it with his/her own money and did not understand why he/she could not keep it in his/her room; -He/She had a private room, so a roommate that might not be able to have coffee would not get into it; -He/She had a guardian, but did not have any restrictions that he/she was aware of regarding coffee; -He/She did not think his/her physician cared if he/she drank coffee. Review of the resident's medical record showed no documented reason why the resident could not keep his/her own possessions, including coffee. 2. Review of Resident #50's face sheet showed he/she had a guardian. Review of the resident's care plan, revised 2/24/21, showed the resident was ordered a regular diet with regular liquids. (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/24 at 10:30 A.M., the resident said the following: -He/She had coffee, that he/she had purchased, locked up in the medication room; -He/She could only use it when staff said he/she could; -There had been issues in the past with other residents trading coffee, but that did not involve him/her, and he/she did not understand why he/she was being punished for someone else's actions. Review of the resident's medical record showed no documented reason as to why the resident could not keep his/her own possessions, including coffee. 6. Review of Resident #91's face sheet showed the resident had a guardian. Review of the resident's admission MDS, dated [DATE], showed it was somewhat important to the resident to take care of his/her personal belongings or things. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact and did not have a swallowing disorder. Review of the resident's March 2024 POS showed the resident was ordered a regular diet, regular texture with thin/regular consistency. During an interview on 3/5/24 at 12:23 P.M., the resident said the following: -He/She had purchased his/her coffee to drink, but the facility kept it locked up and he/she could only use it at certain times of the day; -He/She was under guardianship and had no restrictions on coffee; -He/She did not understand why he/she could not keep his/her own possessions; -He/She felt controlled when there was no reason for it. Review of the resident's medical record showed no documented reason as to why the resident could not keep his/her own possessions, including coffee. 7. Review of Resident #106's care plan dated 8/8/23 showed the following: -The resident receives a regular diet, has good appetite and enjoys snacks; -Provide and serve diet as ordered. Review of the resident's face sheet showed he/she had a legal guardian. Review of the resident's quarterly MDS dated [DATE] showed the resident was cognitively intact. During an interview on 3/7/24 at 11:22 A.M., the resident said the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His/Her family member sends him/her a check and he/she spends it on coffee; -His/Her coffee was locked up behind the desk and he/she could not use his/her own coffee when he/she wanted; -The residents can only drink their personal coffee at scheduled times; -He/She saves some of his/her coffee to drink at times other than the scheduled times; -When staff are late giving the residents coffee, it causes problems. Some of the residents get aggravated and upset when coffee is served late. Review of the resident's medical record showed no documented reason as to why the resident could not keep his/her own possessions, including coffee. 8. During an interview on 3/8/24 at 5:33 P.M., the Director of Nursing (DON) said the following: -Residents should have access to their own property; -Coffee becomes a currency with the residents; -The residents trade coffee, steal coffee from each other, etc. which is why the coffee is kept locked up. During an interview on 3/13/24 at 2:40 P.M., the Administrator said the following: -Residents should be able to retain their personal property; -The residents were using coffee as coffee shooters, making the coffee too strong, selling the coffee and overusing it resulting in increased behaviors; the residents were using coffee to get a high on caffeine; -The residents agreed in activities to have limited personal coffee so it would last longer too. They came up with guidelines on coffee use that the residents agreed to. The residents agreed verbally to the agreement. Nothing was in writing.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 36219 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of resident needs and preferences for one resident (Resident #81) in a review of 34 sampled residents, when staff did not ensure the resident had an appropriate and comfortable alternative chair to sit in when the resident would request to get out of bed. The facility also failed to provide adequate seating in the Station 2 common/dining area. This affected all residents residing in Station 2. The facility census was 116. Review of the facility policy, Resident Rights, revised 07/25/2023 showed the following: -The resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences; -The resident has a right to be free from chemical or physical restraints. 1. Record review of Resident #81's Physician Order Sheet (POS) showed the resident's wheelchair was to be evaluated for repairs and fixed as needed (order dated 11/07/23). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 12/05/23, showed the following: -Cognitively intact; -Independent decision making ability; -Diagnosis of depression; -No behaviors or rejection of care; -Totally dependent on staff for self-care; -Maximal assist of two staff for bed mobility; -Totally dependent on two staff and a lift for transfers. Review of the resident's Care Plan, dated 12/20/23, showed the following: -Encourage the resident to become engaged in facility life through group activities, meals in dining rooms and therapeutic groups if applicable to needs; -The resident's preferences will be considered when providing care; -The resident prefers to stay in bed unless he/she requests to be gotten up; (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident has limited physical mobility related to multiple sclerosis (MS, a neurological disease where the immune system attacks the nerves, causing loss of motor function, and weakness). Uses a wheelchair and staff propels; -The resident is non-weight bearing; -The resident is totally dependent on one staff for locomotion; -Physical Therapy (PT)/Occupational Therapy (OT) referrals as ordered, PRN (as needed) Observation on 03/05/24 at 11:00 A.M. showed the resident was in bed waiting for lunch. During an interview on 03/05/24 at 11:00 A.M., the resident said the following: -He/She required a Hoyer lift (mechanical lift) and two people to get out of bed; -He/She only got up one time every four or five days; -He/She would like to get up more often; -Staff say they don't have time or they need help, then they never come back; -He/She ate his/her meals in his/her room, but would sometimes like to go to the cafeteria. Observation on 03/06/24 at 10:00 A.M. showed the resident lay in bed sleeping. There was no wheelchair (neither manual or electric) in the resident's room. Observation on 03/06/24 at 10:28 A.M. showed the resident lay in bed sleeping. The resident's electric wheelchair was along the wall in the hall outside the resident's room. During an interview on 03/06/24 at 10:30 A.M., Certified Nurse Assistant (CNA) O said the following: -The resident's custom electric wheelchair was in the hall; -The electric motor wasn't working, and the headrest was broken; -The wheelchair had been broken for one month; -Staff do not get the resident up because the chair is broken and they have no other options for the resident; -He/She has manually pushed the resident in the electric wheelchair before, but it was hard. Observation on 03/06/24 at 11:46 A.M. showed the resident lay in bed asleep. Observation on 03/06/24 at 12:00 P.M. showed the resident was in bed, awake, waiting for lunch. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/07/24 at 1:46 P.M. showed the resident lay in bed awake. During an interview on 03/07/24 at 1:46 P.M., the resident said the following: -He/She asked Nurse Aide (NA) P to get him/her out of bed two hours ago. NA P said he/she needed help and has not been back since; -It had been six days since he/she has been out of bed, other than for a shower two days ago; -When staff got him/her up for the shower, staff put him/her directly in the shower chair, take him/her to the shower, then straight back to his/her room, and put him/her back in bed; -His/Her custom electric wheelchair has been broken for two months; -He/She wants to purchase a new custom wheelchair. Observation on 03/07/24 at 2:00 P.M. showed the following: -NA P entered the resident's room; -The resident requested to get out of bed; -NA P told the resident he/she had to wait for help; -NA P left the room. Observation on 03/07/24 at 2:25 P.M. showed the resident lay in bed awake. During an interview on 03/07/24 at 2:32 P.M., the Activity Director said the following: -The resident's wheelchair has been broken over one month; -The therapy department evaluated the wheelchair and had to call the company to come look at it; -Someone looked at it and said the motor was broken and needed to be replaced; -That is the last she heard before she took over as Activity Director (one month ago), and has not had any updates since then. Observation on 03/07/24 at 2:42 P.M. showed the resident contained to lay in bed awake. Observation on 03/07/24 at 4:58 P.M. showed the resident lay in bed awake. During an interview on 03/07/24 at 4:58 P.M., the resident said staff never returned to get him/her out of bed. Observation on 03/08/24 at 10:00 A.M. showed the resident lay in bed asleep. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/08/24 at 1:46 P.M. showed the resident lay in bed awake. During an interview on 03/08/24 at 1:46 P.M., the resident said the following: -He/She wanted to be out of bed more; -He/She asked staff again today to get out of bed and nothing has been done; -He/She can still sit in his/her wheelchair and it can be used manually; the motor just doesn't work; -The alternate wheelchair they tried hurt to sit in for long periods of time; -He/She would like to go to the cafeteria for meals and to go outside to smoke; -Being stuck in bed and in his/her room, makes him/her feel claustrophobic and trapped. During an interview on 03/08/24 at 12:18 P.M., Physical Therapist (PT) Q said the following: -The Therapy Director said the power module for the resident's wheelchair needed to be replaced. They are waiting for insurance approval to replace it; -According to the Therapy Director, the resident's wheelchair can still be used manually. During an interview on 03/08/24 at 3:30 P.M., CNA K said the following: -The resident's wheelchair did not work; -It can be pushed manually, but it's very hard; -The resident has another chair available to use, but the resident complains it is uncomfortable, so he/she doesn't want to use it. During an interview on 03/08/24 at 3:34 P.M., Occupational Therapist (OT) R said the following: -If nursing identifies a problem with the custom wheelchair, they notify therapy; -Therapy will request in-house maintenance to evaluate the custom wheelchair; -If a minor problem that maintenance can fix, they will fix it; -If a more serious problem that maintenance cannot fix, therapy will call the vendor to schedule an assessment; -Pending findings of the vendor assessment, therapy will help coordinate insurance approval for repairs and/or replacement. During an interview on 03/19/24 at 1:14 P.M., the Therapy Director said the following: (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The typical process for custom wheelchair repairs is nursing notifies therapy of the issue and she then calls the wheelchair company for an evaluation. The evaluation usually occurs within one to two weeks of her calling. After the evaluation is completed, if repairs are needed, they will proceed with getting a physician face-to-face documentation and start the paperwork process; -The longest part of the repair process is getting the paperwork and approval from insurance; this can take anywhere from a few weeks to months, depending on the type of insurance and repairs; -She found out about the resident's broken wheelchair in passing when she went to borrow the charger for his/her wheelchair. Staff said it was okay to use the charger as the resident's wheelchair was not working anyway; -She requested an evaluation from the wheelchair company on 11/21/23; -The evaluation took place the week of 12/11/23; -No repairs have been scheduled; waiting for insurance approval; -The therapy department keeps alternative wheelchairs to use if there are issues with the residents' personal wheelchairs; -Typically, a resident using a custom wheelchair would need an evaluation to determine what alternative wheelchairs available would be appropriate; -She was not notified of the resident using an alternative wheelchair or being uncomfortable in the alternate wheelchair used; -The resident's custom wheelchair can be switched to manual mode and used safely. During an interview on 03/08/24 at 6:13 P.M., the Director of Nursing (DON) said the following: -She expected staff to get residents out of bed, if they requested to; -She expected staff to either use the broken, but safe to sit in and use, wheelchair, or find an alternative; -There are other wheelchairs available to get residents up, if necessary; -She would not expect staff to manually push a resident in a non-functioning electric wheelchair as they are very heavy and his/her staff are very small. During an interview on 03/13/24 at 2:40 P.M., the Administrator said the following: -He expected staff to get residents out of bed, if they requested to; -He was not aware the resident's wheelchair was not functional; (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the case of a broken wheelchair, he would expect maintenance to check the wheelchair to see if they could fix it. If maintenance was not able to fix it, he would expect steps to be taken to fix the wheelchair or come up with a solution; -He expected staff to get the resident up to the broken, but safe for use, wheelchair over an alternate, if the resident says it is more comfortable. -He expected the staff to manually push the non-functioning electric wheelchair, if the resident requested it. During an interview on 03/21/24 at 3:07 P.M. the primary physician said the following: -He would expect staff to get residents out of bed; -He would expect staff to get a resident out of bed, even if the electric wheelchair was broken, but safe for use. 2. Observation on 3/6/24 at 12:40 P.M. in the Station 2 common area showed the following: -Staff served meal trays; -Seven residents were unable to sit at the tables due to lack of space at the table and not enough dining room chairs. -The seven residents sat in high back chairs that lined the walls with their trays sitting on their laps or on the arms of the chairs. Observation of the locked, secured unit (station 2) dining room/common area, on 3/6/24 at 12:40 P.M., showed Resident #69 sat in a high back chair with his/her lunch tray on his/her lap eating his/her meal. There were no available seats at any of the dining room tables for the resident to sit in and eat his/her meal. During an interview on 3/6/24 at 12:40 P.M., Resident #69 said there was never enough chairs at tables for residents to sit at a table and eat. You have two choices, wait and risk having your meal tray being given to someone else because you are not there to get your tray (if you wait for others to eat, opening up a place at a table) or eat with your tray on your lap. He/She would rather eat at a table in a regular dining room chair than in a chair with a tray on his/her lap. Observation of the locked, secured unit (station 2) dining room/common area, on 3/6/24 at 12:47 P.M., showed Resident #109 sat in a high back chair with his/her lunch tray on his/her lap eating his/her meal. There were no available seats at any of the dining room tables for the resident to sit in and eat his/her meal. During an interview on 3/6/24 at 12:50 P.M., Resident #109 said there were not enough open spaces or chairs for all residents to sit at the tables during meal time. He/She does not like sitting with his/her meal tray on his/her lap to eat but does not feel he/she has a choice. Sometimes it is a balancing act and it is difficult to not spill or knock off your tray. If you wait for there to be seating to eat, then your food gets cold. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the locked, secured unit (station 2) dining room/common area, on 3/6/24 at 12:55 P.M., showed Resident #36 sat in a high back chair with his/her lunch tray on his/her lap eating his/her meal. There were no available seats at any of the dining room tables for the resident to sit in and eat his/her meal. During an interview on 3/6/24 at 1:04 P.M., Resident #36 said he/she did not see an open spot at a table to be able to sit down and eat. Sometimes he/she was able to sit at a table and sometimes he/she was not; it just depended on when you came to the dining room to eat and if others had cleared out yet or not. Review of the resident roster on 3/6/24 showed 59 residents resided on the locked, secured unit (station 2). None of those residents were in the hospital or on leave. There was one open bed on the unit. The unit could hold 60 residents when at full capacity. Observation of the locked, secured unit (station 2) dining room/common area, on 3/6/24 at 9:55 P.M., showed there were 14 square tables that could seat four people each, making available seating for 56 people. There were only 39 dining room chairs available for seating at the tables. During an interview on 3/8/24 at 8:00 A.M. the Maintenance Supervisor said he was not aware there were not enough chairs for the residents (in Station 2) to sit in during meal time. During an interview on 3/8/24 at 5:33 P.M. the Director of Nursing (DON) said there should be an adequate number of chairs for all the residents in Station 2. 50189		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on interview and record review, the facility failed to act promptly and follow up with a response to residents' concerns that were voiced in resident council meetings. The facility also failed to have monthly resident council meetings. The facility census was 116. Review of the resident council meeting minutes, dated 12/2023, showed the following: -Station one: -No old business listed; -New business concerns: one resident needing clothes out of storage, laundry shrinking clothes, missing nightgown and socks; -Request for dietary to serve frozen fruit; -There was no documentation of the concerns being communicated to the staff for resolutions; -No documentation of a resolution related to the concerns; -Station two: -Old business: unclear as to what this was referring to, just listed a few resident names and winter coat; -Concern of vending machine taking money, therapy with two residents listed with a question mark, two residents needing new glasses, one wants off crushed medications, two staff members listed as being mean and hateful, maintenance issues with drawers broken for one resident, maintenance issue of one resident's toilet leaking, missing laundry (Chiefs long sleeve shirt, Chiefs pants, [NAME] jersey, Mossy Oak t-shirt, sweats - red with a stripe, socks, pants, underwear, [NAME] pants, [NAME] Mouse pants and a Navy Seal hat); -Request for dietary for one resident requesting milk, one resident requesting oatmeal, and the request for more Reubens; -There was no documentation of the concerns being communicated to the staff for resolutions; -No documentation of resolution related to the concerns. The facility did not provide minutes for a January 2024 resident council meeting as one was not held for station one or station two. Review of the resident council meeting minutes, dated 02/2024, showed the following: (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Director of Nursing (DON), activity director, resident care coordinator and social services director were in attendance; -Twenty-six residents in attendance from Station two; -Old business was resolved (no indication of what old business was); -New business listed one concern regarding guardianship with a notation that social services has been working with the resident on this concern; -Notation at end of meeting minutes: All resident names will be given to the department head with whom they wish to speak. Administrator will be made aware of all requests and designated department head will follow-up with resident requests; -No indication of a resident council meeting was held with station one for February 2024. During resident council group interview on 03/06/24, at 1:04 P.M., residents in attendance said the following: -The residents who resided in station one did not remember when the last resident council meeting occurred, but did not feel like one had occurred for a couple of months; -The residents who resided in station two reported many issues had been brought up in the recent past that have not been resolved at this point; -Resident council is done spur of the moment with no specific schedule, and no specific agenda; -If there was a specific agenda and a schedule, it would be easier to get problems or concerns together to present during resident council. During an interview on 03/07/24, at 12:01 P.M. and 3/8/24 at 12:44 P.M. the Activity Director (AD) said the following: -She had only been in the position for about a month; -If a complaint is brought up in resident council, she will email the team and department head with the concern and follow-up with the resident and staff member in three to five days to see if the problem has been resolved; -She is new to the position but she knew resident council needed to meet monthly and there was a meeting with station two in February; -It was her understanding that no resident on station one wanted to be the resident council president for that unit, but they do need to have meetings monthly; -If missing clothing is reported to her she goes and looks for it; (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If she can't find the missing clothing she reports it to the Business Office Manager (BOM) and Laundry Staff KK. During an interview on 03/08/24, at 4:20 P.M., the Social Services Director (SSD) said the following: -She was not sure if she had any specific role in missing items like clothing, but if something is reported as missing, she goes and looks for it in laundry or tried to find the missing item; -She was new to the position and was unaware of the specific process to follow if a resident voices a concern during resident council. During an interview on 3/8/24 at 5:35 P.M., the Director of Nursing (DON) said the following: -Concerns brought up in resident council go out in an email to all department managers and should be followed up by the next day; -Each department manager was responsible for a resolution then responds back to the individual person. During an interview on 03/13/24, at 2:40 P.M., the Administrator said the following: -The AD was responsible for reporting concerns voiced during resident council; -The AD was new and did not know the specific process to follow, but he expected the AD to send out the resident council minutes to every department head, the department head in turn will respond to the group in red letters to let the group know the response and resolution; -He does not have documentation of December and February resident council meeting minutes; -January resident council did not occur as the facility did not have an activity director and it fell through the cracks; -During the transition of not having an AD and getting a new AD, some things fell through the cracks, like meetings and meeting minutes.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 34003 Based on observation, interview, and record review, the facility failed to post the results of the most recent survey and complaint investigations in a place readily accessible to all residents, family members and legal representatives. The facility census was 116. Review of the facility policy Resident Rights, dated 7/5/23, showed the resident has the right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be made available by the facility in a place readily accessible to residents and the facility must post a notice of their availability. 1. During the resident council meeting on 3/6/24 at 1:00 P.M., the residents said they were not aware they could see the results of the annual inspections/surveys or any complaint investigations. They did not know where the book with the results was kept. Observations on 3/5/24 at 9:00 A.M., 3/6/24 at 8:30 A.M., 3/7/24 at 10:15 A.M., in the front foyer/common area of the facility, showed no survey results located in this area. Observations on 3/5/24 at 10:30 A.M., 3/6/24 at 10:01 A.M., 3/7/24 at 5:22 P.M., 3/8/24 at 8:38 A.M., in Station 2 (secured unit), showed no survey results located or accessible to residents in this area. During an interview on 3/7/24 at 11:22 A.M., Resident #106 said the following: -He/She resided on Station 2; -He/She hasn't seen the survey results in Station 2. During an interview on 3/8/24 at 1:20 P.M., the Business Office Manager (BOM) said the following: -The survey results should be on the cabinet at the front door; -There was a sign inside the nurses' station on Station 2 telling the residents they could ask staff to see the survey results binder; -The sign inside the nurses' station on Station 2 must have fallen down. -She was not aware the survey results had to be accessible to the residents without having to ask staff to see them. During an interview on 3/8/24 at 1:25 P.M., the Director of Nursing said the BOM was responsible for posting the survey/complaint results. There was no place to put the survey binder on Station 2. The residents on Station 2 have to ask staff to see the survey results. She did not know the survey results had to be accessible to residents without having to ask staff. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 3/13/24 at 2:40 P.M. the Administrator said the following: -He is responsible for ensuring survey results are posted for all residents/visitors to view in the facility; -He would you expect the survey results to be available for viewing on Station 2; -He was not aware the survey results were not posted on Station 2. The BOM took the survey results binder to update it and it did not get taken back to Station 2; -The survey results binder got moved from the lobby when some new furniture was placed, and it did not get put back in the foyer for Station 1.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to notify the physician and/or responsible parties when three residents (Residents #19, #55 and #106), in a review of 34 residents, had a change in condition. The facility census was 116. Review of the facility's Notifying Clinicians Policy, revised 08/23/22, showed the following: -The purpose of the policy is to outline indications of when to notify the physician; -The physician is to be called on, but not limited to: a. Medical emergency: excessive nausea/vomiting/diarrhea, falls, incidents/injuries, hypo/hypertensive episodes (low/high blood pressure), hypo/hyperglycemic episodes (low/high blood sugar), desaturation (drop of oxygen level)/respiratory distress, any changes in lung sounds/positive results in rapid Covid tests, change in condition; b. Behavioral emergencies; -The nurse will initiate verbal communication with physician, nurse practitioner, or professional nurse when a condition or incident arises with resident which would warrant an immediate implementation of a change in plan of care to include physician advisement or initiation of physician orders to avoid a delay in treatment that may cause worsening in condition. Review of the facility's Significant Change Policy, revised on 11/06/23, showed the physician, family member/legal guardian/responsible party and interdisciplinary team will be informed of any significant changes. 1. Review of Resident #19's care plan, last revised 12/6/23, showed the following: -The resident has a guardian to assist in decision making due to mental illness; -The resident has oral/dental health problems related to upper left broken jaw/tooth and obvious cavity; -Coordinate arrangements for dental care. Transportation as needed/as ordered. Review of the resident's progress notes, dated 3/1/24 at 9:55 A.M., showed the following: -The resident left this morning for a dental appointment with facility transport; -The resident had #13 tooth extracted; -Upon receiving paperwork from dentist, it was confirmed resident had tooth extraction. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician's orders, dated 3/3/24, showed an order for clindamycin (antibiotic) 300 milligrams (mg) by mouth three times daily for 10 days for oral infection. Review of the resident's medical showed no documentation the resident's legal guardian was notified regarding the tooth extraction or new orders received for antibiotics. During an interview on 3/6/24 at 3:41 P.M., the resident's legal guardian said the following: -He/She did not know the resident was on an antibiotic for a dental problem; -Staff was supposed to let him/her know about medication changes; -He/She just found out today the resident had a tooth pulled on 3/1/24; -He/She was very disappointed he/she was not notified of changes in the resident's health condition. 2. Review of Resident #55's face sheet showed he/she had a guardian. Review of the resident's nursing progress notes, dated 01/23/24, showed the resident had increasing cough, no fever, lung coarse at bases and no respiratory distress. Physician was notified with orders for a chest x-ray to be obtained. Review of the resident's nurse practitioner progress note, dated 01/25/24, showed the following: -The resident was seen at request of the facility for follow-up of chest x-ray results; -Pneumonia (and infection that inflames the air sacs in one or both lungs) due to infectious organism and pleural effusion (a build up of fluid between the tissues that line the lungs and the chest); -Plan: Augmentin (an antibiotic used to treat infections) 875 milligrams (mg) twice a day for seven days, Mucinex (a medication used to thin and loosen mucus associated with chest congestion) 600 mg twice a day for seven days, duo nebs (an inhaled aerosol breathing treatment used for shortness of breath an increased coughing) four times a day for seven days. Repeat a two view chest x-ray in two weeks. Review of the resident's nursing progress notes showed no documentation staff notified the resident's guardian of the infection/pneumonia or treatment plan for infection/pneumonia. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Sometimes able to make self understood and sometimes understood others. During an interview on 03/05/24, at 5:06 P.M., the resident's guardian said the following: -He/She was not notified with the last upper respiratory infection the resident had; (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was reviewing the bills for the resident and noticed a new charge for an antibiotic late January; -He/She would like to be notified of changes, including the small things, that occur with the resident. During an interview on 03/18/24, at 3:11 P.M., Licensed Practical Nurse (LPN) AA said the following: -He/She normally called a resident's guardian with any new orders; -He/She thought he/she notified Resident #55's guardian about the new order for a chest x-ray related to increased cough and change in lung sounds and was unsure why he/she did not document the notification; -Staff should call a guardian with any condition change or new order. 3. Review of Resident #106's care plan, dated 8/8/23, showed the following: -The resident has hypertension (high blood pressure); -Give anti-hypertensive medications as ordered; -Monitor for side effects such as orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down) and increased heart rate and effectiveness. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of the resident's progress notes dated 11/4/23 showed the following: -At 4:15 P.M., staff documented the resident had weakness when standing and went to left knee in common area. Blood pressure 90/40 (a normal blood pressure is usually less than 120/80 mm Hg. Low blood pressure is blood pressure that is lower than 90/60 mm Hg) lower than baseline, and pulse 104 (normal heart rate 60 to 100 beats per minute). The resident's blood pressure this morning was 114/71. Director of Nursing (DON) aware; -At 6:08 P.M., staff documented the resident's blood pressure was 80/60 at 5:45 P.M. The resident was flushed and sweaty and said he/she was dizzy and light headed. DON notified and resident approved to be sent to emergency room (ER) for evaluation. The resident left the facility at 6:07 P.M. Unsteady gait with stand by assistance needed. The resident continued to say he/she was dizzy. Review of the resident's hospital records, dated 11/4/23, showed the resident was admitted to the hospital for hypotension (low blood pressure). During an interview on 3/8/24 at 2:22 P.M., Certified Medication Technician (CMT) W said the following: -On 11/4/23, the resident was weak. The resident fell down on his/her knee when he/she stood; (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's blood pressure that day was lower than usual; -Staff tried to push fluids, allowed the resident to smoke in hopes of raising the resident's blood pressure, and notified the Director of Nursing (DON); -He/She did not notify the resident's physician regarding the resident's change in condition; -The CMT/Team lead usually notifies the nurse if there is a condition change, then the nurse notifies the physician; -The resident's blood pressure continued to go lower so he/she called the DON a second time. The DON said to transfer the resident to the hospital. During an interview on 3/7/24 at 11:22 A.M., the resident said the following: -Back in November, he/she almost passed out because of his/her medication; -His/her blood pressure got real low, and he/she had to go to the hospital and get IV (intravenous) fluids. During an interview on 3/21/24 at 3:07 P.M., the resident's physician said the following: -He expected staff to notify him if the resident's blood pressure was 90/40, he/she was increasingly weak and stumbled, fell down to one knee, and had to be assisted up by staff; -He expected staff to notify him at the beginning (of decline or changes) and then notified when the resident left in the ambulance. 4. During an interview on 03/08/24, at 5:35 P.M., the Director of Nursing (DON) said the following: -She expected nursing staff to notify a guardian of condition changes, new medication orders, tooth extractions, etc; -She expected staff to notify the physician with condition changes. During an interview on 03/13/24, at 2:40 P.M., the Administrator said the following: -He expected staff to notify a resident's responsible party with condition changes and medication changes like antibiotics; -He expected staff to notify the physician with resident condition changes.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services to maintain a clean, sanitary and orderly environment. The facility census was 116. Review of the facility policy, Clean Check Training System, dated 2015, showed the following: -Routine cleaning of an occupied room included: - Remove trash and dispose of sharps; -Clean and disinfect high touch surfaces; -Spot clean walls and glass; -Clean resident restroom; -Hard floor care; -Additional periodic common area cleaning task; -Additional surface disinfection; -Windows; -Floor burnishing. 1. Observation on 03/06/24, at 9:29 P.M., showed the door frame going into the shower room/bathroom on 200 hall was marred and had missing paint in multiple places. Observation on 03/06/24, at 9:24 P.M., in occupied resident room [ROOM NUMBER] showed the following: -Multiple areas in the room with torn drywall exposing the under lying drywall paper; -Multiple gouged areas behind bed 1 exposing the white drywall underneath; -The bed for Bed 1 had only the bed frame and there was no mattress on the frame; -The privacy curtain track was pulled out of the wall and the metal track hung down approximately 1 inch from the ceiling. Observation on 03/06/24, at 9:34 P.M., in occupied resident room [ROOM NUMBER] showed two areas of water stains on the ceiling from a prior water leak. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/06/24, at 9:44 P.M., in occupied resident room [ROOM NUMBER] showed the following: -Paint was missing from the entrance door frame in multiple areas exposing the metal underneath; -The entrance door had multiple black marred areas on the kick plate; -No personal items on the walls or on shelves to create a homelike appearance; -Both sets of dresser drawers were marred with missing paint; -The bathroom floor was stained with a build up of dark brown debris; -The bathroom door had multiple black marred areas on the kick plate. 2. Observation on 3/5/24 at 11:39 A.M. in occupied resident room [ROOM NUMBER] showed the following: -Multiple nicks/chips in the white paint on the drawers (by the sink) exposing the wood underneath; -Multiple black scuff marks on the door frame; -In the bathroom, the ceiling texture was peeling away around the ceiling vent. The flooring was discolored a grayish-black color. Observation on 3/5/24 at 11:32 A.M. in occupied resident room [ROOM NUMBER] showed the following: -A golf ball sized hole in the wall below the night light (by the bathroom door); -Multiple holes on the exterior of the bathroom door; -The paint on the bathroom door was worn and exposed the bare wood underneath; -There were multiple nicks/chips in the white paint on the drawers (by the sink) exposing the wood underneath; -In the shared bathroom, there was liquid standing on the bathroom floor behind the toilet; -The flooring in the bathroom was discolored brownish-black; -The white door trim around the bathroom door was discolored and dingy. Observation on 3/5/24 at 2:37 P.M. in the bathroom for occupied resident room [ROOM NUMBER], showed the following: -The floor tiles were discolored grayish-black; -There were gray-black scuff marks on the bathroom door; (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was black discoloration at the base of the toilet; -There was black discoloration at the bottom of the walls near the floor; -The bottom section of wood on the interior of the bathroom door was peeling away from the door. Observation on 3/5/24 at 2:38 P.M. in occupied resident room [ROOM NUMBER] showed the following: -The paint above the air conditioning unit was peeled away from the wall; -The white paint on the door to the room was worn exposing the wood underneath. The white paint on the door was also discolored and dingy. Observation on 3/5/24 at 3:06 P.M. in occupied resident room [ROOM NUMBER] showed the following: -Multiple black scuffs on the paint above the baseboard heating unit; -The metal side of the baseboard heating unit was warped; -Multiple chips/nicks in the white paint on the drawers. 3. Observation on 3/6/24 at 9:47 P.M. in occupied resident room [ROOM NUMBER] showed the following: -There were multiple black marks on the tile floor; -In the bathroom (used by four residents), there were black marks on the floors and walls, and a brown-black discoloration around the base of the toilet. Observation on 3/5/24 at 10:10 A.M. in occupied resident room [ROOM NUMBER] showed the following: -There were multiple black scuff marks on the floor; -In the bathroom (used by four residents), there was rust around the base of the toilet and rust on the door trim. 4. Observation on 3/5/24 at 10:15 A.M. in occupied resident room [ROOM NUMBER] showed the curtains were coming off the curtain rod. Observation on 3/5/24 at 10:20 A.M. in occupied resident room [ROOM NUMBER] showed the following: -Only one bed was in the room. The wall at the head of the place where the first bed would be was heavily gouged with dry wall exposed and the wall behind the bed closet to the window was gouged with dry wall exposed; -There was several areas on the surrounding walls that had been patched but not painted; -The curtain was coming off the curtain rod; (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A toilet riser was on the toilet in the shared bathroom and was dirty with a brown substance; -Dirty linen was on the floor of the bathroom; -The sink in the room was pulled away from the wall; -The resident did not have a TV. The resident said someone came and took the TV. He/She said he/she would like to have a TV to watch. Observation on 3/5/24 at 11:00 A.M. in occupied resident room [ROOM NUMBER] showed the following: -Dirty soiled clothing was on the shared bathroom floor; -A black substance covered the caulk around the base of the toilet and was wet. 5. Observation of the shared shower room on the 600 hall, on 3/6/24 at 9:07 P.M., showed the following: -The painted concrete walls had chipping paint; -The painted concrete walls had a yellow and black mold-like appearance on the lower walls and corners where the walls met; -The painted concrete flooring around the drain had peeling paint and a black, slime-like substance around the drain; -The white, plastic shower bench had a yellow, scum-like substance on the seat of the bench. Observation of the bathroom for occupied resident room [ROOM NUMBER], on 3/6/24 at 9:11 P.M., showed the following: -The ceiling exhaust vent had a build up of a thick, dust-like matter; -The ceiling matter around the vent was peeling and chipping away. Observation of the locked, secured units (Station 2) day/common area on 3/6/24 at 9:15 P.M. showed the following: -The blue and gray painted walls had multiple nicks/chips in the paint where the chairs had rubbed against the walls, exposing the drywall underneath; -The gray painted wall, under the facility rules posting, had large black scuff marks on the wall; -In the day/common area wall to the right of the 400 hall entrance, an electrical outlet cover was pulled away from the wall; the outlet had a sound speaker plugged into it; -The baseboards in the entire room had a thick, black buildup where the baseboards met the flooring; (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The tile flooring under multiple chairs, tables and in front of the ice machine/beverage counter had black scuff marks that also gave the floor a dirty appearance; -A cigarette butt lay on the tile flooring under the menu board posting and to the right of the nursing office; -Four high back vinyl chairs had significant rips in the seats; the rips exposed the underneath cloth material. Observation of the locked, secured units (Station 2) resident snack/vending room on 3/6/24 at 9:21 P.M. showed the tile flooring under the vending machine legs had a large amount of chipped, loose, and crumbling tiles. 6. Observation on 03/05/24 at 10:25 A.M. of Resident #24's room showed the following: -The resident resided in Bed 2 (bed closest to the window) and Bed 1 was unoccupied; -The walls on Bed 1 side of the room had areas of drywall compound, that had not been painted over. During interviews on 03/05/24 at 10:25 A.M. and on 03/06/24 at 10:10 A.M., the resident said the following: -He/She used to have two televisions (TV) in the room; -The TVs were not his/her TVs; -Maintenance took one TV out, and staff took out the other; -He/She told staff he/she would like a TV; -Staff told him/her they were working on it. Observation on 03/07/24 at 2:15 P.M. showed the following: -The resident requested more water; -Nurse Aide (NA) P told the resident he/she could get water from his/her sink; -The resident replied there was only hot water. During interview on 03/07/24 at 2:22 P.M., the resident said the following: -The cold-water faucet on his/her sink did not work; -He/She could not remember how long it had been broken. Staff had to fix a leak and it hasn't worked since; (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She can't get cold water, unless he/she gets a bunch of ice. Observation on 03/07/24 at 2:25 P.M. of resident's room sink showed the following: -No water came out of the faucet when the cold water was turned on; -Warm water immediately came out of the faucet when the hot water was turned on. The water continued to heat as the water was running. During interview on 03/07/24 at 4:32 P.M., the Activity Director said the following: -He/She can remember the resident having a TV a week or two ago when the resident complained of the remote not working; -He/She reported the non-working remote to nursing staff. During interview on 03/07/2024 at 04:46 P.M., Licensed Practical Nurse (LPN) S said the following: -If a resident has an item needing repair, nursing staff is notified; -Nursing will send through the proper channels; -TVs go through maintenance; -Items needing evaluated by maintenance go on a maintenance log kept at the nurses station. 7. During an interview on 3/6/24 at 11:36 A.M., Housekeeper LL said the following: -He/She cleaned resident rooms; -He/She did not know who cleaned the bathroom vents, the shower rooms or the day/common area floor. During an interview on 3/8/24 at 8:00 A.M., the Maintenance Supervisor said the following: -He assessed a couple of rooms each week; -It took awhile to patch holes, mud, tape and paint; -He just painted the hallways and was trying to get more paint. He was running out of paint; -He hadn't had time to get to all the areas in the facility that needed repairs, specifically the dining rooms; -He was not aware the chairs in the dining room were in poor condition; -If furniture was in poor condition, it should be removed from the area. During an interview on 3/13/24 at 2:40 P.M. the Administrator said the following: (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Maintenance is responsible for ensuring the walls, doors, floors, ceiling and furniture are in good repair; -He would expect walls, doors, floors, ceiling and furniture to be in good repair/condition. 41412 42592 50189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34003 Based on interview and record review, the facility failed to ensure residents knew how to file a grievance, where grievance forms were located or how to complete a grievance form. Residents said they felt there concerns were not heard or addressed. The facility census was 116. Review of the facility policy, Resident Rights, dated 7/5/23, showed the following: -The resident has the right to: 1. Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; 2. Prompt efforts by the facility to resolve grievances the resident may have including those with respect to the behavior of other residents; -The resident has a right to voice grievances and recommend changes to policies and services to facility staff or outside representatives of his/her choice; -The resident has the right to be free from restraint, interference, coercion, discrimination, and reprisal from the facility for exercising his/her rights. Review of the facility policy, Grievance Policy - Residents, revised 09/25/23, showed the following: -The purpose of the policy is to set forth the resident's right to file a grievance and the process to be followed; -A resident or their legal representative can bring concerns to a staff member, the resident concern group, or call the compliance hotline; -Additionally, each resident has the right to use the formal grievance process; -Every resident has the right to voice their grievance with the facility or other agency; -Grievances could include care and treatment that was not provided, behavior or staff or other residents, or any other concerns regarding their stay; -A grievance is a formal complaint, not a question or concern brought to a staff member or a call to the compliance hotline; -To avoid any confusion, the resident should make it clear that they are filing a formal grievance; -No resident shall be retaliated against in any way for voicing a grievance; (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Each resident shall be given information regarding the grievance policy when they are admitted to the facility;. -The social service director (SSD) shall serve as the grievance officer; -If the facility does not have an SSD, the administrator shall serve as the grievance officer; -A resident, his/her legal representative, or family/friend may voice their grievance orally to the grievance officer or in writing; -A form will be provided to the residents to assist them in documenting their grievance, but use of the form is not required; -The grievance officer shall track all grievance received; this should include name of resident (if not anonymous), date of grievance, manner received, investigation and resolution; -The grievance officer shall endeavor to complete an investigation as soon as reasonable and within 7-14 days. 1. During the resident council group interview on 03/06/24, at 1:04 P.M., residents in attendance said the following: -Some residents who resided on Station Two did not know how to file a grievance; -Multiple residents voiced they did not feel like they could file a grievance or call the state hotline to file a compliant without fear of retaliation from staff; -The residents felt like retaliation would be in the form of privileges being taken away, getting yelled at or discharged to a different facility. During an interview on 3/7/24 at 5:22 P.M., Resident #27 said the following: -He/She has been missing clothing since December; -He/She reported his/her missing clothing to staff but he/she hasn't heard anything back; -He/She doesn't know anything about a written grievance form. During an interview on 3/7/24 at 11:49 A.M., Resident #12 said the following: -He/She has been missing clothing; -He/She has asked laundry about his/her missing clothes and told other staff, and he/she hasn't got his/her clothing back; -He/She didn't file a grievance for his/her missing clothing because he/she wouldn't know where to find a grievance form. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/24 at 5:14 P.M., Resident #97 said the following: -He/She is missing clothing; -He/She told staff about his/her missing clothing, but he/she is not sure who he/she told; -He/She doesn't know where to find a grievance form. During an interview on 3/8/24 at 2:54 P.M. the Ombudsman said the residents were concerned about retaliation from staff if they have complaints. The residents were worried staff would seek them out following ombudsman/state agency visits to the facility. During an interview on 03/08/24, at 4:20 P.M., the social services director (SSD) said the following: -She was new to the position and was not sure what part she played in the grievance process; -Since she has been the SSD, there had not been any grievances filed. During an interview on 3/8/24 at 5:35 P.M., the Director of Nursing (DON) said the following: -Grievances were filed using a grievance form. The residents and/or visitors had to ask for the form. The completed form goes to social services, then the SSD takes the form to the DON, Administrator, and the department involved. -There is a 24-48 hour turn around time from the time a grievance is filled until a resolution is obtained. -Social Services follows up on grievances and either he/she or the Administrator will follow up with the residents. During an interview on 03/13/24, at 2:40 P.M., the administrator said the following: -Residents should be able to file a grievance without fear of retaliation from staff; -There should be written grievance forms available for residents/families to obtain and file without having to ask staff for the form; -The SSD is new and was unaware of the grievance process; -The process to file a grievance is to complete the form and turn it into the SSD, the SSD will investigate and then discuss with the management team or address with pertinent department.		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on observation, interview and record review, the facility failed to assess three residents (#19, #47, and #115) for the ability to consent prior to having sexual relations and failed to protect one resident (Resident #47) from sexual abuse by a resident (Resident #115). Resident #47 reported feeling worthless, having a flashback, and fear of contracting STDs (Sexual Transmitted Diseases). A sample of fourteen residents was selected for review. The facility census was 115. Review of the facility's Sexual Activity/Abuse and Neglect Policy, last reviewed 4/18/22, showed the following: -The purpose of this policy is to ensure the facility provides protective oversight and care for all residents requesting to engage in sexual activity/intercourse while at the same time protecting their rights; -Residents that are wishing to engage in sexual activity/intercourse will be allowed to participate in these activities as long as both parties consent and have the ability to consent. Non-consensual acts and acts that impact negatively on the resident community, such as public displays, shall not be allowed; -Determination of ability to consent: -a. If the resident has a guardian or a physical and/or cognitive impairment, an assessment should be completed to determine the resident's ability to consent. This assessment will be completed by the Interdisciplinary Care Team (ICT), with the assistance of the resident's physician and/or psychiatrist as needed. The assessment shall include an awareness of the relationship including awareness of who is initiating the relationship, identity of the other person, and comfort level with sexual intimacy, the ability to avoid exploitation including the resident's values and ability to refuse unwanted advances; and an awareness of potential risk associated with the relationship, including STDs or pregnancy, if applicable, or reaction if the relationship ends; -The resident's guardian (if applicable) will be invited to provide their guidance/opinion to the ICT. Family members may be involved in the assessment as appropriate; -b. All documentation regarding the resident's ability to consent shall be maintained in the resident's medical file and, if appropriate, in the resident's care plan; -Residents will be assessed for the capacity to consent to sexual activity if they have a history of sexual activity, have indicated that they wish to engage in sexual activity, or if the facility or guardian otherwise believes that they should be assessed. All residents do not need to be assessed. Residents will be reassessed as needed; -If a resident has been deemed to be unable to consent to sexual activity, the resident will be told that they are not permitted to engage in sexual activity; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Employees will not allow sexual activity to take place unless both residents have been deemed to have the capacity to consent; -If non-consensual sexual activity occurs, the abuse and neglect policy will be followed. Review of the facility's Abuse and Neglect Policy, last reviewed 1/05/23, showed the following: -Sexual abuse is non-consensual contact of any type with a resident. Sexual abuse includes, but is not limited to, the following: a. Unwanted intimate touching of any kind especially of the breasts or perineal area; b. All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; This also includes failure to intervene or attempt to stop or prevent non-consensual sexual activity or performance between residents; -The facility is committed to protection of our residents from abuse by anyone including, but not limited to, Facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis; -Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents and employees in the facility. Review of the facility's Covenant Guidelines, dated 10/12/22, showed the following: -Residents residing on Station 2, after administrative approval, may visit other residents of the same gender with the approval from staff working the unit and that of the roommate in the room being visited as long as there are no guardian limitations and charge nurse is aware. Door must be open while visiting and the light on if dark; -Any and all visits in other resident rooms/stations will be determined by guardian limitations before the ICT makes a determination for approval. ICT to review and make recommendations to the guardians if they feel the resident has displayed appropriate behaviors during a set time frame to be determined by the ICT; -Residents who have legal guardians will follow all legal guardian imposed limitations as outlines in their individualized plan of care; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-All guidelines were discussed with a committee of residents, staff, a guardian, and the ombudsman. The guidelines were voted on by the residents, with the majority being the final decision. All limitations may be modified by an individual resident's guardian should there be the need; -These covenants are not negotiable, and are put into place and enforced for the safety of the residents/staff and the facility. 1. Review of Resident #47's Pre Admission Screening and Resident Review Level Two (PASARR II), dated 7/05/13, showed the following: -Diagnoses included mood disorder (a mental health condition that primarily affects your emotional state), impulse control disorder (a group of behavioral conditions that involve an inability to control impulses and behaviors), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life), major depression (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), mixed personality disorder (the occurrence of traits of more than one personality disorder), borderline personality disorder (a mental illness that severely impacts a person's ability to manage their emotions), and mild mental retardation (deficits in intellectual functions pertaining to abstract/theoretical thinking); -The resident communicates without problem/expresses self well; -Cognitively the resident does not make good decisions and cannot follow complex directions; -He/She had a cooperative, childlike manner which he/she was guarded, easily frustrated, and easily distracted; -The resident required monitoring, 24 hours per day supervision and support due to limited intellectual disability, impaired judgement, and history of being taken advantage of; -He/She required redirection for inappropriate behaviors and support for increased anxiety; -The resident would benefit from short term nursing facility level of service for stabilization of mood; -If admitted to a nursing facility, he/she would need implementation of systematic plans to change inappropriate behavior, medication therapy/monitoring to change inappropriate behavior or alter manifestations of psychiatric illness, provision of structured environment, and development of personal support networks. Review of the resident's care plan, dated 7/09/22 showed the following: -The resident has a guardian to assist in decision making due to mental illness (dated 7/09/22); -Ensure guardian wishes are followed (dated 7/09/22); (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Encourage resident to participate in social situations and monitor interactions with others (dated 7/09/22); -Resident can be childlike in demeanor. Review of the facility's guardian limitations report dated 12/22/23, showed the resident must follow covenant guidelines. Review of the resident's progress notes dated 2/11/24 at 1:52 P.M., showed the following: -The resident was noted to hold hands and be flirtatious with a peer. The resident was educated on proper friendly boundaries and not having guardian permission for relationships; -The resident acknowledged understanding and said he/she would be friends until guardian approves otherwise with no signs and symptoms of pressure or distress from peer; -Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Resident Care Coordinator aware. Review of the resident's care plan, revised on 2/21/24 showed the following: -The resident experienced flirtation with a peer and needs reminding to maintain platonic friendship and refrain from physical touching, kissing, hand holding, etc.; -He/She needs reminders not to enter peers' rooms without invitation or staff permission and was not to be on the 400 hall or a hall that he/she does not live on. Review of the resident's medical record from admitted to 1/2/24, showed no assessment for the resident to consent to sexual activity. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/20/24, showed the resident was cognitively intact. During an interview on 4/24/24 at 11:41 A.M. and 4/25/24 at 10:24 A.M., the resident said the following: -He/She thought Resident #115 had been admitted to the facility around 1/2/24; -He/She had been in a relationship with Resident #115 for about two months; -He/She told Resident #115 he/she was thinking of moving closer to his/her family and Resident #115 told him/her he/she did not want him/her to move as he/she truly liked him/her as a friend, but liked him/her more as a lover; -He/She had performed oral sex on Resident #115 two times, once after supper and once before lunch, and both times the act took place in Resident #115's room; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #115 came to his/her room and asked him/her to give him/her oral sex, so they went to Resident #115's room; -He/She had agreed to perform oral sex, but told Resident #115 he/she did not want to complete the act. Resident #115 held his/her head in place so he/she could not move and did it anyway; -His/Her guardian told him/her he/she could not be in a relationship with Resident #115 or anyone else; -This all occurred after supper and right before shift change; -The second time he/she gave Resident #115 oral sex it happened the same way, even though he/she had asked him/her not to complete the act, Resident #115 did not listen and did it anyway without his/her permission; -The second occurrence happened after the 1:30 P.M. smoke break, when staff were outside with smokers; -He/She did not want to give Resident #115 oral sex a second time, but he/she wanted to keep him/her as a friend and felt obligated to give him/her oral sex; -He/She said Resident #115 said this was their little secret and he/she should not tell anyone what they are doing. -After the second time he/she gave Resident #115 oral sex, Resident #115 was in his/her bed and Certified Nurse Aide (CNA) E walked into the room; -CNA E told them if they want to be in each other's rooms, they knew the rules and the door should be open and reminded them if it was night the light had to be turned on; -The reason he/she waited so long to talk about it, he/she did not know he/she could get into trouble. He/She did not want to get Resident #115 into trouble; -He/She told the DON he/she wanted to be tested for STDs; -He/She did not have any physical injuries, but has had a flash back and woke up the night before sweating. He/She said he/she was dreaming and when he/she woke up he/she felt worthless. Review of the resident's written statements for the facility, dated 4/21/24, showed the following: -The resident had sexual relations with Resident #115; -Resident #115 forced him/herself on him/her by making the resident give him/her oral sex; -Both residents were caught by CNA E; -The resident told the Administrator about the incidents which happened in late January early February; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The resident told the Administrator he was worried about getting AIDS. During an interview on 4/26/24 at 11:09 A.M., CNA E said the following: -The day Residents #47 and #115 were caught sitting on Resident #115's bed, the door was closed and when he/she opened the door he/she found the two residents sitting on Resident #115's bed, staring into each other's eyes and he/she reminded them to keep things in the friend zone; -He/She left her job around 3/15/24 and management had a meeting with Resident #47 and #115's guardian and there was no consent obtained at that time for a physical relationship. During an interview on 4/24/24 at 1:33 P.M., the resident's Caseworker D said the following: -The facility had reported Resident #47 had been forced to perform oral sex on another resident back in January; -He/She did not feel the resident had the mental capacity to be in a relationship. During an interview on 4/30/24 at 2:41 P.M., the resident's legal guardian C said the following: -He/She was not aware the resident and Resident #115 had been in a relationship; -In order for him/her to consent for the resident to be in a relationship, he/she would have needed to have had a conversation with the facility on an as needed basis when these issues arise. Review of the resident's Capacity to Consent to Sexual Activity Form, dated 4/22/24, showed the following: -The resident could not say what level of sexual intimacy he/she would be comfortable with; -The resident did not have the capacity to say no to uninvited sexual contact; -The resident could not describe how he/she would react when the relationship ended; -The resident had been assessed, for the purpose of determining whether he/she is capable of understanding the purpose, nature, risks, benefits, and alternatives (including nonparticipation) in giving consent, making a decision about participation, and understanding that the decision about participation in the sexual activity, otherwise entitled: Capacity to Consent to Sexual Activity; -On the basis of this examination the evaluator arrived at the conclusion that this participant clearly lacks this capacity at this time; -The resident signed the document along with the evaluator, the ADON and the Social Services Director (SSD). 2. Review of Resident #115's PASARR II, dated 11/15/23, showed the following: (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Diagnoses included oppositional defiant disorder (a type of behavior disorder. It is mostly diagnosed in childhood in which individuals show a pattern of uncooperative, defiant, and hostile behavior toward peers, parents, teachers, and other authority figures), attention-deficit hyperactivity disorder (ADHD) (neurodevelopmental disorders usually first diagnosed in childhood and often lasts into adulthood in which individuals have trouble paying attention or controlling impulsive behaviors (may act without thinking about what the result will be or be overly active), borderline intellectual functioning (a group of people who function on the border between normal intellectual functioning and intellectual disability), bipolar disorder, autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), moderate intellectual disabilities, intellectual disability moderate to severe (Individuals with moderate intellectual disability possess basic communication skills and can maintain self-care, often with some degree of support. Those with a severe intellectual disability exhibit considerable developmental delays), pervasive developmental disorder (characterized by delays in the development of social and communication skills), learning disorder, developmental disorder of scholastic skills (include dyscalculia (difficulty learning arithmetic) but also dyslexia (a condition of neurodevelopmental origin that mainly affects the ease with which a person reads, writes, and spells, typically recognized as a specific learning disorder in children), mood disorder, Post Traumatic Stress Disorder (PTSD) (a real disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), disruptive mood dysregulation disorder (condition in which children or adolescents experience ongoing irritability, anger, and frequent, intense temper outbursts), and impulse control disorder with recurrent self-harm; -He/She needs nursing facility placement due to behavioral difficulties and/or mental illness symptoms requiring 24 hour monitoring/management; -His/Her individual limitations include intellectually disability, poor insight/judgment, and limited interpersonal support system; -His/Her individual strengths include guardianship in place and he/she is able to make his/her wants/needs known; -He/She needs a structured environment in order to assess and plan for the level of supervision required to prevent harm to his/herself or to others; -He/She requires ongoing assessment of mood, thought process and behaviors for early recognition of changes to promote early intervention and proactive modifications to plan of care. Review of the facility's guardian limitations report dated 12/22/23, showed the resident was to follow covenant guidelines. Review of the resident's care plan, dated 2/03/24 and revised 2/20/24, 4/23/24 and 4/24/24, showed the following: (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Problem: The resident has a history with extensive psychiatric history, including oppositional defiant disorder, ADHD, bipolar disorder, depression, anxiety, suicidal ideation with attempts of self-harm, moderate to severe intellectual disabilities including autism (varying with hospitalization s and placements), PTSD, with symptoms including anxiety, labile mood, hopelessness, worthlessness, loss of appetite, fearfulness, aggressive and assaultive behavior, paranoia, perseveration, defiance, poor concentration, lack of insight and poor judgement (dated 2/03/24); -Problem: The resident has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include hypersexuality, seeking sexual relationship from peers (dated 2/20/24); -Intervention: He/She continues to be advised to refrain from physical contact intimacy. Discussed alternatives including masturbating privately and seeking assist to procure device to aid in such if desired. Review of the resident's progress notes, dated 2/11/24, showed the resident was noted to hold hands and be flirtatious with a peer. Resident educated on proper friendly boundaries and not having guardian permission for relationships. Resident acknowledged understanding and states will be friends until guardian approves otherwise with no signs or symptoms or pressure or distress from peer. Review of the resident's admission MDS, completed by facility staff, dated 2/14/24, showed the resident had moderately impaired cognition. Review of the facility clinical census, dated 3/17/24, showed the resident was moved to another hall. Review of the resident's progress notes dated 4/01/24 at 1:04 A.M., showed the resident attended 7:30 P.M. supervised smoke break and when finished he/she went to common area to sit at a table with peer (Resident #19). The resident got up from the table a couple of minutes later, and approached the peer at the same table. The resident leaned over and kissed the peer on the lips. Staff immediately intervened and educated resident on facility guidelines of no physical contact with other peers. DON, Administrator. and guardian notified. Review of the resident's progress notes dated 4/06/24 at 4:11 A.M., showed the resident became upset when redirected from peer, and became belligerent. Staff counseled the resident on guidelines and the resident walked away. The resident then friended a new peer. Was seen chatting and following new peer. Review of the resident's facility acquired written statement dated 4/21/24, showed the following: -He/She and Resident #47 were having sex, kissing, making out and were caught by CNA E in his/her bed together; -He/She and Resident #47 engaged in oral sex and kissed behind the building; -The sexual acts were done out of love; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She has a new boy/girlfriend and Resident #47 was jealous and has been trying to cause problems with his/her new relationship. During an interview on 4/24/24 at 12:15 P.M. and 4/25/24 at 11:38 A.M. and 12:14 P.M., the resident said the following: -He/She was not currently in a physical relationship, but he/she was in an emotional relationship with Resident #19; -He/She used to be boy/girlfriend with Resident #47; -He/She did not force Resident #47 to have oral sex, it was consensual and happened many times in each of their rooms; -He/She had oral sex with Resident #47 about two to three months ago; -He/She did not have permission from his/her guardian to have a relationship with anyone; -He/She started a relationship with Resident #19 about one month ago and had oral sex, but now cannot do anything until guardians give them permission. Review of the Resident's Capacity to Consent to Sexual Activity Form, dated 4/22/24, showed the following: -The resident was not aware of who was initiating sexual contact; -The resident could not state what level of sexual intimacy he/she would be comfortable with; -The residents' behavior was not consistent with formerly held beliefs/values; -The resident could not describe how he/she would react when the relationship ended; -The resident had been assessed, for the purpose of determining whether he/she is capable of understanding the purpose, nature, risks, benefits, and alternatives (including nonparticipation) in giving consent, making a decision about participation, and understanding that the decision about participation in the sexual activity, otherwise entitled: Capacity to Consent to Sexual Activity; -On the basis of this examination, the evaluator arrived at the conclusion that this participant clearly lacks this capacity at this time; -The resident signed the document along with the evaluator, the ADON and the SSD. During an interview on 4/24/24 at 1:43 P.M., the resident's legal guardian A said the following: -He/She was not aware Resident #115 was in a physical relationship; -He/She did not think the resident understood what it meant to be in a healthy relationship as he/she does not believe the resident ever witnessed a healthy relationship; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The issue with giving permission for a relationship never came up for Resident #115. 3. Review of Resident #19's PASARR Level II dated 9/07/18 showed the following: -Diagnoses included: Mood disorder, impulse control disorder, schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions which include delusions (false beliefs), hallucinations (seeing or hearing things that don't exist), unusual physical behavior, and disorganized thinking and speech.), PTSD, adjustment disorder, ADHD, major depressive disorder (when an individual has a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, agitation, sleep disturbances, or suicidal thoughts.) (MDD), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), bipolar disorder, borderline personality disorder, developmental delay, history of traumatic brain injury (a sudden injury that causes damage to the brain); -Historical symptoms or behaviors included seeing a psychiatrist around the age of seventeen due to depression, auditory and visual hallucinations following the death of his/her adopted father. He/She was hospitalized around the age of twenty due to suicidal ideation. He/She has attempted suicide several times in the past. He/She has self-mutilating behaviors with numerous scars on lower legs where he/she cut, burned, scratched, or otherwise hurt him/herself. He/She has chronic suicidal ideation's as he/she hears voices telling him/her to kill him/herself, paranoid thoughts, and elopement from facility; -He/She has had numerous hospitalization s for depression and suicidal ideations; -He/She requires secured/behavioral unit; -His/Her thought process/cognitive status included poor concentration, poor judgement, tangential (a communication disorder in which the train of thought of the speaker wanders and shows a lack of focus, never returning to the initial topic of the conversation), disorganized, short term memory deficit, and poor insight; -His/Her manner was cooperative and childlike; -He/She requires a nursing facility due to ongoing for safety, medication, medical and psychiatric monitoring and requires ongoing medical management and review of medications; -He/She does not make good or safe decisions. Review of the resident's care plan, initiated 5/23/22 and revised on 4/29/23, showed the following: -Problem: PASRR showed the resident had a history of behavioral challenges that require protective oversight in a secure setting. He/She began experiencing hallucinations at seventeen after the death of his/her adopted father. He/She experienced auditory and visual command hallucinations as well as suicidal and homicidal ideation. He/She has a history of suicide attempts. He/She also practiced self-mutilation by cutting self, leaving numerous scars. He/She has a diagnoses of schizoaffective and mood disorder, anxiety, major depression, and psychosis (dated 5/23/22); (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Problem: The resident has a history of PTSD. PTSD affects the resident symptoms and may flare up without any known trigger. Alterations in reactivity from the traumatic event, including aggressiveness, and self-destructive behavior. Intrusion or persistently re-experienced stressors in at least one of the following ways: recurrent memories, traumatic nightmares, flashbacks, prolonged distress following traumatic reminders, significant physical symptoms after exposure to stressors. The resident states he/she was bullied in school, physically and emotionally. Triggers include loud noises, accusing him/her of doing things and unwanted touching (dated 4/29/23). Review of the facility's guardian limitations report, dated 12/22/23, showed the following: -The resident must follow covenant guidelines; -The resident may not have any relation with opposite sex peers. Review of the resident's quarterly MDS, completed by facility staff, dated 3/03/24, showed the resident was cognitively intact. Review of the resident's progress notes, dated 4/01/24 at 1:20 A.M., showed the following: -Resident attended 7:30 P.M. supervised smoke break, and when finished, went to common area and sat at a table with peer. A couple of minutes later, the peer (Resident #115) got up from table and kissed this resident. Staff immediately intervened and educated resident on facility guidelines of no physical contact with other peers. DON and Administrator notified. Left message on voicemail for guardian. Review of the resident's guardian email, dated 4/03/24 at 9:16 A.M. and 4/03/24 at 12:48 P.M., showed the following: -The email was sent to the SSD; -The guardian would like to make the facility aware of this guardian directive. The resident is not to be in a relationship with anyone (male or female). Relationships always cause him/her to become confused and when they end he/she becomes suicidal. The resident can have friends, but no romantic relationships. There should be no public display of affection between the resident and another resident. Review of the resident's progress notes, dated 4/06/24 at 5:34 A.M., showed the resident became upset at staff for redirecting him/her away from another peer. Resident became verbally aggressive, but was easily redirected. During an interview on 4/24/24 at 11:31 A.M., 4/24/24 at 4:08 P.M. and 4/25/24 at 11:46 A.M. and 12:16 P.M. , the resident said the following: -He/She had consensual oral sex in Resident #115's room about one and a half weeks ago; -He/She can only be with Resident #115 in the dining room and on smoke breaks; -He /She can kiss and hold hands with Resident #115; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She just wanted to do a favor for Resident #115, because he/she said he/she was horny. Review of the resident's Capacity to Consent to Sexual Activity Form, dated 4/22/24, showed the following: -The resident's behavior was not consistent with formerly held beliefs/values; -The resident did not realize that the relationship may be time limited due to placement of male/female on unit was temporary; -The resident could not describe how he/she would react when the relationship ended; -The resident had been assessed, for the purpose of determining whether he/she is capable of understanding the purpose, nature, risks, benefits, and alternatives (including nonparticipation) in giving consent, making a decision about participation, and understanding that the decision about participation in the sexual activity, otherwise entitled: Capacity to Consent to Sexual Activity; -On the basis of this examination the evaluator arrived at the conclusion that there was doubt about this participant's capacity at this time and further evaluation was necessary; -The resident signed the document along with the evaluator, the ADON and the SSD. Observation on 4/24/24 at 4:02 P.M. showed Resident #115 knocked on the resident's door while the surveyor interviewed the resident. Resident #115 was not supposed to be allowed on the hall as he/she did not live on the hall. During an interview on 4/24/24 at 1:57 P.M. and 5/01/24 at 12:21 P.M., the resident's legal guardian B said the following: -He/She did not want Resident #19 to have any relationships; -He/She felt the resident did not have the capacity to consent to a relationship of any kind; -There had been times in the past when Resident #19 has been in a relationship and when it ended he/she was taken to the hospital for suicidal ideations; -He/She felt the resident could not handle any breakup without it causing suicidal ideations; -He/She emailed a directive to the facility on [DATE] stating the resident could not have a boy/girlfriend relationships; -The resident does not know what a relationship was because he/she has never been in a loving relationship; -The resident can be easily taken advantage of by anyone dealing with anything, for example, there were other residents who were trying to get his/her coloring books and pencils and a fight would ensue; (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-When he/she spoke with the resident on the phone he/she had told him/her that he/she had a boy/girlfriend and he/she told him he/she did not agree and that he/she knew what could happen if/when the relationship ended; -He/She sent the email on 4/03/24, because the resident told him/her he/she was in love with another resident; -His/Her family member called after speaking with the resident to report he/she was afraid the resident was going away with Resident #115 to another family 's home in another city; -He/She then contacted the resident and told him/her he/she could not have a relationship with anyone; -He/She felt romantic relationships could cause the resident to harm him/herself as the resident does not handle his/her feelings very well when relationships come to an end; -He/She did not expect or approve of the resident having/giving o		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 34003 Based on interview and record review, the facility staff failed to ensure one resident (Resident #46), out of 34 sampled residents, remained free from misappropriation of property, when a facility employee took \$450.00 of Resident #46's money when the resident offered to assist the employee with unpaid bills. The facility census was 116. The administrator was notified on 3/12/24 at 10:00 A.M., of the Past Non-compliance which occurred on 3/2/24. On 3/2/24, the administrator became aware of the violation of misappropriation of resident money. The facility began the investigation and terminated the employee on 3/2/24 for taking money from Resident #46. The resident received \$450.00, full reimbursement of his/her funds. Staff were inserviced regarding the facility policy for misappropriation and facility expectation. The D grid deficiency was removed and corrected on 3/2/24. Review of the facility policy for Abuse and Neglect with a revision date of 1/5/23 showed the following: -Purpose: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property; -Misuse of funds/property - the misappropriation or conversion of resident's funds or property for another person's benefit. This includes: a resident who provides monetary assistance to staff, after staff had made the resident believe that staff was in financial crisis. 1. Review of Resident #46's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/11/23 showed: -The resident was alert and oriented and able to make decisions: --Dependent upon staff for Activities of Daily Living (ADLs); -Diagnoses of quadriplegia (paralysis of all extremities), heart disease, anxiety and pain. During an interview on 3/6/24 at 4:00 P.M. Resident #46 said the following: -Around 1/25/24, Certified Nurse Aide (CNA) J approached him/her and said that he/she needed some money to pay the power bill; -The employee said his/her power was going to be turned off and he/she had several children; -The employee said he/she would pay the resident back; -They agreed that CNA J would pay back the money in three installments. CNA J paid one installment when CNA J got paid, but he/she never paid any additional money that he/she owed the resident; (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident contacted his/her family member and reported what happened; -The family member had reported this to the administrator. During an interview on 3/7/24 at 11:51 A.M., the Assistant Director of Nursing (ADON) said: -On 3/2/24, she received a phone call from the Administrator who reported that a family member shared Resident #46 had given CNA J money and CNA J had not paid him/her back as promised; -She began an investigation into the allegation; -She interviewed the resident who told her that CNA J told the resident that he/she needed \$450.00 to pay a power bill or his/her power was going to be shut off; -She then interviewed CNA J who admitted to taking the money from the resident; -She suspended CNA J pending the investigation; -She called the administrator and reported her findings and was told to terminate CNA J due to taking money from a resident; -CNA J was terminated from employment on 3/2/24. During an interview on 3/7/24 at 12:30 P.M. Human Resource Director (HR) said: -On 3/2/24, he/she was asked to sit in with the ADON when she was interviewing CNA J; -CNA J said that he/she had asked the resident for money and when the resident offered the money, he/she took the money; -CNA J was terminated from the facility on 3/2/24. During an interview on 3/11/24 at 10:40 A.M. CNA J said: -The resident had over heard him/her talking with another staff member about not having enough money to pay the power bill; -The resident offered him some money, he/she refused at first, but he/she finally took \$450.00; -He/She should not have taken the money. During an interview on 3/13/24 at 9:20 A.M. the Administrator said: -He would expect staff to decline when and if a resident would offer them money; -He would expect staff not to take any personal property from residents; -He would expect staff not to discuss personal problems with the residents. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 3:07 P.M. the primary physician said: -He would expect staff not to accept money from residents; -He would expect not take any money or other items from any resident. MO232621, MO232626, MO232618		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50189 Based on interview and record review, the facility failed to complete required pre-employment screenings for four of eight sampled employees hired since the previous survey. The facility failed to request a criminal background check (CBC) for two employees, check the Employee Disqualification List (EDL) for three employees, and check the Nurse Aide (NA) Registry for three employees, prior to hire as directed by facility policy. The facility census was 116. Review of the facility policy, Screening - Applicant, Employee, Volunteer and Vendor, revised 06/29/23, showed the following: -The Human Resources (HR) department will conduct pre-employment screenings on applicants to determine if the applicant has committed a disqualifying crime, is an excluded provider in any Federal or State healthcare programs and is duly licensed or certified to perform the duties of the position they applied, if applicable. -HR staff will conduct the following screens on potential employees prior to hire: Criminal History, Federal Exclusion Lists, Licensure, Family Care Safety Registry (FCSR, a registry maintained by the state agency for facilities to utilize for completion of the criminal background check and EDL check), EDL, NA Registry, and 1-9 verification. -The results of each check must be printed with the original initiated and dated by the person who conducted the check. 1. Review of the Maintenance Supervisor's employee file showed the following: -Hire date 07/06/23; -No documentation staff completed a NA Registry check prior to hire or at anytime after his/her hire date. 2. Review of Certified Nurse Assistant (CNA) K's employee file showed the following: -Hire date 07/25/22; -No documentation staff completed an EDL check prior to hire or at anytime after his/her hire date. 3. Review of Hall Monitor L's employee file showed the following: -Hire date 05/04/23; -FCSR check requested 05/23/23 (19 days after hire); -NA registry check completed on 05/23/23 (19 days after hire). (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of NA M's employee file showed the following: -Hire date 01/22/24; -No documentation staff requested a CBC prior to hire; -No documentation staff completed an EDL check prior to hire; -No documentation staff completed a NA Registry check prior to hire; -No documentation staff completed a CBC, EDL, and NA Registry check anytime after his/her hire dated. 5. During an interview on 03/07/24 at 10:33 A.M., Human Resources staff said the following: -She took over all HR checks about one month ago; -The employee's hire date was the same as the start date; it was their first paid day; -After interviews were completed and it had been decided to offer the position, he/she ran the background check and all other checks, prior to the hire/start date; -He/She checked the FCSR, NA registry, and the CBC; -All checks must be completed, or at least requested, prior to the staff's first paid day. During an interview on 03/13/24 at 2:40 P.M. the Administrator said he expected all new employees to have a CBC, EDL, and NA registry check completed prior to their first paid day.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 36219 Based on observation, interview and record review, the facility failed to ensure staff prepared and safely administered medications to five residents (Resident #67, #6, #102, #60 and #108) when Certified Medication Technician (CMT) I prepared the resident's medications and Certified Nurse Aide (CNA)/CMT/Team Lead G administered the medications. The facility failed to obtain a physician order for Resident #60 to self-administer his/her own eye drops. The facility failed to complete accuchecks (a test to check sugar levels in the blood) as ordered for one resident (resident #81), in a review of 34 sampled residents, and failed to obtain a urinalysis when ordered for one resident (Resident #12). The facility failed to document the narcotic counts were completed by two staff. The facility census was 116. Review of the facility's Medication Administration and Monitoring Policy, revised 09/20/23, showed the following: -The purpose is to ensure a process is in place for proper administration of medications, techniques of administering medications, effective monitoring of residents for adverse consequences associated with side effects to medications; -Medications are to be given per physician orders; -Steps for medication administration: B. Dispense the medication; C. Watch the resident take the medication; H. It is imperative that all medications are given using the seven rights to medication administration and the professional caregiver ensures that medications are swallowed; I. Ensure that documentation is correct in electronic medication administration record; J. Narcotics must be counted with the on-coming shift nurse. Review of the facility's Resident's Rights Policy, revised 07/05/23, showed an individual resident may self-administer medications if the interdisciplinary team has determined that this practice is safe. Review of the facility's Transcription of Orders/Following Physician's Orders policy, dated 07/05/22, showed the following: -The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed, that a process is in place to monitor nurses in accurately transcribing and following physician orders; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in resident's electronic medical records in orders section; -Clarification of physician's orders will be obtained in the event that the order is either unclear or the nurse is uncomfortable in implementation of the physician's order; -The resident care coordinator (RCC)/unit director/licensed practical nurse (LPN)/Director of Nursing (DON) designee will audit all physicians orders daily to ensure all new physician's orders are recapped and followed completely and accurately. Review of the facility's Blood Glucose Monitoring and Insulin Administration, dated 06/29/23, showed the following: -The blood sugar monitoring/accucheck orders will be obtained from the physician, including the recommended time and frequency of the monitoring; -The charge nurse/designee will transcribe the blood sugar monitoring/accucheck to the physician order sheet and the medication administration record/accucheck/insulin record. 1. Review of Resident #67's medical diagnoses sheet showed he/she had diagnoses that included schizoaffective disorder (mental illness), anxiety and diabetes. Review of the resident's March 2024 physician order sheets (POS) showed orders the following: -Clonazepam (a sedative) 0.5 milligrams (mg) three times daily for anxiety; -Lactulose 30 milliliters (ml) every afternoon; -Gabapentin (a nerve pain medication) 200 mg three times daily for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Observation of a medication pass on the locked unit on 3/5/24 at 12:32 P.M. showed CMT I prepared the resident's medications at the medication cart. CNA/CMT/Team Lead G stood at the medication cart but did not observe what CMT I prepared. CMT I handed the medication cup containing the resident's medication and a cup of water to CNA/CMT/Team Lead G. CNA/CMT/Team Lead G walked up to the resident, who sat at the dining room table, and administered the medications that CMT I had prepared. (CMT I did not administer the medications he/she prepared for the resident, and CNA/CMT/Team Lead G administered medications he/she had not prepared.) Review of the resident's March 2024 medication administration record (MAR), showed CMT I documented he/she administered the resident's scheduled 10:00 A.M. medication: -Clonazepam 0.5 mg; -Lactulose 30 ml; -Gabapentin 200 mg. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #6's medical diagnoses sheet showed he/she had a diagnosis of mood disorder. Review of the resident's March 2024 POS showed orders the following: -Depakote (an anticonvulsant used to treat seizures and mood disorder) 500 mg three times daily for mood; -Calcium carbonate antacid, one tablet three times daily for calcium supplement. Observation of a medication pass on the locked unit on 3/5/24 at 12:32 P.M. showed CMT I prepared the resident's medications at the medication cart. CMT I crushed the medications and placed them in applesauce. When CNA/CMT/Team Lead G returned to the medication cart after administering another resident's medications, CMT I handed CNA/CMT/Team Lead G the cup of crushed medications in applesauce and a cup of water. CNA/CMT/Team Lead G walked up to the resident, who sat at the dining room table, and administered the medications that CMT I had prepared. (CMT I did not administer the medications he/she prepared for the resident, and CNA/CMT/Team Lead G administered medications he/she had not prepared.) Review of the resident's March 2024 MAR, showed CMT I documented he/she administered the resident's scheduled 11:00 A.M. medication: -Depakote 500 mg; -Calcium carbonate antacid. 3. Review of Resident #102's medical diagnoses sheet showed he/she had a diagnosis of anxiety disorder. Review of the resident's March 2024 POS showed the resident had an order hydroxyzine (an antihistimine used to treat anxiety) 50 mg three times daily for anxiety. Observation of a medication pass on the locked unit on 3/5/24 at 12:32 P.M. showed CMT I prepared the resident's medications at the medication cart. CNA/CMT/Team Lead G stood at the medication cart but did not observe what CMT I prepared. CMT I handed the medication cup containing the resident's medications and a cup of water to CNA/CMT/Team Lead G. CNA/CMT/Team Lead G walked up to the resident, who sat at the dining room table, and administered the resident's medications that CMT I had prepared. (CMT I did not administer the medications he/she prepared for the resident, and CNA/CMT/Team Lead G administered medications he/she had not prepared.) Review of the resident's March 2024 MAR, showed CMT I documented he/she administered the resident's scheduled 11:00 A.M. hydroxyzine. 4. Review of Resident #60's medical diagnoses sheet showed he/she had diagnoses that included pain, anxiety disorder and dry eyes. Review of the resident's March 2024 POS showed orders the following: -Clonazepam 0.5 mg three times daily for anxiety; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gabapentin 100 mg three times daily for pain; -Tylenol 1000 mg three times daily for pain -Artificial tears, one drop in both eyes three times daily for dry eyes (no order to self administer). Observation of a medication pass on the locked unit on 3/5/24 at 12:32 P.M. showed CMT I prepared the resident's medications at the medication cart. CNA/CMT/Team Lead G stood at the medication cart but did not observe what CMT I prepared. CMT I handed the medication cup containing the resident's medications, a box of eye drops, and a cup of water to CNA/CMT/Team Lead G. CNA/CMT/Team Lead G walked up to the resident, who sat at the dining room table, and administered the resident's oral medications CMT I had prepared. CNA/CMT/Team Lead G handed the bottle of eye drops to the resident who self administered the eye drops in his/her own eyes. (CMT I did not administer the medications he/she prepared for the resident, and CNA/CMT/Team Lead G administered medications he/she had not prepared. The resident administered eye drops and did not have an order to self administer medications.) Review of the resident's March 2024 MAR, showed CMT I documented he/she administered the resident's scheduled 1:00 P.M. medication: -Clonazepam 0.5 mg; -Gabapentin 100 mg; -Tylenol 1000 mg; -Artificial tears. During an interview on 3/5/24 at 12:50 P.M., CNA/CMT/Team Lead G said he/she usually offered to administer the resident his/her eye drops, but the resident preferred to do it himself/herself. 5. Review of Resident #108's medical diagnoses sheet showed he/she had a diagnosis of anxiety disorder. Review of the resident's March 2024 POS showed the resident had an order hydroxyzine 25 mg three times daily for anxiety. Observation of a medication pass on the locked unit on 3/5/24 at 12:32 P.M. showed CMT I prepared the resident's medication at the medication cart. When CNA/CMT/Team Lead G returned to the medication cart after administered another resident's medications, CMT I handed CNA/CMT/Team Lead G the cup of medication and a cup of water. CNA/CMT/Team Lead G walked to the resident's room and administered the resident's medications that CMT I had prepared. (CMT I did not administer the medications he/she prepared for the resident, and CNA/CMT/Team Lead G administered medications he/she had not prepared.) Review of the resident's March 2024 MAR, showed CMT I documented he/she administered the resident's scheduled 11:00 A.M. hydroxyzine. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/24 at 12:50 P.M., CNA/CMT/Team Lead G said he/she could identify each resident's medications that he/she had administered. He/She had not watched CMT I prepare each of the resident's medications but he/she had been passing medications to these residents for quite some time and he/she knew they were right. He/She had been trained to administer what you prepare when preparing and administering medications. During an interview on 3/14/24 at 4:52 P.M., CMT I said CNA/CMT/Team Lead G had not passed medications on the unit very much and wanted to do the pass together to get more comfortable with the residents. He/She should have made sure CNA/CMT/Team Lead G was watching what he/she prepared. He/She had been trained to administer what he/she prepared when preparing and administering medications. During an interview on 3/5/24 at 1:45 P.M., the Administrator said both CMT I and CNA/CMT/Team Lead G probably just know the residents and their medications really well, but not administering what you prepare, or administering what someone else prepares, without watching what they prepare, just set you up for failure and was not a safe form of medication administration. If a resident is self-administering medications, including eye drops, they should have a physician order to do so. 6. Review of the locked units (station 2) controlled count sign on/off log, documenting the nurses narcotic log count, on 3/5/24 at 2:53 P.M., showed the 6:00 A.M. to 6:00 P.M. narcotic count on 3/5/24 documented only one staff had completed the shift change narcotic count at 6:00 A.M. Documentation showed the off-going staff completed the count, but no documentation the on-coming staff completed the narcotic count with the off-going staff. During an interview on 3/5/24 at 2:55 P.M. showed CNA/CMT/Team Lead G said he/she had accepted the narcotic keys from CMT W around 2:00 P.M. He/She had not documented completing a narcotic count with CMT W at the time he/she received the keys. He/She did not know if CMT W had completed a count with the off-going shift the morning of 3/5/24. During an interview on 3/14/24 at 4:49 P.M., CMT W said he/she usually flipped through the narcotic log pages and confirmed the count with the number on the page, but he/she did not always have a pen and was not good about actually documenting his/her name on the log sheet. He/She knew that if his/her name was not documented, it looked like the count had not been completed. 7. Review of the locked unit's (station 2) controlled count sign on/off log, documenting the nurses narcotic log count, on 3/6/24 at 10:00 P.M., showed the 6:00 P.M. to 6:00 A.M. narcotic count on 3/6/24 documented only one staff had completed the shift change narcotic count at 6:00 P.M. Documentation showed the off-going staff completed the count but no documentation the on-coming staff completed the narcotic count with the off-going staff. During an interview on 3/6/24 at 10:05 P.M., Licensed Practical Nurse (LPN) X said he/she had not documented the narcotic count with the off-going shift at shift change because there had been an issue with a resident that distracted him/her. 8. Review of Resident #81's Care Plan, initiated on 07/06/22, showed the following: -Unstable blood glucose level; -Administer medications as prescribed; (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Consult dietician per order; -The resident's blood glucose level will be within desired range; -Educate representative/resident regarding prescribed treatment plan to manage blood sugars; -Evaluate blood glucose level per ordered frequency; -Monitor for signs/symptoms of hyperglycemia (higher than normal levels of sugar in the blood); -Monitor for signs/symptoms of hypoglycemia (lower than normal levels of sugar in the blood); -Monitor laboratory results; -Monitor medication effectiveness for management of blood glucose level. Review of the resident's Physician Order Sheets (POS) for February 2024 showed an order for accuchecks two times a day for diabetes mellitus (DM; a condition where the body has trouble controlling blood sugar and converting it to energy), original order dated 05/25/23. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for February 2024 showed no documentation staff was to obtain accuchecks two times a day as ordered on the resident's POS, and no documentation staff conducted an accucheck to obtain the resident's blood sugar on any day during the month. Review of the resident's POS for March 2024 showed an order for accuchecks two times a day for diabetes DM, original order dated 05/25/23. Review of the resident's MAR and TAR for March 2024 showed no documentation staff was to obtain accuchecks two times a day as ordered on the resident's POS, and no documentation staff conducted an accucheck to obtain the resident's blood sugar on any day during the month. During an interview on 03/07/24 at 2:25 P.M., the resident said the following: -Staff checked his/her blood sugars before, but it had been a month or more since the last check; -He/She believed staff was supposed to check his/her blood sugar two times a week. During an interview on 03/07/24 at 2:42 P.M., Licensed Practical Nurse (LPN) S said the following: -He/She was completing accuchecks today; -The accucheck orders are on the TAR; -He/She has one resident with an accucheck order today and it is not Resident #81. During an interview on 03/08/24 at 9:01 A.M., LPN AA said the following: (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The physicians order the accuchecks; -The physician or a nurse, if it is a telephone or verbal order, enter the orders into the chart; -Ordered accuchecks flow to the accucheck order tab on the TAR; -He/She was not aware the resident had orders for daily accuchecks; the last he/she knew they were weekly. 9. Review of Resident #12's face sheet showed his/her diagnoses included benign prostatic hypertrophy (BPH) (an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine) without lower urinary tract symptoms. Review of the resident's physician progress notes, dated 2/15/24, showed the following: -Chief complaint/nature of presenting problem: Urinary issues; -At the request of facility staff, resident is seen today for urinary issues; -The resident has a history of BPH (benign prostatic hypertrophy), and takes Flomax (urinary retention medication used to treat an enlarged prostate); -The resident reports nocturia (urinating frequently at night) and a couple of episodes of bedwetting; -The resident also reports some dysuria (discomfort, pain, or burning when urinating) and urgency (abnormally frequent urination); -Plan: Urinalysis with culture and sensitivity (UA with C&S) (test to check for urinary tract infection), if indicated. Review of the resident's physician's orders, dated 2/15/24, showed an order for UA with C&S, if indicated. Review of the resident's progress notes, dated 2/15/24 through 2/18/24, showed no documentation facility staff obtained the UA as ordered. Review of the resident's electronic health record (EHR) showed the following: -UA with C&S collected 2/19/24, received 2/20/24 and reported 2/23/24; -Results reviewed by the Director of Nursing (DON) on 2/24/24. During an interview 3/8/24 at 11:45 A.M., the Resident Care Coordinator (RCC) said the provider enters orders into the EHR. Nurses can see the new orders and should follow orders as written. She is not sure why the UA was not obtained until 2/19/24. The UA should have been obtained when ordered. 10. During an interview on 3/8/24 at 5:33 P.M., the Director of Nursing (DON) said the following: (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected staff to complete and document accuchecks as ordered; -She expected the staff who prepared medication to also administer the medication; -She expected a resident to have a self-administration order if the resident administers his/her own eye drops; -She expected two staff to complete and document the narcotic count, at the time of the count; -She expected staff to follow physician's orders; -She expected a UA to be obtained as ordered within 24 hours of the order; -The lab comes to the facility to pick up labs on specific days. The resident's UA might not have been picked up from the lab the day after it was obtained. Sometimes, they have to wait for a culture to come back but not that long; -She would have to look at the resident's progress notes regarding notifying the provider of the resident's UA results. During an interview on 3/21/24 at 3:07 P.M., the residents' physician said the following: -He would expect staff to follow physician's orders as written; -He would expect staff to obtain accuchecks as ordered; -He would expect staff to obtain a UA as ordered and be notified of the results in a timely fashion. 41412 50189		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to provide an ongoing program of meaningful activities on a daily basis to meet the interests and the physical, mental, and psychosocial well-being of each resident for five residents (Resident #25, #48, #110, #116 and #96) out of 34 sampled residents. The facility census was 116. Review of the facility's Activities Policy, revised on 07/19/23, showed the following: -Purpose: the purpose of this policy is to ensure that all residents in the facility are provided on ongoing program of activities designed to meet, in accordance with comprehensive assessments, their interests and there physical, mental and psychosocial well-being; -The life enhancement director coordinates section F of the comprehensive assessment and ensures that activities are designed to promote and enhance the emotional health, self esteem, pleasure, comfort, education, creativity, success ad independence for all residents, based on interview and assessing the resident's likes and dislikes; -If the resident requires more intensive interventions for activities, 1:1 programming that is relevant to the resident's specific needs, interests, culture, and history/background, than an individualized activities plan of care will be developed to enhance their psychosocial well being. 1. During a resident council meeting on 3/6/24 at 1:04 P.M., residents in attendance said the following: -There were not a lot of activities on the unit (Station Two) and very few activities were offered to those who lived off the unit (Station One); -There was an activity calendar but it was not followed; -There were no activities on the weekends or after supper. 2. Review of Resident #48's care plan for cognitive stimulation, dated 7/10/22, showed the following: -The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. The resident likes to look at magazines and picture books as well as flash cards and play with his/her dolls. Staff assists him/her to get flash cards and magazines; -The resident will maintain involvement in cognitive stimulation, social activities as desired; -All staff to converse with the resident while providing care; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ensure the activities the resident is attending are compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation); compatible with individual needs and abilities and age appropriate; -Provide the resident with activities calendar. Notify resident of any changes to the calendar of activities; -The resident needs one-on-one bedside/in-room visits and activities if unable to attend out of room events; -The resident needs assistance/escort to activity functions. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 7/19/23, showed the following: -Sometimes made self understood, and sometimes understood others; -Unable to make decisions; -No behaviors; -Dependent on staff for activities of daily living (ADLs); -Diagnoses of schizophrenia (a serious mental disorder in which people interpret reality abnormally), anxiety, depression, autism (a neuro developmental condition of variable severity with lifelong effects that can be recognized from early childhood, chiefly characterized by difficulties with social interaction and communication and by restricted or repetitive patterns of thought and behavior); -Activities were important and the resident's likes included reading books, magazines, listening to music, animals, being around people and going outside. Review of the resident's medical record for December 2023 showed no documentation of any activity progress notes and no documentation the resident participated in activities. Review of the Resident Daily Activity Attendance record showed no activities documented for the resident in December 2023. Review of the resident's care plan, dated 1/6/23, showed the resident will attend groups with his/her peers. He/She enjoys to color, draw and watch TV. His/Her favorite group activity is movies. He/She enjoys all types of music. Review of the resident's medical record for January, February or March 2024 showed no documentation of any activity progress notes and no documentation the resident participated in activities. Review of the Resident Daily Activity Attendance record showed no activities documented for the resident in January, February or March 2024. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/5/24 from 9:30 A.M. to 11:00 A.M. showed the resident was in his/her room playing with a baby doll. The resident yelled and screamed with no staff intervention. Observation on 3/6/24 during various times of the day showed the resident was in bed with no staff interactions, no TV was in the room, and no radio was on. There was no activities conducted by the activity department or the nursing staff. Observation on 3/7/24 at various times of the day showed the resident was in his/her room with no staff providing activity, no TV or radio was on or stimulation. There was no activities conducted by the activity department or the nursing staff. 3. Review of Resident #96's care plan for preferences, dated 1/5/23, showed the following: -The resident will attend groups depending on if the group is something he/she is interested in. -He/she likes to watch TV in his/her room and listen to country music. Review of the resident's Activity Progress Note, dated 4/5/23 at 11:21 A.M., showed the resident has dementia and gets easily confused. He/She doesn't talk much but does smile when you engage with him/her. Will continue to encourage participation with activities. Review of the resident's Activity Progress Note, dated 7/7/23 at 10:54 A.M., showed the resident has dementia therefore doesn't really interact with people. He/She will briefly look at magazines but does not have a long attention span. Will continue to encourage participation with activities. Review of the resident's Activity Progress note, dated 10/11/23 at 10:11 A.M., showed the resident is diagnosed with dementia. He/She does not participate in activities but will answer questions when he/she is asked. The resident does enjoy pet therapy. Will continue to encourage participation with activities. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Usually made self understood and usually understood others; -Unable to make decisions; -Wanders; -No behaviors; -Diagnoses of dementia, depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Review of the resident's Activity Progress Noted dated 1/5/24 at 10:42 A.M., showed the resident does not attend activities. Observations showed the following: (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/5/24 at various times of the day, the resident lay in the bed with no TV or radio on in the room. -On 3/6/24 at 4:00 P.M., the resident stood in the hallway with no staff interaction. Staff sat at the end of the hall with a computer, and did not interact with any resident; -On 3/7/24 at various times of the day, the resident lay on the bed with no TV or radio on in the room. -There was no scheduled activities conducted by the activity department or the nursing department on these days. 4. Review of Resident #110's Activity Interest Survey, dated 1/18/24, showed the resident's interests included dominos and drawing. The resident had no religious preference. Review of the resident's admission MDS, dated [DATE], showed the following: -Usually made self understood and usually understood others; -Moderately impaired in decision making; -Activity preferences included books, magazines, music, animals and news somewhat important. Group activities, going outside and religious activity were all somewhat important; -Diagnoses of dementia, anxiety and depression. Review of the resident's care plan, dated 1/18/24, showed no care plan for activities. Review of the Resident Daily Activity Attendance sheets on 3/08/24 at 1:26 P.M. showed no documentation of any resident activity participation for January, February or March and no one to one program established. Observations on 3/5/24, 3/6/24 and 3/7/24 at various times of the day showed the resident paced in his/her room or stood in the hallway. There were no activities conducted by the activity department or the nursing staff. 5. Review of Resident #25's face sheet showed his/her diagnoses included diffused traumatic brain injury (also known as a TBI, an injury that affects how the brain works), schizoaffective disorder (a mental health disorder that is a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of the resident's activity progress notes, dated 04/18/23, showed the following: -He/She participated in some activities if he/she was not sleeping; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She also spent a lot of his/her time with his/her girlfriend/boyfriend; -Will continue to encourage participation with activities. Review of the resident's activity progress notes, dated 07/21/23, showed the following: -He/She preferred to stay in bed and sleep; -When he/she was up, he/she would participate in activities; -Will continue to encourage participation with activities. Review of the resident's activity progress notes, dated 09/20/23, showed the following: -The resident is diagnosed with a diffused TBI and uses a wheelchair; -It is very hard to understand him/her because of his/her speech; -He/She participates in some activities if he/she is awake; -Most days he/she prefers to stay in bed; -Will continue to encourage participation with activities. Review of the resident's activity interest survey, dated 09/30/23, showed the following: -Interests in card games, sports, cooking, gardening, helping include spades, rummy, poker, blackjack, 21, bingo, Yahtzee, dominos, bowling, volunteering and helping others; -Interests in crafts, arts, music, exercise and spiritual include drawing, listen to music, dancing, exercise, bible study, book study, singing hymn and attending services; -Interests in outdoor, walking, wheeling and social events include BBQ/cook outs, socials, going to movie theater, going shopping and going out to eat; -Summary staff reviewed interest survey and will encourage resident to attend activities and groups that interest them and are beneficial to them; -The residents will be given a daily messenger with the facility's activities that occur daily so they can be aware of the activities and groups that are happening. Review of the resident's activities quarterly participation review, dated 12/25/23, showed the following: -Describe the resident's attendance preferences ad participation level with activities - attends at times; -Describe resident's favorite activities, special accomplishments, and/or new interests - any; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident's activity-related focus(es) including needs, strengths and preferences - activity-related focuses remain appropriate/current as per current care plan; -Progress toward resident's activity goals - goals were met; -Summary - resident attends groups he/she likes. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Unclear speech, usually able to make self understood, usually understands others; -No behaviors with disorganized thinking at times; -Activity preferences that are somewhat important include having books/newspapers/magazines to read, listening to music he/she likes, being around animals such as pets, keeping up with the news, doing things with groups of people, doing his/her favorite activities, getting outside for fresh air when the weather is good, participating in religious services when provided. Review of the resident's care plan, revised 12/31/23, showed the following: -The resident attends groups of his/her choice with his/her favorite group is games; -He/She doesn't like to nap; -He/She likes to get up around 10:00 A.M. and go to bed around 10:00 P.M.; -He/She likes to watch television, color and draw and his/her favorite music is old time rock 'n roll; -The resident is independent for meeting emotional, intellectual, physical and social needs; -The resident will maintain involvement in cognitive stimulation, social activities as desired; -Ensure the activities the resident is attending are compatible with physical and mental capabilities and compatible with known interests and preferences; -Invite the resident to scheduled activities; -Provide with activities calendar. Review of the activity calendar for Station One on 03/05/24 showed exercise at 10:00 A.M. and a craft at 2:00 P.M. Observations on 03/05/24 at 11:50 A.M. showed the resident lay in bed with his/her eyes closed sleeping. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/05/24 at 2:30 P.M. showed the resident lay in bed with his/her eyes closed sleeping. The craft activity was in progress with three to four residents in attendance at this time. The resident did not attend the activity. Observation on 03/06/24 at 9:15 A.M. showed the resident lay asleep in bed. Review of the activity calendar for Station One on 03/06/24 showed making cards for your social services department at 10:30 A.M. and national Oreo day at 2:30 P.M. Observations on 03/06/24 showed no group activities for residents in Station One. Observation on 03/06/24 at 3:10 P.M., showed the resident lay in bed with his/her eyes closed but was able to answer questions. The resident said he/she just wanted to sleep. During an interview on 03/06/24, at 9:50 P. M., the resident said the following: -He/She sleeps all of the time because he/she is bored; -He/She does not get up during the day because there is nothing to do; -He/She likes music and Bingo, but there has not been an activity director for the past few months; -He/She likes the new activity director, but the activity director will not get any help so nothing will change. 6. Review of Resident #116's face sheet showed the following: -Admission on 02/06/24; -Diagnoses include schizophrenia (a mental health disorder that affects a person's ability to think, feel, and behave clearly) and insomnia (a sleep disorder where a person may have trouble falling asleep, staying asleep or getting good quality sleep). Review of the resident's care plan, dated 02/08/24, showed no care plan for choices or activities. Review of the resident's activity interest survey, dated 02/09/24, showed the following: -Interests in card games, sports, cooking, gardening, helping include rummy, planting flowers, Pictionary, bingo, board games, table games, pool, Yahtzee, bowling, playing video games, volunteering and helping others; -Interests in crafts, arts, music, exercise and spiritual include sewing, knitting, decorating, drawing, jewelry making, sings music, listen to music, dancing, exercise and no religious preference; -Reading, writing, watching television/movies include can read, enjoys reading material, newspaper, magazines and currently writes and enjoys writing; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interests in outdoor, walking, wheeling and social events include BBQ/cook outs, walking, going to movie theater, going shopping and going out to eat; -Summary information received from resident, staff reviewed interest survey and will encourage resident to attend activities and groups that interest them and are beneficial to them; -The residents will be given a daily messenger with the facility's activities that occur daily so they can be aware of the activities and groups that are happening. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -No hearing or speech issues; -No behaviors or disorganized thinking; -Activity preferences that are somewhat important include having books/newspapers/magazines to read, listening to music he/she likes, being around animals such as pets, keeping up with the news, doing things with groups of people, doing his/her favorite activities, getting outside for fresh air when the weather is good, participating in religious services when provided. Observation on 03/05/23, at approximately 2:20 P.M., showed the resident participated in a craft activity with the activities director. During an interview on 03/06/24, at 9:34 P.M., the resident said the following: -He/She liked to do adult coloring pages and has many of them in his/her room, but it gets boring only doing the coloring pages; -He/She would like to do more activities and activities in the evening; -He/She has not seen very many activities since he/she has been at the facility. 7. During interviews on 3/8/24 at 12:44 P.M. and 1:15 P.M., the Activity Director said the following: -She had been the activity director since 01/29/24; -She did not have any activity aides but the nursing staff helped out a lot; -Activities on the 100 - 300 hall included crafts, Bingo, bubbles, and group exercises; -She did not routinely have activities on the weekend or evenings, but will do activities if she is at the facility or worked late; -She had not scheduled anything specific for the weekends or evenings as she was the only activities personnel at the present; (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing staff did things with the residents on the evenings and nursing staff had games to sit out for the residents on the weekends; -She tried to follow the activity calendar unless the residents did not want to do the activity listed. She then asked them what they wanted to do; -She has not had any residents say they are bored in the evening; -She was aware Resident #25 slept a lot because he/she was bored and will focus more on him/her now; -She was not aware Resident #116 was bored in the evening; -Activities depend upon the resident. Resident #48 should be on a one-to-one activity program. The resident did not participate in activities and she has not have a one-to-one program set up at this time as she is the only person in activities and has not had the time; -She will take things for the nursing staff to do on the locked unit with the residents. During an interview on 3/8/24 at 2:15 P.M., the Assistant Director of Nurses said the following: -She develops the activity care plan using the Activity Care Area Assessment (provides guidance on how to focus on key issues identified during a comprehensive MDS assessment.) and includes all staff to follow through with the interventions; -If a resident attends or participates in activities, then the Activity Director should document the participation. During an interview on 3/8/24 at 2:30 P.M., Nurse Aide BB said the following: -Activities will bring some items back for them to do with the residents; -If they have the time, and residents will participate, they will play cards or ring toss with them; -They do not document the participation anywhere. During an interview on 3/8/24 at 5:35 P.M., the Director of Nursing said the following: -The activities staff should conduct activities; -If the nursing staff have time, they can do some activities on the locked unit (Station Two). 42592 50189		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50189 Based on observation, interview, and record review, the facility failed to prevent a decline in limited range of motions or development/worsening of contractures (shortening and hardening of the muscles, tendons, and other tissues, often causing deformity and rigidity of joints) for one resident (Resident #28), in a review of 34 sampled residents. The facility census was 116. The restorative nursing policy was requested and not provided. Review of the facility policy, Physician's Orders for Therapy, revised on 06/29/23, showed the following: -Nursing to therapy communication forms will be initiated by a licensed Registered Nurse (RN); -All admissions, re-admissions and changes in functional status, that require therapeutic intervention will be screened for therapy services; -Therapy screening forms will be attached to the therapy recommendation form, a copy will be given to the Director of Nursing (DON) and Minimum Data Set (MDS) Coordinator to review and obtain Physician approval; -If the therapy screening indicates further evaluation, nursing staff will contact the physician. The physician will determine if further evaluation or diagnostic testing is needed prior to further therapy evaluation. -No therapy services will be initiated without an order being received; -When therapy receives evaluation only orders and the evaluation shows therapy is indicated, the therapist will document on the Therapy to Nursing Recommendation sheet, the type of therapy, times per week, number of weeks, and functional reason. 1. Review of Resident #28's undated face sheet showed the following: -admitted [DATE]; -Diagnoses included contracture to the left hand, hemiplegia (paralysis) and hemiparesis (partial weakness) of the left side, and chronic pain. Review of resident's Restorative Therapy Assessments dated 10/19/22, 01/21/23, 04/21/23, 07/24/23, 10/24/23, and 11/01/23 all showed no assistive devices and not enrolled in the restorative therapy program. Review of the resident's care plan, dated 11/08/23, showed the following: -Alteration in musculoskeletal status related to contracture of left hand; (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Remain free of injuries or complications related to left hand contracture; -Check nail length weekly during skin assessment, trim nails as needed; -Clean palm of hand at least daily; -Refer to therapy as needed for appropriate appliances to prevent injury related to contracture. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 02/02/24, showed the following: -Impairment of upper (shoulders, elbows, wrists, and hands) and lower (hip, knee, ankles, and feet) extremities on one side; -Pain medication as needed; -No therapy in the previous seven days. Review of resident's Physician Order Sheet (POS) for February 2024 showed an order for Physical Therapy (PT) and Occupational Therapy (OT) evaluation left hand pain and contracture. Order placed 02/27/24. Observation on 03/05/24 at 10:50 A.M. showed the resident had a contracture of his/her left hand/fingers. During an interview on 03/06/24 at 12:00 P.M., Nurse Aide (NA) P said the resident was not currently getting therapy or restorative services. During an interview on 03/07/24 at 1:43 P.M. the resident said the following: -Staff does not check or clean his/her contracted left hand regularly. This occurred maybe once a week; -He/She was not getting any therapy or exercises for his/her hand. During an interview on 03/07/24 at 2:27 P.M., NA P said he/she does not know if there was a restorative care program at the facility. During an interview on 03/07/24 at 2:28 P.M., Certified Nurse Aide (CNA) O said he/she was not aware of any restorative care program at the facility. During an interview on 03/07/24 at 5:15 P.M., Physical Therapist (PT) Q said the following: -The resident has orders for occupational therapy for his/her hand contracture; -The orders are pending insurance approval. During an interview on 03/08/24 at 8:31 A.M., the resident's guardian said the following: (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a slight contracture on admission to the facility; -He/She was unsure if the resident had received any therapy services since admission; -If the services are available and would benefit the resident, he/she would want them offered to the resident. During an interview on 03/08/24 at 9:01 A.M., Licensed Practical Nurse (LPN) AA said the following: -He/She does contracture checks, or attempts to do contracture checks every shift on the resident; -Contracture checks included assessing and cleaning the skin and fingernails for comfort and safety; -He/She was not aware if the resident had a brace to wear; -He/She was not aware if the facility had a restorative aide. Observation on 03/08/24 at 3:54 P.M. showed the following: -The resident's left hand was contracted; -His/Her pinky finger was turned under, and his/her fingernail was to the palm of his/her hand; -His/Her ring finger touched the palm of his/her hand. The top joint/finger tip was bent at 90 degrees, and was pointing out; -His/Her middle finger was straight, and the tip of the finger touched his/her palm; -His/Her index finger was bent at 90 degrees, and did not touch his/her palm; -The fingernail on his/her index finger was long and past the tip of his/her finger. During an interview on 03/08/24 at 3:54 P.M., the resident said he/she has minimal to moderate pain in his/her hand and fingers. During an interview on 03/08/24 at 12:18 P.M., PT Q said he/she was not sure if the facility had a restorative program, but that was something therapy would recommend at the conclusion of therapy services. During an interview on 03/08/24 at 3:34 P.M., Occupational Therapist (OT) R said the following: -For a resident who is admitted with a contracture, he/she would expect there to be an order for therapy evaluation for management; -Contracture care will typically have a therapy to nursing communication to do continued range of motion management, which varied based on each resident's needs. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/24 at 1:14 P.M., the Therapy Director said the following: -All residents receive a screening on admission and every quarter; -She does these screenings; -She completed the resident's initial screen and the resident refused to participate; -The resident did not have any orders for therapy, therapy evaluation, or restorative care on admission; -The resident has not had any contact with therapy, outside of screenings, since admission. During interviews on 03/08/24 at 12:27 P.M. and 5:35 P.M., the Director of Nursing (DON) said the following: -If a contracture was identified on a new resident, she would expect therapy to be notified to evaluate for further treatment or a brace; -If therapy was not already aware, or if there were no orders placed, she would expect nursing to notify therapy for an evaluation; -She would expect a resident with a contracture to have either an order for therapy evaluation and treatment, or a therapy to nursing communication to do continuing range of motion management; -The facility does not have a restorative care program or a restorative aide at this time, as she cannot keep one employed. During an interview on 03/13/24 at 2:40 P.M., the Administrator said the following: -He expected staff to be able to identify a contracture; -Once identified, he expected staff to notify therapy that an evaluation was needed to determine treatment as necessary. During an interview on 03/21/24 at 3:07 P.M., the resident's primary physician said he expected the facility to identify and address a contracture when the resident was admitted .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to ensure systems were put in place for one resident to ensure the resident's safety, (Resident #102), after the resident expressed suicidal ideations and said he/she would self-harm by placing a bag over his/her head, and failed to ensure staff placed one resident's (Resident #48's), feet on wheelchair foot pedals to prevent accidents or injuries of 34 sampled residents. The facility failed to ensure effective interventions were implemented to ensure one resident (Resident #21), of 20 additional residents, was not transported in his/her rollator walker, when another resident routinely pushed Resident #21 backwards in the walker to his/her room. The facility census was 116. Review of the facility policy, Intensive Monitoring/Visual Checks, revised 6/30/23, showed the following: -PURPOSE: To ensure a system is in place for residents who require increased monitoring for behavioral/psychiatric and medical issues; -Residents who require more intensive monitoring due to medical behavioral/psychiatric symptoms will be monitored on visual face checks by the Licensed Nurse and/or designee, and Certified Nurses Aide and/or designee. The Licensed Nurse monitoring shall include a visual assessment of clinical symptom changes or abnormalities; -The definition of intensive monitoring is defined as periodic (e.g. hourly, every two hours, or shiftly) check by a Licensed Nurse or One to One monitoring by the designated employee assigned by the Licensed Nurse. A Face Check is defined by the employee visually seeing the face of the resident. Residents may require more intensive monitoring based on their medical and behavioral/ psychiatric needs; -Residents may require, based on behavior/medical issues, a more intensive monitoring which would require the licensed nurse to visually check the resident more often than every two hours; -Certified Nurse Assistants can be provided direction to monitor the resident in a timely manner at the discretion of Administration for a medical or behavior decompensation; -All documentation of face checks, one to one, or other intensive monitoring will be done in Point Click Care (PCC) under the Task. (the facility electronic medical record) The attached monitoring sheets should only be used in the event that PCC is unavailable. The facility did not provide a policy for use of wheelchair pedals. 1. Review of Resident #102's face sheet showed his/her diagnoses included autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), schizophrenia (mental illness), anxiety disorder and obsessive-compulsive disorder (unreasonable thoughts and fears that lead to compulsive behaviors). (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/12/23, showed the following: -Mild cognitive impairment; -No behaviors exhibited. Review of the resident's care plan showed on 2/1/24 an intervention was added to the care plan to allow the resident to make decisions about treatment regimen to provide sense of control. Review of the resident's nursing notes showed the following: -On 2/18/2024 2:19 P.M., a friend contacted the facility reporting they had spoken with the resident and during conversation the resident said several times that he/she wished to die; that he/she wants to kill him/herself and to escape from the facility. Spoke with the resident who affirms that he/she feels like killing myself and that he/she wished to die because he/she was unhappy at the facility. Denies plan and does not articulate plan. Transferred to emergency room for evaluation and treatment; -On 2/19/24 at 5:38 A.M., resident returned to facility at approximately 9:05 P.M. via facility transport. Review of the resident's care plan showed on 2/20/24 an update was added to the care plan noting the resident was at low risk for suicide. Review of the resident's Columbia Suicide Severity Rating Scale, completed by facility staff, dated 2/20/24, showed the following: -The resident has wished they were dead or could go to sleep and not wake up in the past month; -Has thought about killing self in the past month; -Has not thought about how they might kill self with some intention of acting on these thoughts but has not worked out the details of how to kill self; -Has not previously done anything or prepared to do anything to end life; -Is considered high risk on the suicide severity rating scale. (this was not consistent with the resident's care plan) Review of the resident's Columbia Suicide Severity Rating Scale, completed by facility staff, dated 2/23/24, showed the following: -The resident has wished they were dead or could go to sleep and not wake up in the past month; -Has thought about killing self in past month; -Has thought about how they might kill self without any intention of acting on these thoughts; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Has not worked out the details of how to kill self; -Has not previously done anything or prepared to do anything to end life; -Is considered moderate risk on the suicide severity rating scale. (this was not consistent with the resident's care plan) Review of the resident's care plan, updated 3/1/24, showed the implementation of hourly face checks. (no reason noted for rationale) During an interview on 3/4/24 at 2:54 P.M., the resident said the following: -He/She did not want to live anymore and felt suicidal; -He/She requested to go to the hospital, but the facility would not send him/her to the hospital; -He/She would place a bag over his/her head to kill self; -He/She would rather die than live in the facility the rest of his/her life; -He/She was depressed. During an interview on 3/4/24 at 3:00 P.M., the administrator said the following: -This was a behavior of the resident's; -The resident was sent out to the hospital but returned within an hour and a half to the facility; -The plan was for staff to do 15 minute checks on the resident and nurses would complete hourly checks; -Staff were to ensure the resident's room was free of any items that the resident could use to harm him/herself; -The administrator was to talk to the resident that day. Observation of the resident's room on 3/5/24 at 12:19 P.M. showed a trash can under the resident's bedroom sink and one in the resident's bathroom. Each trash can had a plastic liner bag in the trash can. Observation and interview on 3/5/24 at 12:25 P.M., showed the following: -The resident sat in the dining/common room waiting to be served his/her noon meal; -The resident had an unkempt appearance and was dressed in pajama pants and a top; -He/She said he/she was still feeling suicidal and felt depressed; (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not want to go to the hospital any more and just did not feel like getting dressed today; -He/She had a plan to use a bag to put over his/her head to take his/her life; he/she did not know if that is how he/she would do it if he/she got to that point, but it was an option. During an interview on 3/5/25 at 12:54 P.M., Certified Medication Technician (CMT) I said the following: -Face checks are completed on all residents every hour; -The unit had residents that had occasional behaviors and when that happened, the residents are either placed with a partner for the day and on one on one; -Sometimes residents are on increased monitoring; -There were no residents on increased monitoring at that time and no one with suicidal thoughts that he/she was aware of. During an interview on 3/5/25 at 1:00 P.M., CMT/Team Lead G said the following: -There were no residents on increased monitoring at that time; -No one was having suicidal thoughts that he/she was aware of. Review of the resident's nursing notes and electronic medical record, on 3/5/24 at 1:45 P.M., showed no documented entry regarding the administrator or any staff member speaking with the resident about his/her reported suicidal feeling on 3/4/24. The resident had not been sent to the hospital for suicidal thoughts since 2/18/24. There was no documentation of increased monitoring every 15 minutes by staff or hourly by nursing. During an interview on 3/5/24 at 2:09 P.M., the administrator said the following: -The resident had been placed on increased monitoring after receiving the call from the regional office that the resident reported suicidal thoughts; -The resident remained on 15 minute checks by care staff and hourly checks by nursing; this should be documented in the nursing notes; -The inter-disciplinary team would be the team to release the resident from increased monitoring and the team had not met since the resident was placed on the increased monitoring; -He had instructed CMT W or the Administrator In Training (AIT) to ensure the resident's room was safe from items of self-harm; he was not aware if any items had been removed from the resident's room. During an interview on 3/25/24 at 8:32 A.M. the AIT said he/she could not remember any incident concerning the resident and suicidal ideation. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nursing notes on 3/5/24 at 3:58 P.M., showed a late entry was made by the administrator, for 3/4/24 at 2:20 P.M., noting he/she spoke with the resident and discussed his/her expression of wanting to self-harm and suicidal ideation. He informed the assistant director of nursing (ADON) and resident care coordinator (RCC) who attempted to contact the physician. The resident was placed on intensive monitoring. During an interview on 3/25/24 at 12:10 P.M. the ADON said the following: -She did not work on Monday 3/4/24; -Staff may have notified her on 3/5/24 of the resident's SI on 3/4/24. During an interview on 3/5/24 at 3:00 P.M., Housekeeper LL said the following: -He/She had emptied the resident's trash in the bathroom and under his/her sink; -There had been a trash can bag liner in the cans when he/she emptied the trash; -After removing the trash, he/she placed new bag liners in the trash cans; -No one had told him/her of any concerns with the resident. Observation of the resident's room on 3/5/24 at 3:13 P.M. showed a trash can under the resident's bedroom sink and one in the resident's bathroom. Each trash can had a plastic liner bag in the trash can. During an interview on 3/5/24 at 3:14 P.M., the resident's roommate said the following: -The administrator and the social worker came to his/her room about an hour ago and went through his/her drawers and took trash bags that he/she had that he/she used to put dirty clothes in; -Resident #102 had been making comments that he/she hates his/her life and his/her guardian; -He/She was told Resident #102 wanted to put a bag over his/her head to end his/her life; he/she was told that was why his/her trash bags were removed. (The administrator and social services had not removed the bags in the trash cans.) During an interview on 3/25/24 at 9:38 A.M. the SSD said the following: -She did not go into the resident's room after the resident expressed feeling suicidal; -She does recall the resident had suicidal feelings. She talked frequently with the resident after the incident and followed up with a care plan meeting. During an interview on 3/5/25 at 3:42 P.M., CMT/Team Lead G said the following: -There is not a nurse that had been working the unit this particular day, only CMTs; (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A nurse was on unit 1 and was called if there was an issue that needed addressed or a resident needed an injection; -Licensed Practical Nurse (LPN) S was the nurse on unit 1 that he/she would call if something was needed; -He/She had been back to the locked, secured unit one time since he/she started his/her shift early this morning and that was to give a resident an injection. During an interview on 3/25/24 at 9:09 A.M. Licensed Practical Nurse (LPN) S said the following: -He/She does not recall any incident with the resident as he/she doesn't work on Station 2; -He/She rarely works on Station 2. Observation of the resident's room on 3/6/24 at 9:56 A.M. showed the following: -The resident asleep in his/her bed; -A trash can under the resident's bedroom sink and one in the resident's bathroom. Each trash can had a plastic liner bag in the trash can. During an interview on 3/6/24 at 10:04 A.M., LPN Z said the following: -The resident was on increased monitoring for suicidal precautions; -He/She had heard that the resident was saying he/she was going to place a bag over his/her head to harm him/herself; -When asked what specifically he/she was monitoring, he/she said just that the resident was okay and his/her location; -When asked if he/she had monitored for bags in the resident's room, he/she said he/she had not; -He/She did not know if there were bags in the resident's trash cans in the resident's room and/or bathroom; -He/She provided written increased monitoring sheets for the resident, included monitoring for 3/5/24. Review of the written increased monitoring sheet for 3/5/24, showed CMT/Team Lead G documented completing 15 minute checks on the resident from 12:00 P.M. until 5:45 P.M. (previous interview showed on 3/5/24 at 12:54 P.M. he/she said there was no resident on increased monitoring). During an interview on 3/6/25 at 2:00 P.M., CMT/Team Lead G said the following: -He/She did not know why he/she had told the surveyor on 3/5/24 that there was no resident on increased monitoring; (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had been doing increased monitoring on the resident every 15 minutes for suicidal thoughts; -He/She had been told the resident threatened self-harm by placing a bag over his/her head; -He/She had not checked the resident's room for bags; he/she was not aware the resident's trash cans had bags in them on 3/5/24; -It wasn't until later in his/her shift (time unknown) on 3/5/24 that he/she was told there had to be documentation of the increased monitoring; the written documentation was completed after the fact. During an interview on 3/6/24 at 11:36 A.M., Housekeeper LL said Certified Nurse Assistant (CNA) V had just told him/her today that the resident had threatened to place a bag over his/her head with intent to harm him/herself; when he/she removed the resident's trash, he/she did not place a bag back in the cans. During an interview on 3/8/24 at 5:35 P.M. the DON said the following: -If a resident threatened to harm themselves and said they would use trash bags she would expect trash bags to be removed from the resident's room; -Face checks should be documented when completed; -All staff including housekeeping staff should have been educated regarding the removal of trash bags from the resident's room. 2. Review of Resident #21's face sheet showed his/her diagnoses included dementia, borderline intellectual function (a group of people who function on the border between normal intellectual functioning and intellectual disability), lack of coordination and generalized muscle weakness. Review of the resident's care plan, dated 5/17/21, showed the following: -The resident was a fall risk related to gait and balance problems, dementia, and poor judgment; -Staff needed to anticipate and meet the resident's needs; -The resident had impaired cognitive function or impaired thought processes related to dementia; -The resident needed to be cued, reoriented and supervised as needed; -The resident was up ad lib with a walker assisted as needed with transfers; -The resident was able to ambulate with a walker; -The resident required assist of one at times with ambulation. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderate cognitive impairment; -The resident was independent with the ability to come to a standing position from sitting in a chair or on the side of the bed; -The resident needed supervision or touch assistance: -When he/she was walking at least 10 feet in a room or corridor; -When he/she was walking 50 feet with two turns once standing; -When he/she was walking 50 feet and making two turns, and; -When he/she was walking at least 150 feet in a corridor; -Used a walker for mobility. Observation on 3/06/24 at 12:45 P.M., showed the resident sat on his/her rollator walker, and Resident #73 pushed him/her backwards in the rollator walker down the 200 hallway to the resident's room, which was located half way down the 200 hallway. During an interview on 3/8/24 at 4:43 P.M., Resident #73 said he/she pushed the resident in his/her rollator walker. He/She has been told not to push the resident in his/her rollator walker, but it was a long distance for the resident to walk and he/she liked helping the resident to his/her room. During an interview on 3/8/24 at 4:45 P.M., the resident said Resident #73 pushed him/her to his/her room. It was a long way to walk and he/she gets tired. He/She knew they weren't supposed to do this, but they continued to do it anyway. During an interview on 3/8/24 at 5:31 P.M., Nurse Aide (NA) U said the following: -Residents were not supposed to push the resident in his/her rollator walker; -He/She had seen Resident #73 push the resident in his/her rollator walker in the past; -He/She had told Resident #73 to stop pushing the resident, but Resident #73 would not listen to him/her; -He/She did not feel it was safe for Resident #71 to push the resident backwards in his/her rollator walker. During an interview on 3/08/24 at 5:37 P.M., NA BB said the following: -He/She had seen Resident #73 push the resident in his/her rollator walker in the past; -Resident #73 liked to help the resident; -He/She had told Resident #73 to stop pushing the resident, but he/she would not listen to him/her; (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #73 got an attitude if he/she was told to stop pushing the resident in his/her rollator walker; -He/She did not feel it was safe for Resident #73 to push the resident backwards in his/her rollator walker. During an interview on 3/08/24, at 5:39 P.M., LPN AA said the following: -The resident would get tired and would sit down on his/her rollator walker to rest; -He/She did not feel it was safe for Resident #73 to push the resident backwards in his/her rollator walker; -If staff observed Resident #73 pushing the resident in his/her rollator walker, they should stop him/her and remind Resident #73 that staff needed to help the resident; -Residents should not push other residents in their rollator walker; -Resident #73 got upset when staff told him/her to stop pushing the resident in his/her rollator walker; -Resident #73 tried to help the resident everyday by attempting to push him/her to his/her room on his/her rollator walker. During interviews on 3/08/24 at 6:03 P.M. and 3/21/24 at 4:54 P.M., the Director of Nursing (DON) said the following: -She did not feel it was safe for anyone to push a resident backwards in a rollator walker; -She did not consider the rollator walker to be a transport device; -She did not know how long Resident #73 had been pushing the resident in his/her rollator walker; -She thought this behavior has been going on for approximately three months; -Past interventions have included moving the resident to a hallway away from Resident #73, the resident was educated to ask staff for assistance, Resident #73 was educated to stop pushing the resident in his/her rollator walker, and staff were educated to watch and assist the resident as needed; -Staff had been encouraging Resident #73's good behavior and discouraging his/her bad behavior; -She did not think these interventions were working; -Resident #73 had been educated on not pushing the resident in his/her rollator, but he/she still pushed the resident; -Resident #73 says he/she likes to be helpful. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/24 at 2:40 P.M. and 3/21/24 at 5:08 P.M., the Administrator said the following: -He was unaware Resident #73 was pushing the resident in his/her rollator walker. -He did not consider the rollator walker to be a transport device; -The rollator walker should be used for walking, not for transporting; -He would not expect a resident to push another resident in their rollator walker backwards to their room; -He did not feel it was safe a resident to push another resident in their rollator walker backwards; -If staff observed this behavior, he expected them to not let it happen; 3. Review of Resident #48's care plan for falls, dated 11/19/20, showed the following: -The resident is at risk for falls related to use of psychoactive medications, impaired independent mobility and incontinence. Frequently uses a wheelchair, staff propels; -Ensure footrests are in place and feet are resting on such prior to staff propel wheelchair. Observation on 3/05/24 at 2:19 P.M. showed the following: -Staff propelled the resident down the hallway in a wheelchair; -The wheelchair did not have any foot pedals and the resident's feet were approximately 6-8 inches off the floor unsupported. During an interview on 3/6/24 at 6:00 PM Certified Nurse Aide (CNA) CC said the following: -The resident used a wheelchair and staff should use the pedals when he/she is up in the wheelchair; -Wheelchair pedals should be used when pushing a resident in a wheelchair. During an interview on 3/07/24 at 6:20 P.M., the DON said wheelchair pedals should be used on wheelchairs for resident safety. MO232690 41412		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview and record review, the facility failed to offer sufficient fluids to maintain proper hydration and health when staff failed to pass and offer water to three sampled residents (Resident #48, #96 and #110) out of 34 sampled residents. The facility census was 116. Review of the facility policy for Hydration dated 6/29/23 showed: -The purpose of this policy is to ensure that a hydration program is in place in each facility, to monitor hydration of residents and to define clinical symptoms of dehydration. The policy will also address assessment of residents at risk for dehydration and put a plan in place to identify nursing interventions including an interdisciplinary team approach in addressing the resident who is at increased risk for dehydration or the resident that requires special assistance or special monitoring of fluid intake; -Fluid will be passed every two hours with the exception of meal times and night shift. The night shift staff will ensure that fresh water is passed during the shift and ice water containers will be changed with clean containers.; -This will be monitored on day shift by the Resident Care Coordinator/Charge Nurse, evenings: Charge nurse/Certified Medication Technician (CMT), Nights: the Charge Nurse/CMT. 1. Review of Resident #48's care plan for bladder incontinence dated 4/21/21 showed the following: -The resident has bladder incontinence related to confusion, dementia, and impaired mobility; - Encourage fluids during the day to promote prompted voiding responses. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 1/29/24 showed: -Sometimes makes self understood and sometimes understands others; -Dependent upon staff for Activities of Daily Living (ADLs); -No difficulty with swallowing or at risk for aspiration; -Diagnoses of anxiety, depression, schizophrenia (a serious mental disorder in which people interpret reality abnormally) and autism (a neurodevelopmental condition of variable severity with lifelong effects that can be recognized from early childhood, chiefly characterized by difficulties with social interaction and communication and by restricted or repetitive patterns of thought and behavior). Observation on 03/05/24, 3/6/24, 3/7/24 and 3/8/24 showed no water pitchers or glasses of fluids in the resident's room. 2. Review of Resident #96's care plan for bladder incontinence dated 7/11/22 showed: (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of Urinary Tract Infection (UTI): -The resident will remain free from skin breakdown due to incontinence and brief use through the review date. -Encourage fluids during the day to promote prompted voiding responses. -Limit fluids 2-3 hours prior to bedtime. Review of the quarterly MDS dated [DATE] showed: -Usually make self understood and usually able to understand others; -Requires supervision with ADL's; -No difficulty with swallowing or at risk for aspiration; -Diagnoses of dementia, depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Observation on 3/5/24 at 11:30 A.M. showed the resident in his/her bed with no water pitcher or glass with fluid in his/her room. Observation on 03/05/24, 3/6/24, 3/7/24 and 3/8/24 showed no water pitchers or glasses of fluids in the residents room. 3. Review of Resident #110's admission MDS dated [DATE] showed: -Usually able to make self understood and usually able to understand others; -Mildly impaired decision making; -Supervision with ADL's; -No difficulty with swallow or at risk for aspiration; -Diagnosis of dementia, anxiety and depression. Observation on 3/05/24 at 3:01 P.M. showed: -The resident was in his/her room, his/her lips were dry. There was no water pitcher or glass of fluids in the room. The resident wanted a cup of coffee, a staff member told the resident he/she could have a cup when supper was served. Observation on 03/05/24, 3/6/24, 3/7/24 and 3/8/24 showed no water pitchers or glasses of fluids in the resident's room. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/6/24 at 11:00 A.M. showed an ice chest was on the hall and was almost full of ice. There was no water pitcher in the resident's room or on the ice chest. Observation on 3/6/24 at 12:00 P.M. showed staff served the lunch trays to Resident #96 and #110. Staff did not serve a beverage with the meal. During an interview on 3/6/24 at 12:30 P.M. Certified Nurse Aide (CNA) O said: -Staff should serve fluids at 10:00 A.M. and 2:00 P.M.; -Staff give the residents drinks with meals; -There should be water pitchers for the staff to fill with the ice and water and pass at least every shift; -She did not know why there weren't any water pitchers available. During an interview on 3/6/24 at 9:00 PM CNA CC said ice water should be passed every two hours, each resident used to have pitchers for the water, but many of them were broken and have not been replaced. He/She did not have anything to put fresh water in. During an interview on 3/7/24 at 2:00 P.M. Licensed Practical Nurse (LPN) S said: -Staff should pass ice water every two hours; -Each resident should have their own water pitcher; -Staff should offer residents drinks with their meals. During an interview on 3/8/24 at 5:35 P.M. the Director of Nursing said: - Fresh water should be passed every two hours. If a resident is at risk for aspiration then they will not have a pitcher for water in their room, but if no restrictions then residents should have a water pitcher in their room; -Additional fluids should be passed with meals. During an interview on 3/13/24 at 9:20 A.M. the Administrator said he expected staff to pass fresh water to the residents every two hours during the waking hours and offer fluids frequently. Staff should give fluids with meals. 42592 50189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to assess residents for risk of entrapment, document attempted alternatives prior to installing a bed rail, and failed to obtain informed consent with risks prior to installing and using a bed rail for two residents (Residents #32 and #35), who had assist bars attached to their bed, in a review of 34 sampled residents. The facility census was 116. Review of the facility Bed Siderails policy, reviewed 6/29/23, showed the following: -To ensure all bed side rails in use have been evaluated for safety; -All residents using any size side rail device on their beds will have a Restraint/Entrapment Assessment completed to determine the restraining, enabling, or hazard effect of the device. This assessment will occur upon initial use, quarterly, and as needed if there is a significant change in the resident's condition; -Using steps 1 and 2 of the Restraint/Entrapment Assessment, each resident using a side rail device will be assessed to determine if the side rail has a restraining affect and/or an enabling effect; -Each resident using a side rail device will have a detailed history documented including the symptoms or reasons for using a device; -All possible negative effects and safety hazards of the device will be considered in the assessment; -If a resident is determined to be at Risk with the device in Step 3 of the Restraint/Entrapment Assessment, the use of the device will be discontinued, and the resident will be reevaluated for use of an alternative device; -Using any device requires a care plan. 1. Review of Resident #32's face sheet showed the following: -The resident is his/her own responsible party; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included Type 2 diabetes mellitus (too much sugar in the blood) with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), morbid obesity (Individuals are usually considered morbidly obese if their weight is more than 80 to 100 pounds above their ideal body weight), rheumatoid arthritis (an autoimmune and inflammatory disease), partial traumatic amputation (at least half the diameter of the injured extremity is severed or damaged significantly) of right foot, osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), muscle weakness, lack of coordination, abnormalities of gait (the pattern of how you walk) and mobility, retinal detachment with retinal break (an emergency situation in which a thin layer of tissue (the retina) at the back of the eye pulls away from its normal position), joint disorder, and pain. Review of the resident's care plan, dated 3/14/23, showed the following: -The resident is at risk for fall related to deconditioning, gait/balance problems and psychoactive drug use; -He/She is often non-compliant with asking for assistance when needed; -The resident has a self-care performance deficit related to amputation of right toes, limited mobility, limited range of motion and pain; -He/She is non-compliant with non-weight bearing status and continues to transfer himself/herself and try to walk at times; -The resident has fatigue; -The resident has (chronic) pain related to arthritis and diabetic neuropathy; -The resident takes pain medication and needs to be monitored for confusion, dizziness, and falls; -The resident has impaired visual function related to retinal detachment and needs to be monitored for decline in mobility and sudden visual loss. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/01/23, showed the following: -Cognitively intact; -Highly visually impaired; -Required staff supervision for all mobility areas except rolling from left to right in bed. Observations on 03/05/24 at 11:15 A.M., 3/6/24 at 9:12 A.M., 3/7/24 at 12:28 P.M., and 3/8/24 at 8:37 P.M., showed the resident had 1/8 bed rail on the left hand side of his/her bed in the raised position. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed no documentation the resident's care plan addressed the use of bed rail on the resident's bed. Review of the resident's medical record showed no documentation staff completed a bed rail assessment or obtained consent for the use of the bed rail. 2. Review of Resident #35's face sheet showed the resident was admitted to the facility on [DATE]. The resident's diagnoses included history of fractured right and left femur and cerebral palsy (a condition marked by impaired muscle coordination (spastic paralysis) and/or other disabilities, typically caused by damage to the brain before or at birth). Review of the resident's care plan for Activity of Daily Living (ADL) deficit, dated 3/2/22, showed the following: -The resident has an ADL self-care performance deficit related to cerebral palsy. He/She was dependent on staff for all bedside cares and mobility; -The resident is totally dependent on one to two staff for repositioning and turning in bed. The resident is able, if willing, to pull/hold body to side(s) during cares. -No approaches for the use of the bed rails. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Able to make self understood and understood others; -Moderately impaired with decision making; -Impairments to the both side of the lower body; -Dependent upon staff with rolling from side to side, going from a sitting to a lying position and a lying to a sitting position. Observations on 3/05/24 at 3:15 PM and on 3/7/24 at 2:00 P.M. showed the following: -The resident had assist rails on each side of the bed at the head of the bed. -When staff told the resident to grab the rail, the resident was able to grab the assist rail and assist with rolling over in bed, with staff assistance. Review of the resident's medical record showed no documentation staff completed a bed rail assessment or obtained consent for the use of the bed rail. 3. During an interview on 03/07/24 at 3:27 P.M., the Assistant Director of Nursing (ADON) said the following: -She is the one who would complete an assessment for the use of the bed rails; -She did not complete an assessment for the residents; (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Maintenance staff would do the entrapment assessment, and this has not been done. -No consents were obtained. During an interview on 3/07/24 at 3:20 P.M., the Director of Nursing (DON) said the following: -No assessments or consents were completed for the assist rails; -A consent for the use of a bed rail should be obtained before using a bed rail; -Consents and/or assessments should be done quarterly. During an interview on 3/12/24 at 9:20 A.M., the Administrator said an assessment should be completed before the use of bed rails. 47008		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 36219 Based on interview and record review the facility failed to ensure two nurse aids (NA BB and NA U) of three staff reviewed, completed a certified nurse aid (CNA) training program within four months of their employment in the facility. The facility census was 116. Review of an electronic mail communication on 03/22/24 at 9:52 A.M., the Director of Nursing said the facility did not have a specific policy on Nursing Assistant and Certified Nursing Assistant training program. 1. Review of the facility provided list of employees hired since last annual survey showed the following: -NA BB's date of hire was 02/09/23; -NA U's date of hire was 06/02/23. 2. Review of NA B's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date. 3. Review of NA U's employee file showed no documentation he/she completed a CNA training program without four months of his/her hire date. 4. During an interview on 03/13/24 at 2:40 P.M., the Administrator said the following: -He was responsible for enrolling all NAs in the training program; -He was aware the timeline for completion of the training was four months from date of hire; -The NAs (NA BB and NA U) have not yet tested , but are enrolled in the program, they have just slipped through the cracks; -He was responsible for following up on the progress of their training to ensure completion.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on interview and record review, the facility failed to ensure four residents (Residents #28, #48, #95 and #96), who were prescribed psychotropic medications, in a review of 34 sampled residents, received a gradual dose reduction (GDR), unless clinically contraindicated. The facility census was 116. Review of the facility's Medication Administration and Monitoring Policy, revised 09/20/23, showed the following: -The purpose is to ensure a process is in place for proper administration of medications, techniques of administering medications, effective monitoring of residents for adverse consequences associated with side effects to medications; -The facility will confer the pharmacist consultant and utilize drug reference guideline sources to ensure that residents receive medications safely without negative outcomes; -Each resident's drug regimen will be reviewed monthly by a licensed pharmacist. Any irregularities or concerns will be given to the physician and Director of Nursing (DON); -All pharmacy consultant recommendations will be addressed and followed up with nursing or the physician; -Psychotropic medication will be reviewed by the physician and the licensed registered nurse will assess the psychotropic medication quarterly; -Psychotropic medication reductions will be reviewed by the pharmacy consultant and the prescribing physician. 1. Review of Resident #48's care plan for psychotropic drug use, dated 8/3/23, showed the following: -The resident uses psychotropic medications Ativan (used to treat anxiety), olanzapine (antipsychotic medication), Celexa (an antidepressant) and Haldol deconate injection (used to treat mental/mood disorders); -The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotention (low blood pressure), gait disturbance, constipation/impaction or cognitive/behavioral impairment; -Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/19/24, showed the following: -Sometimes able to make self understood and sometimes understood others; -Unable to make decisions; -Dependent upon staff for activities of daily living (ADLs); -No behaviors; -Diagnoses of anxiety disorder, depression, schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation) and autism (a neuro developmental condition of variable severity with lifelong effects that can be recognized from early childhood, chiefly characterized by difficulties with social interaction and communication and by restricted or repetitive patterns of thought and behavior). Review of the resident's Physician Order Sheet (POS), dated 3/2023, showed the following: -Olanzapine 10 milligram (mg), give one tablet by mouth (PO) one time a day for schizoaffective disorder (original order dated 9/13/22); -Olanzapine 20 mg, give one tablet PO one time a day at bedtime for schizoaffective disorder (original order dated 9/13/22). Review of the resident's Pharmacy Review Notes from 9/22/22 through 2/18/24 showed no recommendation for a GDR for olanzapine 10 mg or the olanzapine 20 mg. Review of the resident's psychiatric physician's notes, dated 6/26/23, 12/5/23, and 1/18/24 showed no documentation of any attempts at a GDR for the olanzapine. 2. Review of Resident #96's care plan for the use of psychotropic medication, dated 12/27/22, showed the following: -The resident uses psychotropic medications aripiprazole (used to manage and treat schizophrenia, mania associated with bipolar I disorder), uses Zoloft and trazadone (antidepressant medication); -The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment; -Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift; (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia (abnormal movements, extrapyramidal symptoms (EPS shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Review of the resident's Pharmacy Review Notes, dated 2/6/23, showed the following: -Physician: Please assess risk versus benefit and if the resident would benefit from a dose reduction of the following psychotropic medication(s): aripiprazole 5 mg every day; -CMS recommends periodic dose reduction attempts to reduce psychotropic medication use. If a dose reduction is clinically contraindicated, please note below; -No documentation found by the physician to address this pharmacy recommendation. Review of the Pharmacy Review note, dated 8/9/23, showed the following: -Note to physician: Please assess risk versus benefit and if the resident would benefit from a dose reduction of the following psychotropic medication(s): aripiprazole 5 mg daily; Trazadone 100 mg (2) bedtime; sertraline (Zoloft) 25 mg daily ; -CMS recommends periodic dose reduction attempts to reduce psychotropic medication use. If a dose reduction is clinically contraindicated, please note below; -No documentation found by the physician to address this pharmacy recommendation. Review of the resident's Physician Order Sheet (POS), dated March 2024, showed the following: -Aripiprazole tablet 5 mg, give one tablet by mouth in the evening related to bipolar disorder (original order dated 6/30/22); -Trazadone HCl tablet 100 mg., give two tablets by mouth in the evening related to insomnia (original order dated 6/30/22); -Zoloft tablet 100 mg, give 100 mg by mouth at bedtime for depression (original order dated 12/20/23). Review of the resident's medical record for March 2024 showed no documentation for any GDR for the use of aripiprazole, Trazadone or Zoloft. During an interview on 3/07/24 at 5:31 P.M., the Director of Nursing said the following: -The psychiatric physician tracks and makes recommendations for GDRs; -The documents are saved in the Electronic Medical Record (EMR); -She could not find any recommendations for a GDR for the resident. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of resident #28's care plan for behaviors related to mental illness, dated 10/27/22, showed the following: -Administer and monitor medications as ordered; -Administer as needed (PRN) medications as needed/ordered when non-pharmacological interventions are noneffective; -Pharmacy consultant will review medications monthly and PRN; -Psychiatry consult for medication adjustments as needed/ordered. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Delusions; -No behaviors; -Diagnoses included anxiety disorder, depressive disorder, schizophrenia (a mental condition involving a breakdown in the relation between thought, emotion, and behavior, leading to abnormal perceptions, inappropriate actions and feelings, withdrawal into fantasy and delusions and a sense of mental fragmentation, or a breakdown of memories), dementia (progressive or persistent loss of intellectual functioning, involving memory and abstract thinking, often with personality changes), transient ischemic attack (TIA; a temporary blockage of flow to the brain), and traumatic brain injury (TBI; an alteration in brain function caused by an external force). -Medications including antipsychotic, antianxiety, antidepressant, and opioid; -No gradual dose reduction (GDR) attempted; -GDR contraindicated by physician on 01/18/24. Review of the resident's Physician Order Sheet (POS), dated March 2024, showed the following: -Invega sustena suspension (an antipsychotic medication) prefilled syringe 234 mg/1.5 ml, inject one dose intramuscularly one time a day every 28 day(s) related to schizoaffective disorder (original order dated 10/19/22); -Prozac (a medication used to treat mood disorders) capsule 20 mg, give three capsule by mouth at bedtime related to schizoaffective disorder (original order dated 10/19/22); -Trazodone HCl (an antidepressant and sedative medication) 100 mg, give two tablets by mouth in the evening related to insomnia (original order dated 10/19/22). Review of the resident's psychiatric physician notes, dated 10/29/23 and 01/18/24, showed no documentation by the physician of any attempts or contraindications on a GDR. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed no evidence a GDR was attempted and no clinical rationale from the resident's physician to show a GDR was contraindicated. 4. Review of Resident #95's face sheet showed the following: -Admission to the facility on [DATE]; -Diagnoses include schizoaffective disorder bipolar type (a mental health disorder that is a combination of symptoms of schizophrenia and bipolar disorder-a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a mental health disorder that affects a person's ability to think, feel, and behave clearly) and anxiety disorder. Review of the resident's care plan, dated 04/28/22, showed the following: -Desired outcome of stabilization of mental illness with treatment regimen ordered by physician and implementation of behavior management; -Administer medications as ordered, and monitor for adverse reactions as well as therapeutic effect; -Long-term psychiatric management and counseling if needed; -The resident is at risk for adverse reaction related to polypharmacy (the use of multiple medicines); -The resident will be free of adverse drug reactions; -Monitor for possible signs and symptoms of adverse drug reactions: falls, weight loss, fatigue, incontinence, agitation, lethargy, confusion, agitation, depression, poor appetite, constipation, gastric upset; -Review pharmacy consult recommendations and follow up as indicated. Review of the long-term psychiatry visit note, dated 08/07/23, showed the following: -Active medication: paliperidone (an antipsychotic used to treat mental disorders) 234 milligrams (mg)/1.5 milliliters (ml), inject one syringe intramuscularly every 28 days for paranoia related to schizophrenia, started on 07/07/22; -Active medication: mirtazapine (an antidepressant used to treat mental disorders) 30 mg in the evening for anxiety related to schizoaffective disorder, bipolar type, started on 04/27/22; -No psychomotor symptoms, observation of normal motor skills and no evidence of involuntary movements: -General assessment comments: resident is at baseline, no behavior issues, compliant with recommended treatments; (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assessment: Continue facility supportive plan of care, medications reviewed, all diagnosis reviewed and updated, continue all other current medications. Review of the long-term psychiatry visit note, dated 10/29/23, showed the following: -Active medication: paliperidone 234 mg/1.5 ml, inject one syringe intramuscularly every 28 days for paranoia related to schizophrenia, started on 07/07/22; -Active medication: mirtazapine 30 mg in the evening for anxiety related to schizoaffective disorder, bipolar type, started on 04/27/22; -Psychomotor symptoms of slight oral buccal (cheek) movements, observation of normal motor skills and no evidence of involuntary movements; -General assessment comments: patient quiet and cooperative, compliant with medications; -Assessment: Continue all other current medications (paliperidone and mirtazapine). Continue to monitor mood, behavior, and side effects of medications. Review of the resident's medical record, Abnormal Involuntary Movement Scale (AIMS) evaluation (an assessment tool that evaluates for potential side effects of psychotropic medications), dated 11/05/23 showed no involuntary movements or concerns. Review of the long-term psychiatry visit note, dated 12/05/23, showed the following: -Active medication: paliperidone 234 mg/1.5 ml, inject one syringe intramuscularly every 28 days for paranoia related to schizophrenia, started on 07/07/22; -Active medication: mirtazapine 30 mg in the evening for anxiety related to schizoaffective disorder, bipolar type, started on 04/27/22; -No psychomotor symptoms, observation of normal motor skills and no evidence of involuntary movements; -General assessment comments: case reviewed with staff, medications reconciled, all diagnosis reviewed an updated. Review of the long-term psychiatry visit note, dated 01/18/24, showed the following: -Active medication: paliperidone 234 mg/1.5 ml, inject one syringe intramuscularly every 28 days for paranoia related to schizophrenia, started on 07/07/22; -Active medication: mirtazapine 30 mg in the evening for anxiety related to schizoaffective disorder, bipolar type, started on 04/27/22; -No psychomotor symptoms, observation of normal motor skills and no evidence of involuntary movements; (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-General assessment comments: case reviewed with staff, medications reconciled, all diagnosis reviewed and updated; -No documentation to show a GDR was contraindicated. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Took antipsychotic and antidepressant medication on a routine basis; -No gradual dose reduction attempted since last assessment. Review of the pharmacy review notes, dated 03/07/23 through 02/19/24, showed a notation monthly for no new suggestions. Review of the resident's medical record, Abnormal Involuntary Movement Scale (AIMS) evaluation (an assessment tool that evaluates for potential side effects of psychotropic medications), dated 02/06/24 showed the following: -Muscles of facial expression such as movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing: observation of minimal, may be extreme normal movements; -Incapacitation due to abnormal movements: none; -Resident's awareness of abnormal movement: not aware. Review of the resident's March 2024 physician order sheets showed the following: -Mirtazapine 30 mg in the evening for anxiety related to schizophrenia (original order dated 04/27/22); -Paliperidone palmitate extended-release 234 mg/1.5 ml, inject one syringe intramuscularly every 28 days for paranoia related to schizophrenia (original order dated 07/07/22). Observation on 03/05/24 at 11:43 A.M., showed the resident lay awake in his/her bed. The resident had a slight mouth tremor with slight lateral movement. The resident said he/she has had the tremor for a while and it bothers him/her. Observation on 03/06/24, at 10:10 A.M., showed the resident lay in his/her bed asleep. Mouth tremor is present but less pronounced than when awake and talking. Review of the resident's medical record showed no evidence a GDR was attempted for paliperidone palmitate or mirtazapine and no clinical rationale from the resident's physician to show a GDR was contraindicated. 5. During an interview on 3/12/24 at 9:20 A.M., the Administrator said the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He expected the facility protocol to be followed for the GDRs; -GDRs should be done per regulations; -If a GDR is not warranted, the physician should document why. During an interview on 3/21/24 at 3:07 P.M., the residents' physician said the following: -He expected staff to consult with psychiatry if a resident is experiencing extrapyramidal symptoms when taking an antipsychotic medication; -A GDR would have to be done with the consideration of how the resident is doing clinically. The lowest dose and the smallest amount of an antipsychotic should be given to keep a resident stable and symptoms manageable. 42592 50189		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41412 Based on observation, interview, and record review, the facility failed to appropriately administer insulin (a hormone used to treat diabetes) to one resident (Resident #76) and one additional resident (Resident#75), of four sampled residents who received insulin injections, when Licensed Practical Nurse (LPN) Y did not prime (remove air bubbles) the insulin pens prior to administration and did not hold the needle in the skin for six seconds after administration as directed by the manufacturer of the medication. The census was 116. Review of the facility's Blood Glucose Monitoring and Insulin Administration Policy, dated 06/29/23, showed it did not address the specific procedure to follow when administering insulin via an insulin pen and only addressed insulin administration via vial and syringe. Review of the manufacturer's information for Novolog insulin FlexPen showed the following: -Before each injection, small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing, turn the dose selector to 2 units. Hold the FlexPen with the needle point up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip; -When administering, insert the needle into your skin and press the dose button until the dose counter shows 0. Keep the needle in the skin for at least six seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. 1. Review of Resident #75's March 2024 physician order sheets (POS) showed the following: -Diagnoses included diabetes; -Novolog (rapid acting insulin, medication to treat diabetes) five units three times daily. Observation on 3/6/24 at 11:45 A.M., showed LPN Y prepared 5 units of insulin in the resident's insulin pen. LPN Y did not prime the insulin pen prior to preparing the 5 units in the insulin pen. LPN Y administered the resident's Novolog insulin and removed the needle from the resident's skin as soon as the button at the end of the insulin pen stopped. He/She did not hold the insulin pen against the resident's skin for at least six seconds after administration to ensure the resident received the full dose of the medication. 2. Review of Resident #76's March 2024 POS showed the following: -Diagnoses included diabetes; -Novolog 8 units every 24 hours; (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Novolog per sliding scale (an amount to be determined after an accucheck procedure (finger stick procedure to determine the amount of sugar in the blood); for accu check result of 283 - 323, administer four units of Novolog insulin. Observation on 3/6/24 at 11:52 A.M., showed LPN Y prepared 12 units of Novolog insulin (8 units of scheduled insulin and 4 units of sliding scale insulin) in the resident's insulin pen. LPN Y did not prime the insulin pen prior to preparing the 12 units of insulin. LPN Y administered the resident's Novolog insulin and removed the needle from the skin as soon as the button at the end of the insulin pen stopped. He/She did not hold the insulin pen against the resident's skin for at least six seconds after administration to ensure the resident received the full dose of the medication. During an interview on 3/7/24 at 1:43 P.M., LPN Y said he/she is aware he/she should prime an insulin pen prior to administration. He/She thought he/she had primed the pen. He/She thought he/she needed to hold the insulin pen against the resident's skin for three seconds after the button on the end of the insulin pen stopped and the insulin had been injected. During an interview on 3/8/24 at 5:35 P.M., the Director of Nursing (DON) said she expected staff to prime an insulin pen with two units prior to administration and to hold for six seconds after administration.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41412 Based on observation, interview, and record review, the facility failed to discard an opened insulin pen after 28 days of use for one resident (Resident #67), in a review of four sampled residents with insulin pens. The facility failed to dispose of house stock influenza vaccine after it had expired. The facility census was 116. Review of the facility's Monthly Inspections - Medications Policy, revised 07/05/22, showed the following: -The purpose of this policy is to ensure that the facility is monitoring the labeling and storage of all medications within the facility on a routine monthly basis; -The facility will utilize a pharmacy consultant to review the facility's storage of medications, that will include inspections of the medication carts and medication rooms; -The charge nurse on night shift will complete a monthly review of all medication carts and medication rooms on the last Saturday of every month; -The medication carts and medication rooms will reviewed for the following areas: a. Refrigerator checks: iii. content, iv. controlled medications - locked and counted; b. To be destroyed medication cabinet: i. locked cabinet; c. Medication/Treatment carts: iv. correct labeling, v. expiration dates, vi. open, dated items an timeframe to be destroyed after opening; d. Medication room: iv. correct labeling, v. expiration dates, vi. open dated items and timeframe to be destroyed after opening; -The charge nurse will correct any concerns identified by the audit; -The monthly medication room and medication cart audit will be turned into the resident care coordinator (RCC)/Director of Nursing (DON) after it is completed. 1. Review of Resident #67's face sheet showed the resident had a diagnosis of diabetes. Review of the resident's Physician Order Sheet (POS), dated March 2024, showed an order for Lantus (medication used to control diabetes) seven units every evening, scheduled for 8:00 P.M. Review of the manufacturer's information for Lantus insulin suggests after opening a pen of Lantus, throw away an opened pen after 28 days of use, even if there is insulin left in the pen. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Medication Administration Record (MAR), dated March 2024, showed staff documented administering the resident his/her Lantus insulin on 3/5/24 at 8:00 P.M Observation on 3/6/24 at 11:40 A.M., of the nurse medication cart, showed one opened Lantus Solostar 100 unit/milliliter pen labeled with the resident's name. The open date on the pen was 2/6/24 (30 days from the date of opening). (Staff had not disposed of the open pen after it had expired on 3/5/24). 2. Observation in the refrigerator at Station One medication room on 03/07/24 at 5:25 P.M., showed 20 vials (two fully closed boxes) of house stock influenza vaccine with an expiration date of 6/2023. During interview on 03/07/24, at 5:40 P.M., Licensed Practical Nurse (LPN) S said the medications are destroyed once a month by the DON. He/She does not know why the Influenza vaccines were in the refrigerator. The pharmacist was at the facility on 03/06/24 and checked everything. Observation in the refrigerator at Station One medication room on 03/08/24, at 3:30 P.M., showed 20 vials (two fully closed boxes) of house stock influenza vaccine with an expiration date of 6/2023. 3. During an interview on 03/08/24, at 5:35 P.M., the DON said the following: -She expected insulin pens to be discarded at the time they were expired; -She and the RCC should destroy the expired medications in the medication room weekly; -The pharmacy checks the medication rooms monthly for expired medications; -The nursing staff/certified medication technician's (CMT's) should be checking the medication rooms and medication carts for expired medications routinely in addition to the monthly pharmacy check; -She was not aware there were expired house stock influenza vaccines in the Station One medication room and they should be destroyed. 42592		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 34003 Based on observation, interview, and record review, the facility failed to ensure one resident (Residents #48), in a review of 34 sampled residents, received dental services and failed to follow up with recommendations for further dental intervention. The facility census was 164. The facility did not provide a policy for dental services. 1. Review of Resident #48's care plan dated 8/14/20 showed no care plan to address dental care or dental issues. Review of the resident's nurses notes dated 11/21/2023 at 3:23 P.M., showed the resident was seen by a local dental clinic. There are multiple areas of decay, non restorable teeth. A referral will be sent to an oral surgeon, the resident needs extraction of all remaining teeth. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/19/24 showed the following: -The resident is sometimes able to make self understood, and sometimes able to understand others; -Unable to make decisions; -Dependent upon staff for Activities of Daily Living (ADLs) and brushing teeth; -Section for oral status is blank; -Diagnoses included anxiety and schizophrenia (a serious mental illness). Observation on 3/05/24 at 10:55 A.M. showed the following: -The resident sat in his/her room. His/Her top front teeth were missing with some teeth remaining on each side of the upper jaw; -The resident's bottom teeth were black and coated with a gray substance; -The resident said his/her teeth hurt and he/she wanted them brushed. - Nurse Assistant (NA) BB brushed the resident's teeth. During an interview on 3/5/24 at 10:55 A.M. NA BB said: -The resident will frequently complain about his/her teeth hurting; -The resident's teeth were decayed and the resident needed to see a dentist. During an interview on 3/7/24 at 3:30 P.M. the Director of Nurses (DON) said the following: (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A referral would have been made to see a dentist of the resident needed to be seen. -Nobody has said that the resident needed to be seen by a dentist. During an interview on 3/8/24 at 8:25 P.M. the facility Receptionist said the following: -He/She schedules appointment for the residents; -Nursing lets him/her know if a resident needs to be seen by a dentist, he/she then will call the local dental office and make an appointment for them to be seen; -Resident #48 was seen by a local dentist on 11/21/23 with a recommendation to have all teeth removed due to multiple areas of decay, with a diagnosis of non restorable teeth; -The recommendations were filed away by mistake and this was brought to his/her attention again today. During an interview on 3/08/24 at 5:33 P.M. the Director of Nursing said: -The Receptionist also schedules transportation when a referral has been made for appointments; -He/She should follow up on these recommendations and ensure that the appointments are made and that the resident has been seen; -She does not know why the appointment was missed. During an interview on 3/21/24 at 3:07 P.M. the primary physician said: -He would expect staff to make arrangements for residents to see the dentist; -He would expect staff to follow the recommendations from a dentist for further consultation as soon as possible, not four months.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 41412 Based on observation, interview, and record review, the facility failed to meet the nutritional needs of the residents and failed to ensure staff served the correct portion sizes to residents as meals. The facility census was 116. Review of the facility's Dietary Food Preparation, revised 07/05/23, showed the following: -Standardized recipes will be used for all products prepared; -Uniform portions shall be established for each diet served to all residents; -Provide proper equipment for portioning out the correct quantity of food for the residents; -Instruct all dietary employees in the procedures of standardized portions; -Recipes and menus will have appropriated portions noted; -The dietary manager will monitor for the cooks and their use of portion control utensils on tray line. Review of the facility policy, Dietary Menu Planning and Nourishment, revised 7/5/23, showed the following: -Menus are implemented by the Dietary Manager in conjunction with the Registered Dietitian; -When changes in the menu are necessary, the changes must provide equal nutritive value; -Menu changes are reviewed and approved in advance by the Dietary Manager. Substitutions will be reviewed by the Registered Dietitian on the next visit; -When substitutions are made, the replacement item must be compatible with the rest of the meal, comparative in nutritive value, and reviewed by the Dietary Manager for appropriateness; -Menu Planning Criteria: -The food and nutritional needs of residents shall be planned to meet the recommended dietary allowances as adjusted for age, sex, and activity in order to provide menus that include safe and adequate intake of essential nutrients; -The daily menus shall be in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, to include the following food groups and quantities or to meet nutritional requirements for persons [AGE] years and over; -Meat Group: Two or more servings; (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nutritional analysis must be available for each cycle menu and is the final basis used to determine nutritional adequacy; -Large or Double Portions: -Large or double portions are to be physician ordered; -Procedure: follow the Health Technologies menu binder -Menu Substitutions: -Substitutions in the menu actually served, being of equal nutritional value, will be recorded directly on the menu or on Substitution List and filed in accordance with licensure regulations; -Substitutions of a menu item may occur when: item or ingredient is unavailable, item was prepared improperly, holiday or special occasion dictates changes, seasonal availability of an item changes, cost of item increases -Substitutions must be of equal nutritive value taking into consideration vitamins, minerals, and calories. Color, texture, and flavor must also be considered. 1. Review of the facility's Diet Spreadsheet for lunch meal on 3/5/24 showed staff were to serve residents on a regular diet a 3-ounce portion of Italian marinated pork loin. During an interview on 3/5/24 at 11:27 A.M., Cook D said turkey slices were to be served as a substitution for pork loin (listed on the diet spreadsheet menu), for the lunch meal on 3/5/24 since most of the residents preferred turkey over pork loin. Observation on 3/5/24 from 12:04 P.M. to 12:42 P.M., during the lunch meal service in the kitchen, showed Cook D served residents one slice of turkey for the main meal entree. Residents with orders for double portions received two slices of turkey. During an interview on 3/5/24 at 1:04 P.M., the dietary manager said the following: -She weighed a slice of turkey served during the lunch meal on 3/5/24 and it weighed 1 ounce. The portion size should have been 3 ounces, or at least three slices of turkey, served to residents; -Staff should use the diet spreadsheet menu to aide them in determining the appropriate portion size to serve to residents and she should monitor the portion sizes dietary staff serve to residents during the meal service. During an interview on 3/6/24 at 10:12 A.M., Cook D said the following: -Protein items were to be served at a portion size of 3 ounces; -He/She was unaware one slice of turkey did not measure 3 ounces. 2. Observation on 3/5/24 at 10:51 A.M., in the kitchen food preparation area, showed the following: -Cook D used a 3-ounce spoon to scoop tomatoes into bowls; (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She placed the tray of bowls containing tomatoes into the reach-in cooler. Observation on 3/5/24 from 12:04 P.M. to 12:42 P.M., during the lunch meal service in the kitchen, showed staff served the bowls of pre-portioned tomatoes, obtained from the reach-in cooler, as an alternate vegetable item to the main vegetable (peas and carrots). During interviews on 3/5/24 at 11:27 A.M. and on 3/6/24 at 10:12 A.M., Cook D said the following: -Tomatoes were the alternate vegetable for the lunch meal on 3/5/24 and should have been served using a 4-ounce scoop because vegetables were to be served at a 4-ounce portion size; -He/She thought he/she had used a 4-ounce spoon but he/she may have accidentally grabbed the wrong spoon size when portioning the tomatoes into bowls. 3. Review of Resident #97's weight record showed the following: -On 12/4/23, he/she weighed 133 pounds; -On 1/5/24, he/she weighed 131 pounds; -On 2/5/24, he/she weighed 130 pounds; -On 3/6/24, he/she weighed 127 pounds. Review of the resident's physician's orders dated March 2024 showed an order for regular diet, Health shakes twice daily with breakfast and supper. Observation on 3/5/24 at 12:31 P.M. in the Station 2 common area showed the following: -Staff served Resident #97 his/her meal tray; -Staff served the resident one thin slice of turkey with gravy, stuffing, peas and carrots and fruit crisp. Review of the facility's Diet Spreadsheet for breakfast on 3/8/24 showed staff were to serve residents on a regular diet cheesy eggs and two slices of bacon for breakfast. Observation on 3/8/24 at 8:38 A.M. in the dining room showed the following: -Staff served the resident cheesy scrambled eggs, a carton of milk, 4-ounces apple juice, one piece of toast, and dry cereal; -Staff did not serve the resident bacon. During an interview on 3/5/24 at 11:30 A.M., the resident said the following: -He/She has lost weight and was trying to gain weight; (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would like more to eat. 4. During interview on 03/05/24 at 11:45 A.M. and 12:45 P.M., Resident #57 said the following: -Most of the time, small portions are served and he/she was still hungry after he/she eats what was served on the tray; -Sometimes he/she can get seconds, but not all of the time when he/she was still hungry; -Sometimes he/she can get a sandwich but not always; -They only served one little slice of processed turkey and stuffing, he/she does not like stuffing; -Lunch today did not fill him/her up and he/she was still hungry. 5. Observation on 03/05/24 at 12:15 P.M., showed staff served Resident #61 a single thin slice of turkey, a serving of stuffing with gravy, peas and carrots and a fruit cobbler for dessert. During an interview on 03/05/24, at 3:30 P.M., the resident said there was not enough food served. He/She was still hungry when the meal was over. 6. During an interview on 03/05/24, at 11:53 A.M., Resident #111 said the following: -The portion sizes are small and sometimes he/she was still hungry after eating; -Sometimes staff offer seconds, but not always. Observation on 03/05/24, at 12:15 P.M., showed staff served the resident a single thin slice of turkey, a serving of stuffing with gravy, peas and carrots and a fruit cobbler for dessert. 7. During an interview on 3/5/24 at 12:11 P.M., Resident #67 said the portion sizes staff provide are small and he/she goes to bed hungry maybe one day a week; sometimes leftovers are offered but not always. During an interview on 3/5/24 at 3:34 P.M., Resident #91 said the following: -The food was terrible; it had no flavor and portion sizes are small; seconds are not always available; -Substitutes are supposed to be available but staff act inconvenienced if you ask for a substitute; -The (600 hall) is always the last to be served; often times what is on the menu is not what is served; they say that is because the kitchen runs out of what was supposed to be on the menu. During an interview on 3/5/24 at 10:40 A.M., Resident #106 said the following: -The residents are not getting enough to eat; (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility doesn't offer an alternate entree and usually there was no extra food. During an interview on 3/8/24 at 9:15 A.M., Resident #63 said the following: -He/She only got cheesy eggs and one piece of toast for breakfast this morning; he/she didn't get any meat; -He/She was still hungry after breakfast so he/she found a breakfast tray on the cart that wasn't eaten, and he/she took two sausage links off that tray and ate them; -The facility does not give the residents enough to eat; -The residents do not get adequate portions and are still hungry after meals. During an interview on 3/8/24 at 8:48 A.M., Cook GG said the following: -He/She looked at today's (3/8/24) breakfast menu; -He/She only gave meat to those residents who couldn't have/didn't want eggs; -He/She just missed the bacon on today's breakfast menu; -He/She didn't serve bacon per today's menu. 8. During an interview on 3/21/24 at 11:50 A.M., the registered dietitian said the following: -Staff should serve appropriate portion sizes to residents according to the diet spreadsheet menu and recipe as applicable; -Staff should follow the menu and serve all items on the menu. If bacon was on the menu, she expected it to be served unless a substitution was made for that item. Substitutions were recorded on a substitution list in a book in the kitchen that she signed during her visits to the facility; -She expected staff to follow the diet menu spreadsheet, recipes, and physician orders when serving food items to residents, including serving appropriate portion sizes per these documents; -When food substitutions were made, she expected the dietary manager to monitor staff to ensure adequate portion sizes of food items were served to residents; -Staff should use a food scale as needed to weigh food items or use a reference, such as the size of a deck of cards as a serving size of protein, to guide them in serving food items; -Staff should follow the applicable diet spreadsheet menu, as well as evaluate other menu items served during that meal, to determine portion sizes of substituted food items. Staff could also contact her if they had questions about the portion size of a menu item to serve; During an interview on 03/13/24, at 2:40 P.M., the administrator said he would expect the menu to be followed for meals and to follow required portions. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42592 44665 50189		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview and record review, the facility failed to provide each resident with palatable meals served at appetizing temperatures or a variety snacks for 10 residents (Resident #67, #91, #57, #61, #100, #33, #70, #81, #97 and #106) in a review of 34 sampled residents and four additional residents (Resident #4, #27, #116 and #24) . The facility census was 116. Review of the facility's Dietary Menu Planning and Nourishment Policy, revised 07/05/23, showed the following: -Menu planning is there responsibility of Health Technologies and meet the requirements of the Department of Health and Senior Services; -The menus are three meal plus a snack; -Nourishments will be provided to offer therapeutic nutritional support; A physician's order will be required; -Residents receiving nourishments may include those who are underweight, who are on therapeutic diets and those with poor intake, weight loss, skin problems low albumin and other problems addressed on care plans; -When an order for a house supplement is received the product may vary depending upon availability and resident preference; -House supplements will be delivered at routine meal times in this facility unless other specified in the physician's order; -The preferred house supplement is a shake supplement; -Dietary will prepare and deliver nourishments daily to the nursing stations; -Individual nourishments will be prepared, covered, labeled, dated, and delivered to each nursing station on ice. Review of the facility's policy Dietary Food Preparation, revised on 07/05/23, showed the following: -Standardized recipes will be used for all products prepared; -Uniform food portions shall be established for each diet and served to all residents; -Instruct all dietary employees in the procedures of standardized portions; -The dietary manager will monitor the cooks and their use of portion control utensils on tray line; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The cook and/or the dietary manager will taste food prepared before serving; -Foods will be served at proper temperature to ensure food safety; -Chill dishes to be used for cold food. Review of the facility policy Snacks dated 12/2022 showed the following: -Daily snacks are provided in accordance with the prescribed diet and in accordance with state law. Individual and/or bulk snacks are available at the nurses' station for consumption by residents whose diet orders are not restrictive; Procedure: -At least one serving or a minimum of two of the following four food components is offered for the bedtime snack: 1. Fruit and/or vegetable or full-strength fruit or vegetable juice; 2. Whole grain or enriched cereals or breads; 3. Milk or other dairy products; 4. Meat, fish, poultry, cheese, eggs; 5. Combo meat sandwiches. 41412 1 Review of Resident #67's face sheet showed he/she had diagnoses that included diabetes. Review of the resident's March 2024 physician orders showed a physician ordered regular diet. Review of the resident's care plan, last updated 12/23/23, showed the following: -He/She was at risk for hypoglycemia (low blood sugar) and hyperglycemia (elevated blood sugar); -Discuss portion sizes and snacks; -Prefers oatmeal for breakfast. During an interview on 3/5/24 at 12:11 P.M., the resident said the following: -He/She was not on a special diet; -The food was bad; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The food is not always seasoned and tastes bland; he/she knows spicy foods upset his/her stomach but this is a basic salt and pepper request; salt and pepper are not available in shakers or packets at meal times; -Bedtime snacks are hit or miss; sometimes they get them and sometimes they don't. If resident do get snacks they are usually just honey buns or sugary snacks and he/she would prefer a more filling snack like a peanut butter sandwich; -He/She does not always get oatmeal for breakfast like he/she has asked for. 2. Review of Resident #91's face sheet showed he/she had diagnoses that included vitamin deficiencies and gastro-esophageal reflux disease (stomach disorder). Review of the resident's March 2024 physician orders showed a physician ordered regular diet. Review of the resident's care plan, last updated 10/26/23, showed the following: -Has nutritional problem or potential nutritional problem related to obesity; -Takes medication for weight loss; -Discuss the resident's feelings about weight and commitment to weight loss/gain quarterly. Allow the resident to express feelings. Discuss positive coping behaviors, alternatives to overeating/under eating, feelings related to food, environmental issues, relationship and self-image concerns. Observation on 3/7/24 at 12:48 P.M. in the Station 2 common area showed the following: -Staff served the resident's meal tray; -The tray consisted of bow tie pasta with a white sauce; -Several of the noodles appeared to be burnt and hard; -The resident received a small piece of yellow cake with chocolate icing. During an interview on 3/5/24 at 3:34 P.M. and 3/7/24 at 12:48 P.M. the resident said the following: -The food was terrible, it had no flavor; -Bedtime snacks are always honey buns and oatmeal cream pies. He/She would prefer fresh fruits once in awhile and protein snacks. He/She has recently lost weight which he/she was proud of and would just like healthier snack options; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His/Her noodles today (3/7/24) were overcooked and hard; -The residents on his/her hall (600 hall) always get less dessert. Observation on 3/6/24 at 9:02 P.M. showed the bedtime snack was honey buns. Observation on 3/6/24 at 9:20 P.M. in the smoke area outside Station 2 showed the following: -Resident #91 asked Certified Nurse Aide (CNA) FF if the snack room was still open (room containing vending machines with snacks and drinks), he/she wanted a snack before bed; -Resident #91 asked CNA FF if he/she had any bananas; -CNA FF said all he/she had were honey buns. 42592 3. Review of Resident #57's care plan, initiated 07/10/22, showed the following: -Resident is on a regular diet; -Educate resident/representative regarding nutritional needs and requirements; -Serve diet as ordered. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No swallowing disorders or dietary restrictions. Review of the resident's March 2024 physician order sheet showed a regular diet, regular texture and thin/regular consistency liquids with a start date of 06/12/23. During interview on 03/05/24 at 11:45 A.M., the resident said the following: -The food was not good at all and there was no variety; -Snacks are always a honey bun or oatmeal cream pie, never anything else; -He/She would like some fresh fruits or vegetables; -He/She would like a variety of drinks, they always have tea and lemonade, he/she does not like lemonade because it hurts his/her stomach. 4. Review of Resident #61's face sheet showed a diagnosis of diabetes mellitus (to much sugar in the blood). (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Set up assistance for eating; -No swallowing disorders or dietary restrictions. Review of the resident's March 2024 physician order sheet showed a diet order for regular diet, mechanical soft texture, thin/regular consistency fluids. During an interview on 03/05/24, at 3:30 P.M. the resident said the following: -Tacos were the only good meal at the facility; -The food was not warm when staff serve his/her meal; -Staff only pass one snack and that is at night. The snack is not substantial and was either a honey bun or oatmeal cream pie. 5. Review of Resident #100's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Set up assistance for eating; -No swallowing disorders or dietary restrictions. Review of the resident's care plan, revised 02/15/24, showed the following: -The resident has impaired cognitive function/dementia or impaired thought process related to dementia and impaired decision making; -The resident will be able to communicate basic needs on a daily basis; -The resident has nutritional problem or potential nutritional problem related to obesity; -Provide and serve diet as ordered. Review of the resident's March 2024, POS showed a regular diet order, regular texture and thin/regular consistency liquids. During an interview on 03/05/24 at 10:52 A.M., the resident said the following: -The food does not taste good, staff don't provide any fruit, and the food was always cold when he/she gets it; -It doesn't do any good to ask for something else - you don't get it; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Snacks are an oatmeal cream pie or a honey bun. During an interview on 03/06/24, at 10:02 A.M. and 9:24 P.M., the resident said the following: -Breakfast was cold this morning and it tasted awful; -He/She would like to have some oatmeal; -He/She stays hungry all of the time; -Residents cannot get sandwiches, those are only for the diabetics; -He/She would like an orange or apple; -He/She had tomato soup and grilled cheese for supper, the tomato soup tasted like watered down ketchup and the grilled cheese was cold and didn't have any cheese; -He/She got a honey bun for snack; -He/She would like something besides a honey bun for a snack. He/She would like something with protein like cheese and crackers or anything besides sweets; -He/She saw bananas on the cart at the nurses station but by the time snacks were passed the bananas were gone; -He/She cannot even have peanut butter and jelly sandwiches because some people are allergic to peanut butter. 6. Review of Resident #116's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Set-up help for eating; -No swallowing disorders or dietary restrictions. Review of the resident's March 2024 physician order sheet showed a diet order of regular diet, regular texture, thin/regular consistency liquids with an order start date of 02/07/24. During an interviews on 03/05/24, at 12:05 P.M. and 03/06/24 at 9:34 P.M., the resident said the following: -He/She wished the food was better; -Supper served on 03/06/24 was tomato soup, coleslaw and grilled cheese; -His/Her grilled cheese had soggy bread where the coleslaw juice had run all over the plate; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The tomato soup tasted bad, like watered down ketchup. Observation on 03/06/24, at 12:32 P.M., showed the following: -Lunch served in the station one dining room included a burrito, a serving of rice, lettuce served on the same plate as the warm food and ice cream that was semi-melted with a very soft appearance; -Resident #57 removed all of the lettuce from his/her plate due to no dressing for the salad; -Resident #57 and #116 said the rice did not taste good; -Resident #116 only ate his/her burrito and ice cream. 47008 7. Review of Resident #33's face sheet showed he/she had a diagnoses that included diabetes. Review of the resident's March 2024 physician orders showed a physician ordered regular diet. Review of the resident's care plan, last updated 10/27/22, showed the following: -The resident has unstable blood glucose level; -Monitor the resident for signs and symptoms of hyperglycemia (elevated blood sugar) and hypoglycemia (low blood sugar). During an interview on 3/05/24 at 10:39 A.M., the resident said the food was terrible and did not taste good. Observation on 3/06/24 at 9:21 P.M., showed the resident had a honey bun on his/her bedside table for a bed time snack. After receiving bedtime insulin dose, the nurse told the resident to make sure and eat his/her snack. 50189 8. Review of Resident #24's face sheet showed he/she had a diagnosis of gastro-esophageal reflux disease (GERD; a disorder where stomach acid repeatedly flows back into the esophagus, or the tube connecting your mouth and stomach). Review of the resident's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 01/07/24 showed the following: -Diagnosis of GERD; -No swallowing issues; -Mechanically altered diet. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/05/24 at 10:25 A.M. the resident said the following: -He/She was recently switched to a mechanically soft diet and doesn't like the food; -The food was always bland; -The same things are served on a rotation, never anything new or different; -Sometimes he/she can ask for leftovers, if there are any left. Usually there are no leftovers. Observation on 03/06/24 at 12:13 P.M. showed the following: -The resident received his/her lunch, it was a burrito and salad; -The resident asked Certified Medication Technician (CMT) EE to take it away; -He/She did not want it, it was the same as the day before and it was gross; -CMT EE offered to cut up the burrito, so he/she could eat the inside, and the resident agreed. Observation on 03/06/24 at 12:36 P.M. showed the resident had not eaten any of his/her lunch. 9. Review of resident #70's face sheet showed he/she had diagnoses of diarrhea, gastric ulcers (open sores on the inside lining of your stomach and small intestine) and type two diabetes (a condition where the body has a problem with the way it regulates and uses sugar as fuel). Review of the resident's Physician Order Sheet (POS) showed an order for a regular diet. During interview on 03/05/24 at 10:35 A.M., the resident said the following: -The food was horrible; -It was bland and had no flavor; -He/She can get an alternate if he/she request one, but the alternate was typically bologna and cheese, or another cold sandwich. During interview on 03/07/24 at 1:34 P.M., the resident said the following: -Lunch was not good, again; -It was [NAME] sauce and spinach; -The [NAME] sauce and spinach was watery and had no flavor or seasoning; -He/She did not eat any of it; -He/She ordered a cold sandwich after trays were passed. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of resident #81's face sheet showed he/she had a diagnosis of type two diabetes. Review of the resident's POS showed an order for a regular diet. Review of the resident's care plan dated 07/06/22, showed he/she had unstable blood glucose levels and to consult a dietician per order. During interviews on 03/05/24 at 11:00 A.M., the resident said the following: -The food was not good, it lacked color and flavor; -The food was usually something processed; -He/She would like more fruit options. During an interview on 03/07/24 at 1:46 P.M., the resident said the following: -Breakfast and lunch were not good; -He/She did not eat and told staff to take it away immediately; -He/She did receive a shake, but it was frozen; -For lunch he/she ate two bags of chips, drank one bottle of cherry Pepsi, and drank his/her shake after it thawed. 11. Review of Resident #27's care plan dated 10/11/23 showed the following: -The resident is on a regular diet; -The resident is independent with eating and enjoys snacks; -Provide and serve diet as ordered. Review of the resident's quarterly MDS dated [DATE] showed the resident had moderately impaired cognition. Review of the resident's physician's orders dated March 2024 showed an order for a regular diet, regular texture. Observation on 3/7/24 at 12:35 P.M. in the Station 2 common area showed the following: -Staff served the resident's lunch tray; -Lunch was bow tie noodles with a white sauce; -Several of the resident's noodles were burnt and appeared hard; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident did not eat the burnt noodles. During an interview on 3/7/24 at 1:00 P.M. the resident said he/she got hard noodles for lunch and he/she didn't eat them. 12. Review of Resident #97's care plan revised 5/2/23 showed no documentation regarding the resident's nutritional needs/risks. Review of the resident's quarterly MDS dated [DATE] showed the resident was cognitively intact. Review of the resident's physician's orders dated March 2024 showed an order for regular diet, health shakes twice daily with breakfast and supper. Observation on 3/7/24 at 12:35 P.M. in the Station 2 common area showed the following: -Staff served the resident's meal tray; -The resident's meal ticket said regular diet, health shakes twice a day; -The resident's health shake was frozen; -The resident did not drink his/her health shake. During an interview on 3/7/24 at 12:35 P.M., the resident said he/she couldn't drink his/her health shake because it was frozen. He/She did not receive a health shake for breakfast. 13. Review of Resident #4's care plan dated 10/5/23 showed the following: -The resident is on a regular diet; -Dietary department will monitor diet monthly to ensure proper dietary recommendations. Review of the resident's quarterly MDS dated [DATE] showed he/she had moderately impaired cognition. Review of the resident's physician's orders dated March 2024 showed an order for regular diet, health shake with supper. Observation on 3/7/24 at 12:51 P.M. in the Station 2 common area showed the following: -The resident ate 100% of his/her bow tie pasta with white sauce and greens; -The resident did not drink his/her health shake; -The resident's health shake was frozen. During an interview on 3/7/24 at 12:51 P.M., the resident said he/she did not drink his/her health shake because it was frozen. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Review of Resident #106's care plan dated 8/8/23 showed the following: -The resident receives a regular diet, has good appetite and enjoys snacks. -Provide and serve diet as ordered. Review of the resident's quarterly MDS dated [DATE] showed the resident was cognitively intact. Review of the resident's physician's orders dated March 2024 showed an order for a regular diet. During an interview on 3/7/24 at 11:22 A.M., the resident said the following: -Last night (3/6/24), for supper staff served the residents grilled cheese with coleslaw on the same plate; -The grilled cheese was soaked in coleslaw juice, it was disgusting. 15. During an interview on 3/7/24 at 2:08 P.M. Assistant Cook A said the following: -He/She did not cut the cake for lunch; -Cook GG cut the cake and all pieces should be the same size; -Some of the health shakes were still frozen but the dietary manager said go ahead and send them out. Observation on 03/05/24 at 12:47 P.M., of the test tray (obtained after all residents had been served the lunch meal), showed the following: -The fruit crisp, served to residents with a mechanical soft diet, had hard pear chunks that were difficult to chew and not soft in texture; -The temperature of the grilled cheese sandwich, served to residents who requested the alternate entree item, had a temperature of 117.9 degrees Fahrenheit and tasted cool. During an interview on 03/05/24 at 1:04 P.M., the dietary manager said the following: -She wasn't aware the fruit crisp served to residents with a mechanical soft diet contained hard pear chunks; -Staff usually served peaches to residents with a mechanical soft diet rather than mixed fruit (which was what the fruit crisp contained) because the grapes it contained could be a choking hazard to residents on a mechanical soft diet; -The grilled cheese sandwiches were on the steam table since at least 9 A.M. that morning until the lunch meal service (serving started at 12:04 P.M.); (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff shouldn't have held the sandwiches on the steam table that long and should have prepared the sandwiches closer to the start of the lunch meal service. During an interview on 03/07/24, at 2:10 P.M., assistant cook B said the following: -He/She was the cook and served the supper meal on 03/06/24; -He/She did not taste the tomato soup that was served because he/she does not like tomato soup, but followed the recipe to cook it; -He/She made the grilled cheese sandwiches with Swiss cheese; -He/She served the grilled cheese and coleslaw on the same plate with a lid to keep the grilled cheese warm; -He/She did not think the coleslaw had much liquid/juice but he/she noticed at the end of serving that it was a little juicy; -He/She could see where the juice on the same plate as a sandwich could possibly run onto a sandwich and make the bread soggy; -He/She should have put the coleslaw in a bowl for the juice, and it should stay cold and should not have been put on the warm plate; -If a resident wants something different they just need to ask staff and staff will come and get an alternate or a sandwich; -Snacks that are provided include honey buns, oatmeal cream pies, bananas, Jello, coffee, pudding, chips and things that are soft for older people to eat; -The only choice for fresh fruit was a banana; -If there is a like/dislike on a resident's meal sheet it should be honored. During an interview on 03/07/24, at 2:25 P.M., the dietary manager said the following: -She would expect cold food to be served cold and hot food to be hot; -She would not expect something like coleslaw, or anything that would have liquid, to be served on the same plate as a sandwich; -If a resident does not like something that is on their tray, the kitchen always has sandwiches or an alternative to serve, the staff will come and ask for something different; -She only orders fresh fruit when it is in season, and the kitchen has bananas all of the time; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She does not order oranges or apples unless they are in season and does not order apples because the apples would need to be cut up for the residents. That was a lot of cutting, and apples are a choking risk; -Meal preferences should be honored, and likes and dislikes are on the meal ticket; -She interviews all of the residents for likes and dislikes as well as fills out the admission dietary assessment for likes and dislikes; She was not sure why she does not have a likes and dislikes list for Resident #100 but will take care of that today; -All of the pieces of cake for lunch (3/7/24) should have been the same size; -Cook GG cut the first pieces of cake too big and then the cake pieces at the end were smaller; -All of the cake pieces should have been 2 by 2; -Cook GG baked the pasta (chicken Alfredo) and it got too hard on the top; -The health shakes just came in on the truck and she told staff to go ahead and serve them even though they were frozen. During an interview on 3/21/24 at 11:50 A.M., the registered dietitian said the following: -Food served to residents should be palatable; -Food that is supposed to be served warm should be served warm, hot foods should be served hot, and cold foods should be served cold; -Cold food items should not be served next to hot food items on a resident's plate; -Food items that could potentially have juice, like coleslaw, should not be served next to items, such as a sandwich, and are typically served in separate bowls or containers; -Staff should thaw frozen health shakes before serving on a resident's meal tray and not be served frozen unless it was per resident preference to have them served frozen; -Staff should honor residents' requests for fresh fruits (ie oranges, apples) and fresh vegetables as those items are available; -Fresh fruits should be available as snacks for all residents if they have no dietary restrictions for those items; -Staff should serve bedtime snacks after the supper meal that are more substantial than other snacks during the day. Bedtime snacks should include a protein, a carbohydrate, and a fat such as a deli sandwich, peanut butter and crackers, cheese and crackers, etc. Residents usually get more than sweets, like honey buns and oatmeal cream pies, unless the facility is out of other snack options; (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For residents on a regular diet, it would not be appropriate to give some residents a smaller-sized food item, such as a smaller piece of cake, than to other residents. Staff should use the food item's recipe and diet spreadsheet menu to prepare food items in a consistent size; -Staff should serve bow tie noodles that are cooked to an al [NAME] or softer texture. It would not be appropriate for staff to serve hard noodles or noodles that residents are unable to chew; -Staff should review and honor resident likes and dislikes when preparing and serving food trays for residents; -If a resident did not like what was on their tray when it was served, residents can ask for the alternate food choice served for that meal or request that another item, such as a grilled cheese sandwich, be made.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42592 44665 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety and sanitation. Staff failed to ensure opened food items were sealed and ensure food items in damaged containers were segregated from food items in active use. Staff failed to ensure resident food items, located in a unit refrigerator outside of the kitchen, were stored under sanitary conditions. Staff failed to ensure trash cans in the kitchen were covered when not in use. Staff failed to ensure ice and water dispensing machines were clean and ensure an air gap was present at each ice machine drain to prevent potential backflow of liquids back into the units. Staff failed to ensure food preparation surfaces were appropriately cleaned and sanitized and staff were knowledgeable about sanitization procedures and use of the dishwashing machine. Staff failed to ensure food and beverage containers and utensils were in good condition and protected from moisture, debris, and other contaminants. Staff failed to ensure kitchen surfaces and equipment, such as floors, ceilings, vents, shelves, drawers, and cooking appliances, were clean and maintained to prevent potential contamination. Staff failed to practice proper hygienic practices, including proper gloving, handwashing, and consumption of personal food and beverage items, when preparing and serving food to residents. The facility census was 116. 1. Review of the undated facility policy, Food Storage, showed the following: -Food items will be stored, thawed and prepared in accordance with good sanitary practice; -Dented or bulging cans shall be placed on Damaged Goods Shelf and returned for credit; -Dry Storage: Any opened products shall be placed in seamless plastic or glass containers with tight-fitting lids or Ziploc bags. Open products may also be sealed utilizing plastic film or tape; -Frozen foods shall be stored in airtight containers or wrapped in heavy-duty aluminum foil, plastic film, or special laminated papers; -Dry, Refrigerated and Freezer Storage Chart Handling Hints: Flour: Once opened store in airtight container. Observation on 3/5/24 at 9:44 A.M., in the kitchen, showed the following: -A 26.48-pound box of frozen breakfast pizza squares and a 12.5-pound box of frozen garlic breadsticks, located in the walk-in freezer, did not have the inner plastic sealed and the food items were exposed to air; -A 25-pound paper bag of flour, located in the dry storage room, was not sealed and open to air. A sign on the dry storage room door read, Close all containers after use, no exceptions; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A 99-fluid ounce can of pickle spears, located in the active canned food storage rack of the dry storage room, had moderate dent damage to the sides of the can. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said the following: -Dented cans should not be in the active can use area and should instead be segregated into a dented can storage area to be returned to the vendor for credit; -Food items should be properly sealed. 2. Review of the facility policy, Resident Food Storage, dated 11/28/22, showed the following: -The purpose of this policy is to ensure that residents' food storage is safe with sanitary storage, handling and consumption; -Facility staff will monitor the snack refrigerators on a daily basis; -Refrigerators will be kept clean. Observation on 3/5/24 at 2:08 P.M., in the 600 hall certified nurse aide (CNA) room, showed the following: -Various containers of milk cartons, juice containers, condiments, and other food items were located in the refrigerator and freezer portions of the refrigerator; -Dried brown residue was on the bottom interior portion of the refrigerator; -Light yellow splatters and pieces of adhered paper were on the interior shelf of the refrigerator; -Dried dark brown residue was in the interior freezer portion of the refrigerator. During interview on 3/5/24 at 2:08 P.M., CNA/Certified Medication Technician (CMT) G said resident food items were stored in the refrigerator in this room. He/She was unsure whose responsibility it was to clean the refrigerator. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said nursing staff was responsible for cleaning the unit hall refrigerators, such as the 600 hall CNA room refrigerator, that contained resident food items. 3. Observation on 3/5/24 at 9:20 A.M., in the kitchen, showed the following: -A large trash can, located by the two-compartment sink, was approximately half full of discarded food packaging, paper towels, and egg shells; -A second large trash can, located by the dishwashing counter, was approximately a quarter full of discarded milk cartons, plastic wrapping, and a face mask; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Both trash cans were uncovered and no staff were actively working in the kitchen or utilizing the trash cans. Observations on 3/5/24 at 10:36 A.M. and 11:38 A.M., in the kitchen, showed the two large trash cans, located by the two-compartment sink and the dishwashing counter, were uncovered and no staff were actively working in the kitchen or utilizing the trash cans. Observation on 3/5/24 at 11:59 P.M., in the kitchen, showed the following: -The two large trash cans, located by the two-compartment sink and the dishwashing counter, were uncovered; -Staff were preparing to serve the lunch meal service and the majority of food items on the steam table were uncovered; -A fly buzzed around the steam table and landed on a container of silverware located on the counter next to the steam table. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said trash cans should be covered when not in use. 4. Review of the undated facility policy, Ice Machine, showed the following: -Daily: wash exterior of machine, use sanitizing solution and clean cloth, allow to air dry; -Monthly: remove ice, wash inside machine, use sanitizing solution and clean cloth, allow to air dry. Observation on 3/5/24 at 2:12 P.M., of the combination ice machine and water dispenser, located in the 600 hall dining room, showed the following: -White crusty debris was visible around the water dispensing spout; -A heavy accumulation of moist pink debris, speckled with black spots, was visible around the ice dispensing spout; -At the back of the machine, two 1-inch PVC pipes exited the machine and each connected to a 3-foot long vertical 1-inch PVC pipe; -The 3-foot vertical pipes each connected to a 3-foot long horizontal pipe; -The 3-foot horizontal pipes each connected to a 6-inch vertical pipe located above a 3-inch flanged drain pipe; -One of the 6-inch pipes was 1.5 inches below the flood rim level of the 3-inch flanged drain pipe and did not contain a sufficient air gap to prevent potential backflow of liquids back into the machine. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 3/6/24 at 11:34 A.M., of the combination ice machine and water dispenser, located in the main dining room (near the 100/200 halls), showed the following: -White crusty debris was visible around the water dispensing spout; -A moderate accumulation of moist brown and light pink debris was visible around the ice dispensing spout. During an interview on 3/5/24 at 10:04 A.M., Cook D said dietary staff wiped the outside of the ice machines and a company cleaned and sanitized the inside of the ice machines. During an interview on 3/6/24 at 11:29 A.M., the maintenance director said the following: -A company cleaned and maintained the ice machines at the facility, including ensuring there was a sufficient drain air gap to prevent potential backflow of liquid back into the unit; -He did not routinely check to ensure the ice machines have a proper drain air gap. 5. Review of the undated facility policy, Sanitizer Use Concentrations for Food Service and Food Production Facilities, showed the following: -All surfaces and equipment shall be washed with a sanitizing solution; -Sanitation buckets must be established with appropriate sanitizing solution (i.e. generally for bleach, 50-100 parts per million (ppm) or quaternary solution (200 ppm)), however follow manufacturer's recommended directions; -Sanitizing cloths must be placed in the sanitizing buckets to be used in sanitizing all work surfaces and equipment; -Dietary shall change these buckets at least every three hours and test with the appropriate litmus strips each time the solution is changed to assure accurate levels of sanitizer. Observation on 3/5/24 at 10:54 P.M., in the kitchen, showed the following: -Cook D took a cloth from a water-based bubbly solution in a small plastic bucket, located on the two-compartment sink counter. The label on the bucket read, Ready to spread vanilla cream icing; -He/She used the cloth to wipe the food preparation counter. During an interview on 3/5/24 at 10:56 A.M., Cook D said the solution in the plastic icing bucket was either sanitizer solution from the sanitizer dispenser at the three-compartment sink or soapy water. He/She thought they were out of sanitizer solution but both the sanitizer solution and soapy water were bubbly and looked alike. During an interview on 3/6/24 at 10:12 A.M., Cook D said the following: (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-When the plastic bucket contained sanitizer, staff should change the solution at least twice per shift or when the solution became soiled or too cold; -When he/she filled the sanitizer solution, he/she wanted the temperature of the solution to be fairly warm; -He/She used a chemical test strip to test the sanitizer solution when he/she filled the bucket; -He/She did not log chemical test strip data on a log sheet or other document; -He/She was unsure what numerical value the chemical parameters should be, but the test paper should turn green if the chemical level was appropriate. Observation on 3/6/24 at 10:14 A.M., in the kitchen, showed Cook D showed obtained a roll of chemical test strip paper, located in a clear plastic container stored in the preparation counter drawer. (This was the test strip paper he/she would use to test the chemical levels of the sanitizer solution). The clear test strip container had no label, chemical level color scale, or associated chemical level parameters. During an interview on 3/6/24 at 10:15 A.M., the dietary manager said she checked with her supervisor who advised her the sanitizer solution in the buckets should be at room temperature and have a pH of 8.2. During an interview on 3/6/24 at 3:56 P.M., Dietary Aide E said he/she used soap and water to disinfect the food preparation counter and did not use a sanitizer solution. 6. Observation on 3/5/24 at 11:18 A.M., in the kitchen, showed the following: -The dishwashing machine, located next to the dietary manager's office, was running; -The machine's temperature gauge read 120 degrees Fahrenheit; -The machines's automatic dispensing unit dispensed a liquid substance into a small metal well attached to the front right of the machine; -The manufacturer's label, located on the front left side of the machine, read: Required 50 PPM (parts per million) available chlorine; -No log sheet, for recording temperature, pressure or chemical levels, was posted near the machine. During an interview on 3/6/24 at 10:18 A.M., the dietary manager and Cook D said the following: -The dishwashing machine in the kitchen was installed within the prior six months; -The installation company did not train them on the operation of the machine other than how to clean out the drain trap; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Chemical test strips were available for staff to use, but the dietary manager and Cook D were unsure of how to test the sanitizer chemical levels or exactly what parameter the chemical level should be; -The dietary manager assumed the chemical level should test between 50 and 100 parts per million because those were the middle two range colors on the test strip bottle; -They were unsure if other staff knew how to or conducted chemical testing with the test strips; -Staff did not document results of chemical test levels on a log sheet or other paperwork. During an interview on 3/6/24 at 3:56 P.M., Dietary Aide E said the following: -He/She used the dishwashing machine but didn't test the chemical parameters of the machine; -He/She thought the maintenance director was responsible for conducting testing of the chemical parameters of the dishwashing machine. During an interview on 3/6/24 at 4:03 P.M., the maintenance director said the following: -He was not responsible for conducting testing of the chemical parameters of the dishwashing machine and was only responsible for fixing leaks on the machine as needed; -He expected the dietary manager to be knowledgeable of and assign dietary staff to conduct chemical and temperature testing of the machine. 7. Observation on 3/5/24 at 10:18 A.M., of the utensil storage drawers, located under the steam table serving counter in the kitchen, showed the following: -In the middle drawer, dried brown residue was visible on the food contact surface of a green-handled utensil and moist tan debris was visible on the food contact surface of a red-handled scoop; -In the third (bottom) drawer, dried bits of debris were visible on the food contact surface of a metal-handled scoop and black encrusted buildup was visible between the handle and food contact surface of a spatula. Observation on 3/5/24 at 11:05 A.M., in the kitchen beverage preparation area, showed the following: -Dietary Aide C prepared and filled beverage dispensers at the coffee maker using a clear plastic pitcher under the coffee maker spout; -The plastic pitcher was discolored brown and stained across 75% of the pitcher's interior surface. The pour spout area of the pitcher was chipped across 50% of its edge and was missing small areas of plastic. Observation on 3/5/24 at 12:15 P.M., in the kitchen, showed the following: (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Non-inverted plate covers sat on the shelf below the meal tray line area; -Dietary Aide C moved the plate covers to a nearby cart for the lunch meal service; -A moderate accumulation of dripping moisture was visible between many of the plate covers. During an interview on 3/6/24 at 10:12 A.M., Cook D said dishes should be stored clean and dry. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said the following: -Trays, plate covers, utensils, and other dishes should be covered or inverted and not contain moisture when stored; -She expected beverage containers, serving utensils, and food containers to be clean and in good condition. During an interview on 3/6/24 at 10:12 A.M., the dietary manager said she was aware the plate covers should not contain moisture between them. The facility had recently installed a low temperature dishwashing machine that was different from the previous high temperature dishwashing machine that dried the dishes better. 8. Observation on 3/5/24 at 9:44 A.M., of the dry storage room in the kitchen, showed the following: -Black speckled residue, in an approximate 18-inch by 18-inch area, was visible on the floor near the dry storage entrance to the right of the room (as viewed facing the entrance of the room); -Gray residue, in an approximate 2-foot by 3-foot area, was visible on the floor under the food storage shelves located on the left side (as viewed facing the entrance of the room) of the room; -Various bits of cardboard, tape, onion skins, noodles, cereal, and plastic wrap were visible across the surface of the dry storage room floor, including underneath the food storage shelves; -Gray-colored shoe prints and various lined tracks were visible across the main walking area of the floor and the floor was sticky; -A moderate accumulation of black debris was visible around the floor of the door frame (both interior and exterior portions) to the dry storage room. Observation on 3/5/24 at 10:11 A.M., in the kitchen, showed the following: -A moderate accumulation of gray debris was visible on the interior of two 2-foot by 2-foot ceiling vents, located above the dishwashing machine and nearby clean dish storage area; -A stack of nine non-inverted clean serving trays and an uncovered box of disposable plastic forks sat on a rack in the clean dish storage area underneath the two ceiling vents. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/6/24 at 11:29 A.M., the maintenance director said the two 2-foot by 2-foot ceiling vents, located above the dishwashing machine and nearby clean dish storage area, were last cleaned two weeks ago. Maintenance staff clean these vents a couple times each month. Observation on 3/5/24 at 10:18 A.M., of the area underneath the steam table serving counter in the kitchen, showed the following: -Various bits of dried food debris, including brown crumbs and dried lettuce, were visible on the interior surface of the middle utensil drawer which housed approximately 20 serving utensils; -Folded cloths and towels sat next to the drawers. The top cloth of one stack of small white cloths had visible brown staining on an approximate 2-inch by 6-inch area of the cloth. Two of three large white towels were discolored brown over large areas of their surface. Observation on 3/5/24 at 10:24 A.M., in the kitchen, showed a heavy accumulation of black debris was visible on the floor by the handwashing sink (located next to the two-compartment sink). A moderate accumulation of black debris was visible on the cove base trim located just above the floor in this area. Observation on 3/5/24 at 10:36 A.M., in the kitchen, showed the following: -Multiple dried, gray-colored drips and debris speckled the surface of the kitchen floor; -Pieces of dried macaroni were visible on the top surface of the six-burner stovetop; -A heavy accumulation of dark gray cobwebs was visible in between the oven, stovetop burner, and flat-top griddle knobs. One knob on the right side by the griddle was missing; -Bits of food debris, French fries, and foil were visible on the floor underneath the stove; -Dried drips of reddish-orange debris were visible on the handles of the oven doors and the handles were sticky to the touch; -Several dried brown drips and a moderate accumulation oil splatters coated the metal back splash of the stove. Observation on 3/5/24 at 10:52 A.M., in the kitchen, showed the following: -An approximate three-foot by six-foot section of ceiling, located above the convection oven, was speckled dark brown on the white textured ceiling tile and associated ceiling tile grid. Observation on 3/5/24 at 11:12 A.M., in the kitchen, showed the following: -Brown, flaky dried debris was on the edge of one of three large steam table pans stacked on the bottom shelf under the steam table; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A moderate accumulation of dust and debris was visible on the wire shelves of two four-tiered green metal clean dish storage racks, located near the dishwashing area. The shelves contained clean trays, mugs, bowls, and utensils. Observation on 3/5/24 at 11:18 A.M., in the kitchen above the beverage preparation and food serving area, showed an approximate 10-foot long section of drywall ceiling hung down approximately 0.5 inches and was not flush with the rest of the ceiling. Loose, flaking paint was visible along the edge of the drywall seams in this area. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said the roof above the drywall ceiling (where the paint was flaking and not flush with the ceiling) was replaced a few months ago and the maintenance staff have the ceiling on their list to fix. Sometimes, she worried the whole piece of drywall ceiling might fall down. During an interview on 3/6/24 at 11:29 A.M., the maintenance director said he was aware of needed repairs to the ceiling above the beverage preparation and food serving area in the kitchen. The ceiling issue was due to a leak in the roof that occurred about three weeks prior. Observation on 3/6/24 at 9:54 A.M., in the kitchen, showed the following: -Two two-tiered white plastic carts sat near the beverage preparation area and food serving area; -One cart contained two semi-moist blue microfiber cloths and the other cart contained a stack of plate covers that were not inverted; -Bits of dried food debris were visible throughout the shelves of the carts; -A moderate accumulation of black and brown debris was visible around the rust-colored bolt heads, located on the bottom interior shelves of the carts, where the wheels attached to the carts. During an interview on 3/6/24 at 10:12 A.M., Cook D said the following: -He/She was unsure how often the dry storage room was cleaned. There was no set schedule or staff assigned to clean the room but he/she worked it into his/her schedule when he/she could; -Staff were to sweep and mop the kitchen floor once during the day shift and once during the evening shift; -He/She was unsure when the kitchen floor was most recently deep cleaned but that it was due for a deep cleaning. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said the following: -Staff should be following and completing the cleaning task checklists located in the cleaning binder in the kitchen but these sheets don't always get filled out; -She expected the kitchen floor to be swept and mopped after the lunch meal and at the end of the day. The kitchen was due for an overnight cleaning to occur later in the month. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Review of the undated facility policy, Hand Washing and Glove Use, showed the following: -Hand washing and glove use promote safe and sanitary conditions; -Hand washing procedure: -Hand washing is a priority for infection control; -Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substances (i.e. raw chicken to fresh fruit), following contact with any unsanitary surface (i.e. touching hair, sneezing, opening doors); -Washing procedure: wet hands, apply soap, lather vigorously rubbing hands together for approximately 20 seconds, rinse hands to remove soap and debris, dry hands with a disposable paper towel, utilize paper towels to turn off the faucet, discard of paper in foot pedal trash can; -Gloves may be used when working with food to avoid contact with hands; Gloves must be worn when touching any ready-to-eat food; -When gloves are used, hand washing must occur per above procedure prior to putting on gloves and whenever gloves are changed, gloves must be changed as often as hands need to be washed, gloves may be used for one task only; -It's important to remember gloves can often give a false sense of security and can carry germs the same as our hands; Observation on 3/5/24 at 9:36 A.M., in the kitchen, showed the following: -The dietary manager entered the kitchen, did not wash her hands, picked up a cup that had dropped onto the floor and placed the cup onto the dirty dish side of the dishwashing machine; -Without washing her hands, she grasped the handle of a cart that contained trays of glasses and a full beverage dispenser and pushed the cart out of the kitchen and into the nurses' station for the 100/200 hall. Observation on 3/5/24 in the kitchen, showed the following: -At 10:17 A.M., Dietary Aide C picked up a Styrofoam cup, located on the top shelf of the clean dish storage rack, that sat next to a stack of nine non-inverted clean serving trays; -Various clean glasses, cups, and silverware sat on other lower shelves of the storage rack; -He/She took a drink from the cup and returned the cup back on the top shelf; -He/She left the kitchen out the back door; -At 10:25 A.M., he/she re-entered the kitchen from the back door; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She did not wash his/her hands and moved two carts to the beverage preparation area; -He/She picked up a drink pitcher by the handle and placed it under the coffee machine; -He/She carried trays of clean cups and placed them on one of the carts; -He/She moved a plate base warmer cart into a different position in the tray serving area; -He/She touched the side of his/her face and nose with his/her finger and pushed an empty cart out the main kitchen door. Observation on 3/5/24 from 12:04 P.M. to 12:42 P.M., during the lunch meal service in the kitchen, showed the following: -Cook D used his/her gloved hands to serve food onto resident plates at the steam table by grasping handles of serving utensils, picking up grilled cheese sandwiches with his/her gloved hands and placing them on resident plates, and sliding slices of turkey (with his/her gloved hands) over on plates to make room for other food items. He/She did not change his/her gloves or wash his/her hands in between these activities and did not use a serving utensil to serve ready to eat food; -Dietary Aide C wore a bandage on a knuckle of his/her left hand and used his/her bare hands to place plate bases onto trays, plate covers on top of prepared food plates, and desserts and beverage items onto prepared meal trays; -Throughout the meal service, Dietary Aide C pushed full carts of prepared resident meal trays out the kitchen door to the dining room and resident halls; -When Dietary Aide C returned to the kitchen with the empty tray carts, he/she applied hand sanitizer from a bottle of sanitizer (located on the food tray serving area) to his/her hands and continued placing plate bases, covers, and food items onto trays. Observation on 3/5/24 at 3:13 P.M., in the kitchen, showed the following: -Assistant Cook B washed his/her hands at the handwashing sink and turned off the faucet handles with his/her clean hands then dried his/her hands with a paper towel; -He/She put on gloves and used his/her gloved hands to pick up baked cookies from a cookie sheet and put them into individual bags. Observation on 3/5/24 at 3:42 P.M., in the kitchen, showed the following: -Dietary Aide F walked through the kitchen eating a sandwich; -While holding the sandwich in his/her left hand, he/she used his/her right hand to moisten a red cloth with water he/she obtained from the faucet of the handwashing sink and used the moist cloth to wipe the food preparation counter; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She left the red cloth on the preparation counter, and while still eating the sandwich, walked into the walk-in cooler with a Styrofoam cup and poured tea from a pitcher into the cup; -He/She exited the walk-in cooler with the cup of tea and drank it as he/she walked to the handwashing sink where he/she sat the cup down on a nearby preparation counter; -He/She washed his/her hands at the handwashing sink and turned off the faucet handles with his/her clean hands and then dried his/her hands with a paper towel. Observation on 3/5/24 at 3:48 P.M., in the kitchen, showed Dietary Aide E washed his/her hands at the handwashing sink and turned off the faucet handles with his/her clean hands then dried his/her hands with a paper towel. Observation on 3/6/24 at 5:06 P.M., in the kitchen, showed the following: -Assistant Cook B used his/her bare hands to turn soup bowls over that were inverted on trays in preparation for the dinner meal service; -Without washing his/her hands, he/she donned gloves and used his/her gloved hands to grasp the handle of a serving utensil and stir a food item on the steam table; -Wearing the same gloves, he/she put both hands into a large container of shredded cabbage and mixed the cabbage. During an interview on 3/6/24 at 10:12 A.M., Cook D said the following: -Staff should wash their hands frequently, such as after completing dirty tasks, when coming inside from breaks, and between glove changes; -Staff should not touch ready-to-eat foods with soiled gloved hands; -Staff should wear gloves if they have bandages on their hands; -Dishes should be stored clean and dry. Observation on 3/5/24 at 2:56 P.M., of the cleaning task checklists binders, located in the kitchen, showed the following: -The binder, labeled 'Food and Nutrition Dietary Aide Cleaning Log - Do not sign off unless task is done, no exceptions,' contained day and evening shift aide daily cleaning tasks: wipe snack carts; sweep, mop and take out trash; -Evening shift weekly aide cleaning tasks: snack carts and wheels, plates and bowl cart and wheels. During an interview on 3/5/24 at 2:54 P.M., the dietary manager said the following: (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-During the lunch meal service on 3/5/24, Dietary Aide C should have washed his/her hands, rather than use hand sanitizer, in between bringing carts of resident meal trays in and out of the kitchen due to him/her doing more than just moving trays; -He/She was unaware Dietary Aide C wore a bandage when performing meal related tasks. Staff should wear gloves if they have bandages on their hands; -Staff should wash their hands constantly, including when they enter the kitchen, in between glove changes, after touching staff's face/self, after completing dirty tasks, or any time cross contamination could occur; -Staff should eat and drink in the dietary manager's office, outside, or in the staff breakroom rather than in the kitchen. During an interview on 3/21/24 at 11:50 A.M., the facility's registered dietitian said resident food and beverage items should be stored, prepared, and served in a sanitary and safe manner.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview, and record review, the facility failed to develop and implement policies and procedures for the inspection, testing, and maintenance of the facility water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD), and failed to perform detection and surveillance of possible cases of LD in a review of 34 sampled residents. The facility also failed to ensure proper signage on the entrance of the building, notifying visitors of COVID outbreak in the building and failed to post transmission based precaution signage outside of two COVID positive rooms for Resident #5 , #46 and #66. The facility failed to ensure there was a private bathroom for two COVID positive Residents #46 and #66 . The facility failed to ensure that COVID positive Resident #46 had the proper personal protective equipment (PPE) on when staff took the resident out of his/her room to a shower room used by other residents. The facility also failed to ensure there were procedures implemented to address the prevention of Tuberculosis (TB) for three staff members in a review of eight sampled employees hired since the previous survey, when the facility failed to ensure Tuberculin Skin Tests (TST) were completed in accordance with the requirements for TB testing for long-term care employees. The facility failed to use appropriate infection control procedures for hand hygiene and changing gloves, to prevent the spread of bacteria or other infection causing contaminants, and when indicated by professional standards of practice, during an accu check procedures (a finger stick procedure where a drop of blood is obtained to determine the amount of sugar in the blood) and insulin administration for two residents (Resident #67 and #76), and one additional resident (Resident #75). The facility failed to store one additional resident's (Resident #36's), respiratory equipment in a way that it remained free of contaminants. The facility census was 116. Review of the facility's Handwashing Policy, revised 06/29/23, showed the following: -Purpose: to provide guidelines to employees for proper and appropriate hand washing techniques that will aid in the prevention of the transmission of infection; 2. The use of gloves does not replace hand washing; 3. Hands are to be washed before and after gloving; 4. A waterless antiseptic solution may be used as an adjunct to routine hand washing; 5. Appropriate ten to fifteen second hand washing must be performed under the following conditions: a. Whenever hands are obviously soiled; b. Before performing invasive procedures; c. Before preparing or handling medications; d. After having prolonged contact with a resident; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. After handling used dressing, specimen containers, contaminated tissues, linens, etc.; f. After contact with blood, bodily fluids, secretions, excretions, mucous membranes, or broken skin; g. After handling items potentially contaminated with a resident's blood, bodily fluids, excretions and secretions; h. After removing gloves; k. Whenever in doubt. A specific glove use policy was not provided by the facility. Review of the facility's undated water management facility documentation showed the following: -An effective Legionella water management plan (WMP) requires a multidisciplinary team including members from management, engineering, infection control, maintenance, and housekeeping, and in some instances a consultant; -The focus of this team is to plan, execute and evaluate the results from a WMP to control Legionella and its potential effects; -Potable water system monitoring provides data for determining whether a water system is operating within the parameters needed to control the growth of Legionella; -Monitoring plan outlined included: 1. Control point - Cold Water Supply (CWS) 1, with a maximum range of 40 degrees Fahrenheit, should be monitored weekly with a corrective action to flush system to maintain cool temperature, if chronic, add piping insulation where needed; 2. Control point - Hot Water Supply (HWS) 1, with a maximum range of 140 degrees Fahrenheit, should be monitored weekly with a corrective action to adjust water heater temperature. If chronic, look for faulty/damaged piping insulation; 3. Control Point - HWS 2, with a maximum range of 145 degrees Fahrenheit, should be monitored weekly with a corrective action to adjust water heater temperature and look for faulty thermostat and or thermocouple; -Domestic water is provided throughout a building for a variety of uses including drinking and/or other human contact. When the cold water becomes sufficiently warm, or hot water is stagnate Legionella bacteria can begin to amplify which presents a potential problem for consumers of the water; -Procedures used and actions taken to maintain the cold-water distribution system included: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Hot and cold-water systems in vacant rooms - if a room is vacant the water should be flushed out of the lines weekly or until the room is occupied. Hot and cold-water faucets should be turned on an ran until hot water gets hot and cold gets colder or 4 minutes; 2. Potable water in vacant rooms - if there is a vacant room during water sampling, the sample for that area of the facility should be taken in the vacant room; 3. During room water temperature monitoring be sure to check hot water heater - the facility uses hot water mixing valves and the hot water heater should be kept at or above 140 degrees Fahrenheit and the mixing valve should reduce the temperature to 105 degrees Fahrenheit minimum to 120 degrees Fahrenheit maximum range. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F. 1. Review of the facility water temperature check sheets, dated December 2023 through February 2024, showed no documentation staff checked the temperature of the cold water throughout the facility. During interview on 3/08/24 at 2:40 P.M., the maintenance director said he had not checked the cold-water temperatures throughout the facility. During interview on 3/8/24 at 2:37 P.M. and 2:49 P.M., the Director of Nursing (DON) said the following: -She was the infection preventionist for the facility and part of the water management team; -She would expect maintenance to obtain the temperature of the cold water; -It was the maintenance supervisor's responsibility to ensure quarterly water testing was completed. During at interview on 03/13/24 at 2:40 P.M., the Administrator said he was not aware cold water temperatures needed to be tested for the water management program. 2. Review of the facility policy, Tuberculosis Testing, revised 06/29/23, showed upon hire, a new employee will receive a two-step Purified Protein Derivative (PPD) skin test. Review of the Department of Health and Senior Services Tuberculosis Screening for Long-Term Care Facility Employees Flowchart, updated 03/11/14, (based on the requirements identified in the state regulation for administering TB testing) showed the following: -Administer TST first step prior to employment. (Can coincide reading the results with the employee start date by administering TST two to three days prior to the employee start date); (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Read results of first step TST within 48-72 hours of administration (results must be read and documented in millimeters (mm) induration prior to or on the employee start date); -If first TST is negative, administer second step within one to three weeks; -Read results within 48-72 hours of administration; -The employee cannot start work for compensation until the first step TST is administered and read. 3. Review of Maintenance Supervisor's employee file and Immunization/TB Test Record showed the following: -Hire date: 07/06/23; -First step TST administered on 07/06/23 (on the employee's start date), and the results read on 07/09/23. 4. Review of CNA K's employee file and Immunization/TB Test Record showed the following: -Hire date: 07/25/22; -First step TST administered on 07/27/22 (two days after the employee's start date), and the results read on 07/30/22. 5. Review of Hall Monitor N's Employee File and Immunization/TB Test Record showed the following: -Hire date: 04/10/2023; -First step TST administered 04/10/23 (on the employee's start date), and the results read on 04/13/23. During an interview on 03/07/24 at 10:33 A.M. Human Resources staff said the following: -The employee's hire date was the same as the start date; it is was their first paid day; -The Assistant Director of Nursing (ADON) was in charge of scheduling and keeping track of all staff TB testing. During an interview on 03/08/24 at 12:05 P.M. the ADON said once staff were hired, they were sent to her to schedule their TB testing. Once scheduled, she notified the department head when the new employee was cleared to start. All new staff must have a two-step TB test completed, with the first step administered and read, prior to or on their first paid day. During at interview on 03/13/24 at 2:40 P.M. the Administrator said he expected all new employees to have the entire first step of their two-step TB testing completed, meaning administered and read, prior to or on their first paid day; 6. Review of the facility's Isolation Precautions policy, revised 6/29/23, showed the following: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The purpose of this policy is to prevent the spread of contagious disease to nursing staff and/or other residents; -1. Isolation precautions will be utilized when a contagious disease is identified; -2. The type and duration of isolation will depend on the type of infectious agent or organism involved. The primary care physician will be consulted to assist in providing guidelines for type and length of isolation precautions, along with CDC guidelines; -3. In the event that isolation precautions are required, the facility will ensure that the isolation is least restrictive for the resident as possible under the circumstances; -4. The resident is placed in a private room with a private bath if indicated or a semi-private room with a bath that is not being shared by any other resident. Residents that are placed in a room with isolation precautions will have a sign placed outside of the door to indicate precautionary measures. The sign that is placed outside of the room will not provide specific information to the cause of precautionary measures to protect the privacy and dignity of the resident; -6. Two large trash containers are placed in the room and lined plastic bags; one labeled for linen with yellow plastic bags, one for trash with red plastic bags; -7. Antiseptic soap and disposable paper towels will be readily available near the resident's sink; -9. All items taken into the room for the use of the resident are to be disposable or left in the room until the resident is taken off isolation precautions; -10. An isolation cart with gowns, gloves, masks and garbage bags for disposal will be placed outside of the resident's room; -11. Before entering the room for any reason, the nursing staff will apply the necessary Personal Protective Equipment required for the diagnosed disease process. 7. Review of the Centers for Disease Control and Prevention's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised 3/18/24, showed the recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection included the following: -Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom; -If cohorting, only patients with the same respiratory pathogen should be housed in the same room; -Limit transport and movement of the patient outside of the room to medically essential purposes; -Health care personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face); (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Supervision to minimal assistance with ambulation and toileting; -Occasionally incontinent; -Diagnoses of Alzheimer's disease. Review of the nurses notes dated 3/5/24 at 4:30 P.M. showed the resident on isolation for COVID. During an interview on 3/5/24 at 9:00 A.M., Licensed Practical Nurse (LPN) AA said the following: -The facility has three COVID-19 positive residents; -Residents #46 and #66 were together in the same room on the locked memory care unit and Resident #5 lived on one of the unsecured halls. Observation on 3/5/24 at 9:30 A.M. showed a three-drawer cart outside of Resident #46's and Resident #66's room. A zippered plastic cover was over the door and the door was open. A trash can sat outside of the door. There was no sanitizer on the cart, and no place to perform hand hygiene. There was no sign posted on the door or on the cart for what personal protective equipment (PPE) should be worn when in the residents' room. There was no sign to show what type of isolation the residents were on. Observation on 3/5/24 at 4:30 P.M. showed the following: -A three-drawer cart sat outside of the residents' room with gowns, gloves, N95 masks, surgical masks, and shoe covers; -No signs were posted to showed staff, visitors and residents what PPE should be worn when entering the residents' room; -No sign was posted to alert staff or visitors to check with the nurse before entering the room; -No hand sanitizer was available and no place to perform hand hygiene without entering another resident's room; -NA BB put on a gown and gloves, did not put on shoe covers, he/she had an N95 mask on, and entered the isolation room; -Upon entering the room with Nurse Aide (NA) BB, Resident #46 was in bed, he/she had an indwelling catheter and was unable to get out of the bed on his/her own. The resident said he/she did not feel well, and had some cold symptoms; - Resident #66 was in the bed asleep and had a moist cough; -The bathroom door was open and was shared with two residents who did not have COVID-19 infection. During an interview on 3/5/24 at 4:30 P.M., NA BB said the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #66 was able to get out of the bed on his/her own and use the bathroom. The two residents who share the bathroom with Resident #66 can and do use the bathroom on their own; -There was no other place for these residents to use the bathroom; -He/She was not aware of what PPE should be used when going into the COVID-19 positive room; the guidelines had changed so much; -There was no hand sanitizer on the isolation cart for staff to use; he/she brings his/her own; -There was no public bathroom or a utility room on the hall for staff to use to wash their hands; -If he/she wanted to wash his/her hands, he/she would have to use another resident's room and that could be spreading the virus. Observation on 3/6/24 at 10:30 A.M. showed a three-drawer cart sat outside of Resident #46's and Resident #66's room. A zippered plastic cover was over the door and the door was open. There was no sanitizer on the cart, and no place to perform hand hygiene. No sign was posted on the door or on the cart for what PPE should be worn when in the residents' room. There was no sign to show what type of isolation the residents were on. During an interview on 3/6/24 at 11:55 A.M. Housekeeper DD said the following: -He/She cleaned the COVID-19 positive room last; -Resident #66 uses the bathroom that is shared with residents who do not have COVID-19 and live in the next room; -He/She cleaned the shared bathroom when he/se cleaned the non-COVID-19 room. During an interview on 3/6/24 at 12:00 P.M., Resident #110 in the adjoining room to Resident #46 and Resident #66 said he/she use the bathroom that was shared with the residents who are on isolation. During an interview on 3/6/24 at 12:00 P.M., Certified Nurse Aide (CNA) O said the following: -Resident #66 will use the bathroom that is shared with the two residents who do not have COVID-19; -The two residents who share the bathroom are independent with toileting and use the bathroom; -There is no other bathroom on the hall the residents could use; -There was no commode or room for a commode to put in the isolation room. Observation on 3/6/24 at 12:09 P.M. showed the following: -CNA O exited the isolation room, removed his/her gown, gloves and a surgical mask that was covering an N95 mask and placed them in a trash can outside of the resident's room; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She then walked to another resident's room and washed his/her hands. During [NAME] interview on 3/6/24 at 12:10 P.M. CNA O said there was no hand sanitizer available to sanitize hands and there was no place besides another resident's room to wash his/her hands after leaving the isolation room. Observation on 3/6/24 at 3:52 P.M. showed the following: -In the main shower room on the 200 hall, NA P was giving Resident #46 a shower room. The resident did not wear a mask, and NA P wore a surgical mask and did not have on any other PPE. NA P pushed the resident out of the shower room, down a short hall and through double doors back to his/her room; -NA P unzipped the plastic over the door, and pushed the resident into his/her room; -CNA O applied a gown, gloves, an N95 mask, and entered the resident's room to assist NA P to transfer the resident into the bed; -NA P left the room and returned wearing a gown and gloves; -CNA O and NA P transferred the resident into the bed using a mechanical lift; -NA P pushed the mechanical lift out of the resident's room and into the hallway, exited the room, removed all of his/her PPE and placed it into the trash can outside of the resident's room; -Licensed Practical Nurse (LPN) S entered the resident's room wearing a gown, KN95 mask, and gloves and applied a treatment to the resident's buttocks; -LPN S and CNA O exited the room, removed all of their PPE and placed the dirty PPE into the dirty trash can outside of the resident's room. They then went into two other resident's rooms to use these resident's sink to wash their hands; -NA P pushed the mechanical lift to the end of the hall and did not clean/sanitize the lift. He/She pushed the shower chair back through the double doors and into the shower room without cleaning/sanitizing the shower chair. During an interview on 3/6/24 at 3:52 P.M., LPN S said the following: -The resident should have had a mask on when he/she left his/her room to get a shower; -Signs should be posted on the residents' door indicating the residents are on isolation and what PPE should be used when entering the room; -Staff should wear a KN95 or higher mask when in the resident's room; -There should be hand sanitizer on the PPE cart to use when leaving the resident's room; -The mechanical lift was used for other residents and should be cleaned with a sanitizing solution before use on other residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/7/24 at 2:30 P.M. showed a three-drawer cart sat outside of Resident #46's and #66's room. A zippered plastic cover was over the door and the door was open. A trash can sat outside of the door. There was no sanitizer on the cart, and no place to perform hand hygiene. No sign was posted on the door or on the cart for what PPE should be worn when in the resident's room. There was no sign to show what type of isolation the residents were on. During an interview on 3/8/24 at 5:35 P.M., the Director of Nursing (DON) said the following: -Staff should wear gowns, gloves, N95 mask, face shields and shoe protectors when going into a COVID-19 positive room; -This PPE should be worn at all times. Both the resident and the staff should wear the full PPE when exiting the room for showers or appointments; -Signs should be posted at the front door to alert staff, residents and visitors that there is currently cases of COVID-19 in the facility; -Signs should be posted at the front door and at the isolation room for what PPE should be worn when going into an isolation room; -Staff should perform hand hygiene with either hand sanitizer or washing their hands; -Hand sanitizer should be on the isolation carts. There is not a separate utility room for staff to use on the locked special care hall to wash their hands; -Equipment that is taken into the COVID-19 positive resident's room is left there unless it is a mechanical lift or a shower chair. These items once removed from the room should be thoroughly cleaned and disinfected; -A COVID-19 positive resident should not share a bathroom with a COVID-19 negative resident. During an interview on 3/12/24 at 9:20 A.M., the Administrator said the following: -There is a system in place to guide staff on what to do when a resident needs to be placed on isolation; -He expected staff to follow the facility policy for signs, PPE, resident placement and hand hygiene. 41412 47008 10. Review of Resident #5's progress notes, dated 3/04/24 at 6:02 A.M., showed the resident tested positive for COVID-19 and was compliant with isolation. Review of the resident's care plan, dated 3/04/24, showed the following: (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident tested positive for COVID-19; -Educate staff, residents, family and visitors of COVID-19 signs and symptoms and precautions to follow; -Follow facility protocol for COVID-19 screening and precautions. Observation on 3/05/24 at 3:25 P.M., showed the following: -There was a plastic barrier duct taped top to the resident's door with a red zipper down the middle facing the hallway; -There was no personal protective equipment outside of the resident's door; -There was no hand sanitizer outside of the resident's door; -There was no trash receptacle outside of the resident's door; -The resident sat on a recliner inside of his/her room; -There was no large trash receptacle inside the resident's room; -There was no signage posted on the resident's door or wall by his/her door stating precaution to take before entering the resident's room; -There was no signage on the front entrance of the building stating there was COVID positive residents in the building. Review of the resident's progress notes, dated 3/05/24 at 3:34 P.M., showed the resident was given education on isolation measures. Observation on 3/06/24 at 8:30 A.M., showed there was no signage on the front entrance of the building stating there was COVID positive residents in the building. Observation on 3/06/24 at 9:13 A.M., showed the following: -There was a plastic barrier duct taped top to the resident's door with a red zipper down the middle facing the hallway; -There was a three-drawer cart sitting outside of the resident's room with gloves, gowns, N95 masks, surgical masks, and shoe covers; -There was no hand sanitizer outside of the resident's door; -There was no place to perform hand hygiene without entering another resident's room; -There was no large trash receptacle to place used personal protective equipment outside of the resident's room; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no signage posted on the resident's door or wall by his/her door stating what precautions to take before entering his/her room; -No sign was posted to alert staff or visitors to check with the nurse before entering the room. Observation on 3/06/24 at 9:30 P.M., showed the following: -CNA JJ applied a gown, gloves, an N95 mask, and entered the resident's room; -CNA JJ exited the room, removed all of their PPE and placed the dirty PPE into the dirty trash can outside of the resident's room. He/She then went into two other residents' rooms to use the sinks to wash his/her hands. Review of the resident's progress notes, dated 3/07/24 at 6:42 A.M., showed the resident was on isolation for being positive for COVID. Observation on 3/07/24 at 11:15 P.M., showed there was no signage on the front entrance of the building stating there was COVID positive residents in the building. Observation on 3/07/24 at 11:48 P.M., showed the following: -There was a plastic barrier duct taped top to the resident's door with a red zipper down the middle facing the hallway; -There was a three-drawer cart sitting outside of the resident's room with gloves, gowns, N95 masks, surgical masks, and shoe covers; -There was no hand sanitizer outside of the resident's door; -There was no place to perform hand hygiene without entering another resident's room; -There was no signage posted on the resident's door or wall by his/her door stating what precautions to take before entering his/her room; -There was no sign posted to alert staff or visitors to check with the nurse before entering the room. Observation on 3/08/24 at 7:45 A.M., showed there was no signage on the front entrance of the building stating there was COVID positive residents in the building. During an interview on 3/21/24 at 3:07 P.M., the primary care physician said the following: -He would expect the facility to post signage notifying staff and visitors of precautions required upon entering a COVID positive room; -It would not be appropriate for a COVID positive resident to share a bathroom with a COVID negative resident; (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He would expect staff to don PPE per current CDC guidelines when entering and providing care for a COVID positive resident. 11. Review of Resident #75's March 2024 physician order sheets (POS) showed the following: -Diagnoses included diabetes and chronic viral hepatitis C (viral infection that affects the liver; spread through contact with blood); -Accu checks three times daily and as needed; -Novolog (rapid acting insulin, medication to treat diabetes) five units three times daily. Observation on 3/6/24 at 11:45 A.M., showed Licensed Practical Nurse (LPN) Y performed an accu check procedure on the resident. After the procedure, LPN Y removed his/her gloves and used hand sanitizer before applying new gloves and administering the resident his/her insulin. (LPN Y did not wash hands with soap and water after the removal of gloves). 12. Review of Resident #76's March 2024 POS showed the following: -Diagnoses included diabetes; -Accu check four times daily and as needed; -Novolog eight units every 24 hours; -Novolog per sliding scale (an amount to be determined after an accucheck procedure (finger stick procedure to determine the amount of sugar in the blood). Observation on 3/6/24 at 11:52 A.M., showed LPN Y performed an accu check procedure on the resident; after the procedure, LPN Y removed his/her gloves and used hand sanitizer (did not wash hands with soap and water after the removal of gloves) before applying new gloves and administering the resident his/her insulin. After administering the resident's insulin, LPN Y removed his/her gloves and used hand sanitizer. (LPN Y did not wash hands with soap and water after the removal of gloves). 13. Review of Resident #67's March 2024 POS showed the following: -Diagnoses included diabetes; -Accu check four times daily. Observation on 3/6/24 at 12:02 P.M., showed LPN Y did not wash his/her hands with soap and water before gloving and performing the resident's accu check. During an interview on 3/7/24 at 1:43 P.M., LPN Y said he/she thought it was okay to use hand sanitizer to wash hands; he/she did not know you should wash hands with soap and water after removing gloves; he/she always starts out his/her process by washing hands with soap and water, he/she just forgot to before performing Resident #67's accu check. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Review of the Mosby's 2024 Nursing Drug Reference showed the following instructions for Ipratropium-Albuterol Solution: -To prevent infections, clean the nebulizer face mask or mouth piece after each use; -Lack of cleaning can cause hoarseness, throat irritation and infections of the mouth. While on conducting the facility annual inspection the Director of Nursing reported the facility did not have a specific policy related to nebulizer storage/oxygen supplies storage. 15. Review of Resident #36's face sheet showed he/she had diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing disorder). Review of the resident's March 2024 POS showed an order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams (mg)/3 milliliter (ml) (breathing medication), inhale one dose orally every four hours as needed (PRN) for wheezing. Review of the resident's March 2024 medication administration record showed LPN X documented administering the resident's PRN Ipratropium-Albuterol Inhalation Solution on 3/5/24 at 5:36 A.M. Observation of the resident's room on 3/5/24 at 10:16 A.M., showed the resident's nebulizer machine sat directly on the floor with the nebulizer tubing and mask connected to the nebulizer machine and draped across the floor and across the knob of his/her bedside dresser. The canister (where the medication is instilled for administration) had a moderate amount of droplets in the canister. The nebulizer mask and tubing was open to air and not covered in any way; there was no bag for storage was noted in the room. During an interview on 3/5/24 at 10:20 A.M., the resident said the following: -He/She had been having increased shortness of breath and more difficulty breathing recently; he/she was having to use his/her nebulizer and inhaled medications more often and had even been started on a steroid; [TRUNCATED]		

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NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on interview and record review, the facility failed to provide the pneumococcal vaccine (a vaccine that can protect against pneumoccal disease) as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines for one resident (Resident #61), who gave consent to receive the vaccine upon his/her admission to the facility, in a review of 34 sampled residents. The facility census was 116. Review of the facility policy for Influenza and Pneumococcal Immunizations, revised 3/18/22, showed the resident or their legal representative will be told the pneumococcal immunization will be offered upon admission and a second pneumococcal immunization may be recommended after five years from the first immunization. The pneumococcal immunization will not be given if the immunization is medically contraindicated, the facility has evidence to support the resident received the immunization, or the resident or their legal representative has refused the immunization. Review of the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 9/22/23, showed the following: -Adults 19 through [AGE] years old with any of these conditions or risk factors: 1. Alcoholism or cigarette smoking; 2. Cerebrospinal fluid leak; 3. Chronic heart disease, including congestive heart failure and cardiomyopathies, excluding hypertension; 4. Chronic liver disease; 5. Chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma; 6. Cochlear implant; 7. Diabetes mellitus 8. Decreased immune function from disease or drugs (i.e., immunocompromising conditions); 9. Immunocompromising conditions include: a. Chronic renal failure or nephrotic syndrome; b. Congenital or acquired asplenia, or splenic dysfunction; c. Congenital or acquired immunodeficiency; d. Diseases or conditions treated with immunosuppressive drugs or radiation therapy; (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. HIV infection; f. Sickle cell disease or other hemoglobinopathies; -Adults 19 through [AGE] years old who never received any Pneumococcal Vaccine, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. The minimum interval (8 weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete; -Adults 19 through [AGE] years old who only Received PPSV23, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination; 2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then complete. -Adults 19 through [AGE] years old who only received PCV13, who have a risk condition (see above) other than an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13 for those with a cochlear implant or cerebrospinal fluid leak. The PPSV23 dose should be given at least 1 year after PCV13 for any of the other chronic health conditions. When PPSV23 is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults 19 through [AGE] years old who have an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13. When PPSV23 is used, they need another pneumococcal vaccine at least 5 years later. At that time, give either 1 dose of PCV20 or a second dose of PPSV23. When PCV20 is used, their vaccines will then be complete. When a second PPSV23 dose is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Adults 19 through [AGE] years old who have received PCV13 and 1 Dose of PPSV23 and who have an immunocompromising condition: 1. Give 1 dose of PCV20 or a second PPSV23 dose; 2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine. Their vaccines are then complete; 3. The second dose of PPSV23 should be given at least 8 weeks after PCV13 and 5 years after PPSV23. No additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults [AGE] years or older who don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete; Adults [AGE] years or older who have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least 8 weeks later. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete. 1. Review of the Resident #61's face sheet showed the following: -Admission to the facility on [DATE]; -The resident was his/her own guardian/responsible party; -Diagnoses included diabetes mellitus (too much sugar in the blood stream), seizures (a sudden, uncontrolled burst of electrical activity in the brain), multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of the resident's admission packet, dated 11/10/23, showed the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A revolving immunization consent form, signed by the resident, showed he/she agreed to receive the pneumococcal immunization on a recurring basis and had been educated on the benefits and potential side effects of immunization; -An annual immunization consent form, signed by the resident, showed he/she agreed to receive the pneumococcal immunization and had been educated on the benefits and potential side effects of the pneumococcal immunization. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 11/23/23, showed the resident was cognitively intact. Review of the resident's March 2024 physician order sheet (POS) showed the resident may have pneumococcal vaccine every five years with written or verbal consent. Review of the resident's medical record and immunization record showed the resident had not received the pneumococcal vaccination. During an interview on 03/08/24, at 8:30 A.M., the resident said he/she had the pneumonia vaccination in the past, prior to admission, but was not sure how long ago. He/She had not received the pneumonia vaccine since he/she admitted to the facility. He/She would like to have a pneumonia vaccination. During an interview on 03/08/24, at 3:31 P.M., the Director of Nursing said the following: -Resident #61 admitted in November; -According to the resident's medical record, the resident had not been offered the pneumococcal vaccine; -She was not sure why the resident had not been offered the pneumococcal vaccine; -Once the resident signs the vaccine consent form nursing will order the vaccine if a pharmacy immunization clinic is not taking place soon; -She is responsible for following up to ensure the vaccine is administered. During an interview on 3/13/24 at 2:40 P.M., the Administrator said the following: -He expected all residents to be offered a pneumonia vaccine; -He expected a new admission to be offered a pneumonia vaccine; -He expected the pneumonia vaccine to be offered to resident upon admission with no delay until the next vaccination clinic. During an interview on 3/21/24 at 3:07 P.M., the primary care physician said the following: -He expected all residents to be offered a pneumonia vaccine; (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Chariton Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Manor Drive Salisbury, MO 65281	
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He expected a new admission to be offered a pneumonia vaccine; -He expected the pneumonia vaccine to be offered to residents in the Fall; -Pneumonia vaccinations work best when given during the Fall.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview and record review, the facility failed to ensure complete entrapment assessments for two residents who had side rails attached to their bed (Residents #32 and #35), in a sample of 34 residents, to ensure the environment remained safe and free of accident hazards. The facility census was 116. Review of the facility Bed Siderails policy, reviewed 6/29/23, showed the following: -To ensure all bed side rails in use have been evaluated for safety; -All residents using any size siderail device on their beds will have a Restraint/Entrapment Assessment completed to determine the restraining, enabling, or hazard effect of the device. This assessment will occur upon initial use, quarterly, and as needed if there is a significant change in the resident's condition; -Using steps 1 and 2 of the Restraint/Entrapment Assessment, each resident using a side rail device will be assessed to determine if the side rail has a restraining affect and/or an enabling effect; -If step 1 of the Restraint/Entrapment Assessment determines that the device is a restraint, it is still considered a restraint even though the device also has an enabling effect; -Each resident using a side rail device will have a detailed history documented including the symptoms or reasons for using a device; -All possible negative effects and safety hazards of the device will be considered in the assessment; -If a resident is determined to be at Risk with the device in Step 3 of the Restraint/Entrapment Assessment, the use of the device will be discontinued, and the resident will be reevaluated for use of an alternative device; -If the resident is using a specialty mattress which inflates based on residents' weight, follow all manufacturer recommendation. The gap between mattress and rail widens when the mattress compresses. As resident changes position, the mattress may inflate and trap the resident's head, chest, neck, or limbs between mattress and side rail resulting in fractures, asphyxiation or even death; -Using any device requires a care plan. 1. Review of Resident #32's face sheet showed the following: -The resident is his/her own responsible party; (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included Type 2 diabetes mellitus (too much sugar in the blood) with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), morbid obesity , rheumatoid arthritis (an autoimmune and inflammatory disease, which means that your immune system attacks healthy cells in your body by mistake, causing inflammation (painful swelling) in the affected parts of the body, mainly attacks the joints), partial traumatic amputation (at least half the diameter of the injured extremity is severed or damaged significantly) of right foot, osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), muscle weakness, lack of coordination, abnormalities of gait (the pattern of how you walk) and mobility, retinal detachment with retinal break (an emergency situation in which a thin layer of tissue (the retina) at the back of the eye pulls away from its normal position), joint disorder, and pain. Review of the Resident's care plan, dated 3/14/23, showed the following: -The resident is at risk for fall related to deconditioning, gait/balance problems and psychoactive drug use; -He/She is often non-compliant with asking for assistance when needed; -The resident has had an actual fall; -The resident has diabetes mellitus and should be monitored for signs and symptoms of hypoglycemia which include lack of coordination and staggering gait; -The resident has a self-care performance deficit related to amputation of right toes, limited mobility, limited range of motion and pain; -He/She can self-propel his/herself in a wheelchair; -He/She is non-compliant with non-weight bearing status and continues to transfer his/herself and try to walk at times; -The resident is at risk for adverse reaction related to polypharmacy and needs to be monitored for possible signs and symptoms of falls, fatigue, lethargy, and confusion; -The resident has (chronic) pain related to arthritis and diabetic neuropathy; -The resident takes pain medication and needs to be monitored for confusion, dizziness, and falls; -The resident has impaired visual function related to retinal detachment and needs to be monitored for decline in mobility and sudden visual loss. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/01/23, showed the following: -Cognitively intact; -Highly visually impaired; (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included diabetic mellitus; -Required supervision by staff for all mobility areas except rolling from left to right in bed; -No restraints were used including bed rails. Observations on 03/05/24 at 11:15 A.M., 3/6/24 at 9:12 A.M., 3/7/24 at 12:28 P.M., and 3/8/24 at 8:37 A.M. showed the resident had a 1/8 bed rail on the left hand side of his/her bed in the raised position. Record review showed no documentation the resident's care plan addressed the use of bed rail on the resident's bed. There was no documentation of abed rail assessment or consent for bed rail. 2. Review of Resident #35's face sheet showed the resident was admitted to the facility on [DATE] with diagnoses of history of fractured right and left femur, cerebral palsy (a condition marked by impaired muscle coordination), diabetes, anxiety, schizoaffective disorder (a mental health disorder), depression and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Review of the resident's care plan for Activity of Daily Living (ADL) deficit dated 3/2/22 showed the following: -The resident has an ADL self-care performance deficit related to cerebral palsy. Dependent upon staff for all bedside cares and mobility; -The resident will have his/her needs met on a daily basis; -The resident is totally dependent on 1-2 staff for repositioning and turning in bed at least every two hours and as necessary. Is able, if willing to pull/hold body to side(s) during cares; -No approaches for the use of the side rails. Review of the resident's quarterly MDS dated [DATE] showed: -Able to make self understood and able to understand others; -Moderately impaired with decision making; -Impairments to the both side of the lower body; -Dependent upon staff with rolling from side to side, going from a sitting to a lying position and a lying to a sitting position; -No bed rails used. Observation on 3/05/24 at 3:15 PM and again on 3/7/24 at 2:00 P.M. showed the following: -The resident has candy cane rails on each side of the bed at the head of the bed; (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When staff told the resident to grab the rail, the resident was able to grab the side rail and assist with rolling over in bed, with staff assistance. Review of the resident's POS for 3/24 showed no order for the use of side rails. Review of the resident's medical record showed no consent for the use of side rails or an entrapment assessment. During an interview on 3/8/24 at 11:30 A.M. the Assistant Director of Nursing (ADON), said the following: -He/She did not complete an assessment, or obtain a physician order for the residents' bed rails; -An assessment and physician order should be obtained; -Maintenance staff would do the entrapment assessment, and this had not been done; -The facility had not obtained consents for the use of the rails. During an interview on 3/8/24 at 12:15 P.M. the Maintenance Director said the following: -He has put bed rails on some beds; -He has not measured any mattress for entrapment; -He was not aware that the mattress had to be measured when putting on side rails. During an interview on 3/07/24 at 3:20 P.M. the Director of Nursing said the following: - No assessments or consents had been completed for the resident's bed rails; -A consent for the use of a side rail should be obtained before using a side rail; - Consents and/or assessments should be done quarterly; -The bed should be measured for the possibility of entrapment; -The maintenance director was responsible for completing measurements. During an interview on 3/12/24 at 9:20 A.M. the Administrator said the following: -An assessment should be done before the use of side rails; -The bed should be measured for entrapment by the maintenance department. 47008		