STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265554	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meramec Nursing	940 Mattox Drive Sullivan, MO 63080

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 48982 Based on record review and interview, facility staff failed to prevent commingling of five residents' funds (Resident #8, #27, #26, #38, and #40) out of 23 sampled personal funds, with the facility operating funds, and failed to reconcile the resident trust monthly for two of 12 months sampled. The facility census was 47. 1. Review of the facility's policy titled Resident Funds, undated, showed resident funds will be maintained by the facility and reconciled regularly. Review of the facility's policy titled Private Collections Policy and Procedures, revised 01/20/21, showed the primary responsibility of the facility's Business Office Manager (BOM) to maintain Account's Receivable (AR) amounts, with oversight provided by the Administrator. Review of the facility's policy titled Facility Resident Trust Fund Policy, revised 05/2012, showed the resident trust fund will be managed and accounted for in accordance with state and federal guidelines. All resident trust should be maintained in one collective interest-bearing bank account separate from any other facility operating accounts and money. The resident fund bank account must be reconciled monthly immediately upon receipt of the bank statement. 2. Review of the facility's monthly resident trust reconciliation records showed it did not contain a monthly reconciliation for March 2024 or June 2024. 3. Review of the facility's-maintained AR Aging report, dated 11/19/24, showed current residents with personal funds held in the facility operating account: -Resident #8 with a credit balance of $26,037.26 with a start date of 05/01/24; -Resident #27 with a credit balance of $698.80 with a start date of 08/01/24; -Resident #26 with a credit balance of $247.89 with a start date of 08/13/24; -Resident #38 with a credit balance of $3,524.00 with a start date of 08/15/24; -Resident #40 with a credit balance of $1,474.00 with a start date of 08/15/24. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Meramec Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Mattox Drive Sullivan, MO 63080	

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 11/20/24 at 8:30 A.M., the Administrator said the BOM is responsible for the facility's Accounts Payable (AP), the Regional BOM is responsible for the facility's resident trust along with reconciliation, and accounts receivable is responsible for the AR/Aging. The Administrator said he/she is ultimately responsible to ensure funds are completed and reconciled. The Administrator said he/she is not able to find the resident trust reconciliations from March 2024 or June 2024 and does not know if they were completed or not. The Administrator said the facility does not have written authorization to hold resident funds and commingle in the facility funds. During an interview on 11/20/24 at 9:00 A.M., Accounts Receivable Employee said he/she took over the position in August 2024. He/She has worked through the Aging Report since he/she took it over trying to determine what credits need refunded, but he/she does not have it completed yet. He/She said the Aging Report should be reviewed monthly and if a credit is discovered he/she should research it to determine if a refund should be issued. He/She said refunds should be issued within 30 days of discharge and that is not happening. He/She said the facility does not have written permission to hold resident funds in the facility funds. During an interview on 11/20/24 at 1:30 P.M., Administrator said resident funds should be returned within 30 days of discharge and that is not happening.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48982 Based on record review and interview, facility staff failed to provide refunds of personal funds to the residents from the facility operating account within 30 days of discharge for three (Resident #58, #59, and #56) out of five sampled residents. The facility census was 47. 1. Review of the facility's policy titled Resident Funds, undated, showed resident funds will be maintained by the facility and reconciled regularly. Review of the facility's policy titled Private Collections Policy and Procedures, revised [DATE] showed the primary responsibility of the facility's Business Office Manager (BOM), is to maintain Account's Receivable (AR) amounts, with oversight provided by the Administrator. Review of the facility's policy titled Facility Resident Trust Fund Policy, revised ,d+[DATE], showed the resident trust fund will be managed and accounted for in accordance with state and federal guidelines. Refund check requests for discharged or expired residents must be completed within five business days of the resident discharge. Per state regulations, a completed discharge/trust fund accounting form reflecting discharge date and monies disbursed must be sent to the caseworker with in five days. Facility shall refund the balance of the resident's personal funds when a resident is discharged , the amount shall be refunded by the end of the month following the month of discharge or by state/federal guidelines if more stringent. 2. Review of the facility's-maintained Account Receivable (AR) Aging report, dated [DATE], showed residents with personal funds held in the facility operating account: -Resident #58, discharged from the facility on [DATE], with a credit balance of $3,060.00; -Resident #59, discharged from the facility on [DATE], with a credit balance of $5,106.00; -Resident #56, discharged from the facility on [DATE], with a credit balance of $2687.09. 3. During an interview on [DATE] at 8:30 A.M., the Administrator said the BOM is responsible for the facility Accounts Payable (AP), the Regional BOM is responsible for the facility's resident trust along with reconciliation, and the accounts receivable is responsible for the AR/Aging. The Administrator said he/she is ultimately responsible to ensure refunds are issued timely. During an interview on [DATE] at 9:00 A.M., the Accounts Receivable Employee said he/she has worked through the Aging Report since he/she took it over to determine what credits need refunded but he/she does not have them completed yet. He/She said the Aging Report should be reviewed monthly and if a credit is discovered he/she should research it to determine if a refund should be issued. He/She said refunds should be issued within 30 days of discharge and that is not happening at this time. During an interview on [DATE] at 1:30 P.M., the Administrator said resident funds should be returned within 30 days of discharge and that is not happening.

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	265554	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meramec Nursing	940 Mattox Drive Sullivan, MO 63080

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48982 Based on interview and record review, facility staff failed to provide the appropriate Center for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC) for three residents (Resident #54, #55, and #248) out of three sampled residents whom the facility-initiated discharge from Medicare Part A Services when benefit days were not exhausted. The facility census was 47. 1. Review of the facility's policy titled Advanced Beneficiary Notices, revised 07/14/22, showed a NOMNC form shall be issued to the resident/representative with Medicare covered services are ending, no matter if the resident is leaving the facility or remaining at the facility. This informs the resident/representative on how to request an appeal or expedite determination from their Quality Improvement Organization (QIO). To ensure the resident/representative has enough time to make a decision whether or not to receive the services in question and assume the financial responsibility, the notice shall be provide within 48 hours of the last anticipated covered day. The notice shall be written legibly in a language and/or format the resident/representative understands, verbal explanations detailing the reasons for determination of possible non-coverage shall be provided. The notice shall be hand-delivered to obtain beneficiary or representative signature. The original notice shall be kept by the facility and a copy provided to the resident/representative. 2. Review of Resident #54's medical record showed: -Medicare Part A skilled services started on 08/16/24; -Last covered day of Medicare Part A skilled services on 08/30/24; -Facility initiated discharge from Medicare Part A services; -discharged to home on 08/31/24; -Did not contain a NOMNC. During an interview on 11/20/24 at 1:30 P.M., the Administrator said the resident used three Medicare Part A days with 77 remaining. 3. Review of Resident #55's medical record showed: -Medicare Part A skilled services started on 07/27/24; -Last covered day of Medicare Part A skilled services on 07/29/24; -Facility initiated discharge from Medicare Part A services; -discharged to home on 07/30/24; -Did not contain a NOMNC. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meramec Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Mattox Drive Sullivan, MO 63080	

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 1:30 P.M., the Administrator said the resident used 31 Medicare Part A days with 49 remaining. 4. Review of Resident #248's medical record showed: -Medicare Part A skilled services started on 10/08/24; -Last covered day of Medicare Part A skilled services on 10/28/24; -Facility initiated discharge from Medicare Part A services; -discharged to home on 10/29/24; -Did not contain a NOMNC. During an interview on 11/20/24 at 1:30 P.M., the Administrator said the resident used 21 Medicare Part A days with 59 remaining. 5. During an interview on 11/20/24 at 1:30 P.M., the Administrator said the previous Social Service Designee (SSD) left employment with the facility in June 2024 and he/she has been responsible since that time to ensure the NOMNCs were completed timely. The Administrator said he/she did not start completing the notices until this month. The Administrator said he/she knows he/she is ultimately responsible to ensure the notices are completed, but he/she did not do them due to trying to cover too many roles in the facility. The Administrator said if the facility initiates a Medicare Part A discharge the NOMNC should be issued and signed by the resident or the responsible party at least 48 hours prior to the Medicare Part A last covered date. The administrator said the NOMNC's had not been completed correctly.

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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. 48982 Based on interview and record review, facility staff failed to check the Employee Disqualification List (EDL) a list of individuals who have been determined to have abused or neglected a resident or misappropriated funds or property belonging to a resident), criminal background check (CBC), Family Care Safety Registry (FCSR), and Nurse Aide (NA) Registry prior to hire in accordance with their facility policy for three employees (Licensed Practical Nurse (LPN) V, Housekeeper W, and Dietary Aide (DA) X) out of six sampled employees. The facility census was 47. 1. Review of the facility's policy titled Background Investigations, revised 12/12/23, showed employee background checks, licensure verification, and criminal conviction record checks are conducted on all personnel making application for employment. The facility will not employ persons having a findings entered into the state nurse aide registry, or disciplinary action on his/her professional license regarding abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of property. 2. Review of DA X's personnel file showed: -Date of hire 08/09/24; -FCSR letter dated requested 08/14/24 and received 08/29/24; -CBC requested 08/14/24 and dated 08/29/24. Review of DA X's timecard showed his/her first day of work as 08/09/24. 3. Review of Housekeeper W's personnel file showed: -Date of hire 10/28/24; -FCSR letter requested and recieved on 10/30/24; -EDL verification dated 11/19/24; -Did not contain documentation of CBC or NA Registry verification. Review of Housekeeper W's timecard showed his/her first day of work as 10/28/24. 4. Review of LPN V's personnel file showed: -Date of hire 11/04/24; -Did not contain documentation of a FCSR or CBC. Review of LPN V's timecard showed his/her first day of work as 10/07/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 11/20/24 at 8:30 A.M., the Administrator said he/she is responsible to complete the pre-employment screenings on all new hires since June 2024. The administrator said once the facility decides to hire a new employee, he/she completes the pre-employment screenings of the FCSR, CBC, EDL, and NA registry checks. The administrator said all screenings should be completed prior to the employee's date of hire. The administrator said the reason pre-employment screenings were late or did not get done is due to him/her having too many job roles in the facility since the change of ownership and things just get missed.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on record review and interview, facility staff failed to thoroughly complete a quarterly Minimum Data Set (MDS), a federally mandated assessment tool, as directed by the Resident Assessment Instrument (RAI) manual for four residents (Resident #1, #2, #4, and #11) out of twelve sampled residents. The facility census was 47. 1. Review of the RAI manual, dated 10/1/2024, showed the Quarterly assessment is an Omnibus Budget Reconciliation Act of 1987 (OBRA) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. -The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status; -The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts; -Section C, Cognitive Patterns, determines the resident's attention, orientation, and ability to register and recall information, and whether the resident has signs and symptoms of delirium; -A dash value indicates that an item was not assessed; -Residents should be the primary source of information for resident assessment items; -Most residents are able to attempt the Brief Interview for Mental Status (BIMS), a structured cognitive interview; -A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance; -Without an attempted structured cognitive interview, a resident might be mislabeled based on their appearance or assumed diagnosis; -Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care; -Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted but was not done. 2. Review of Resident #1's Quarterly MDS, dated [DATE], showed the resident interview portion of the BIMS assessment and mood assessment coded as not assessed. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed the resident interview portion of the BIMS assessment and mood assessment coded as not assessed. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #4's Quarterly MDS, dated [DATE], showed the resident interview portion of the BIMS assessment coded as should not be assessed due to being rarely/ never understood and the staff interview portion of the assessment coded as not assessed. Review showed the resident mood assessment coded as should not be assessed due to being rarely/never understood and the staff interview portion coded as not assessed. 5. Review of Resident #11 Quarterly MDS, dated [DATE], showed the resident interview portion of the BIMS assessment blank and the staff interview portion of the assessment coded as not assessed. Review showed the resident interview of the mood assessment coded as not assessed and the staff interview portion coded as not assessed. 6. During an interview on 11/21/24 at 11:42 A.M., The MDS coordinator said he/she has been in this position since May, but has been working night shifts. The DON was the back up person for completing MDS assessments. During an interview on 11/21/24 at 11:46 A.M., the Director of Nursing (DON) said the Social Services Director (SSD) is supposed to complete the resident interview assessments. The DON said the SSD did not complete the assessments, so when the MDS assessment came due he/she did not have the information and coded the assessments as not assessed. The DON said he/she did not complete the assessments himself/herself,because he/she had been instructed by corporate to not do the SSD's job. During an interview on 11/21/24 at 1:02 P.M., the Administrator said the DON is the Registered Nurse (RN) responsible for checking the MDS input since the MDS Coordinator is a Licensed Practical Nurse. The Administrator said he/she did not know at the time the MDS assessments were not being done correctly. The SSD had been responsible for the BIMS portion. The Administrator said he/she became aware last month the assessments were not done correctly. The SSD did not do his/her job. The DON who is an RN signs off and would be responsible as well. 45489 50361

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on observation, interview, and record review, facility staff failed to review and revise the comprehensive care plan for two residents (Resident #4 and #5) for changes in Activities of Daily Living (ADL) needs, one resident (Resident #8) who developed a pressure ulcer, and for one resident (Resident #11) with weight loss out of a sample of 12 residents. The facility census was 47. 1. Review of the facility policy titled, Comprehensive Care Plans, dated 06/02/2022, showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, professional standards of practice, medical provider orders, and resident's goal and preferences. The comprehensive care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS - a federally mandated assessment tool) assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 2. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as dependent on staff for chair/bed to-chair transfers and used a wheelchair for transportation with staff assistance. Review of the resident's care plan in use during the survey, dated 07/20/23, showed staff documented the resident required assistance from two staff members with transfers. The care plan did not contain interventions on how to transfer the resident. Observation on 11/18/24 at 3:22 P.M., showed staff transferred the resident with a mechanical lift. During an interview on 11/21/24 at 10:08 A.M., Certified Nurse Aide (CNA) G said staff use a mechanical lift to transfer the resident. The CNA said staff know how to transfer the resident from communication with the nurses, but it should be in the resident's care plan. During an interview on 11/21/24 at 10:11 A.M., the Assistant Director of Nursing (ADON) said the resident required a mechanical lift for transfers and this should be on the care plan. The ADON said the MDS coordinator is responsible for updating the care plans and in his/her absence the Director of Nursing (DON) is responsible. During an interview on 11/21/24 at 11:50 A.M., the MDS coordinator said if a resident required a mechanical lift for transfers the care plan should show it. The MDS coordinator said if the care plan shows a resident required assistance from two staff members for transfers and staff are using a mechanical lift the care plan is inaccurate. The MDS coordinator said he/she is not sure why it had not been updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 12:17 P.M., the DON said the resident's care plan should be updated to showed the resident required a mechanical lift for transfers. He/She said it was an oversight that it was not updated. During an interview on 11/21/24 at 1:05 P.M., the Administrator said the resident's transfer needs should be accurate on the care plans. The MDS coordinator is responsible for updating the care plans. It is ultimately the responsibility of the DON to ensure the care plans are complete and accurate. 3. Review of Resident #5's Annual MDS, dated [DATE], showed staff assessed the resident as dependent on staff for oral hygiene, toileting hygiene, bathing, dressing, personal hygiene, bed mobility and transfers. Review of the resident's care plan, revised 11/15/24, showed staff documented the resident required assistance from one staff member with bathing, dressing, personal hygiene and oral care, and toileting. The resident required supervision from staff for bed mobility and transfers. Observation on 11/20/24 at 10:20 A.M., showed CNA C and CNA G assisted the resident with a transfer from the bed to his/her wheelchair with the use of a gait belt. During an interview on 11/21/24 at 10:04 A.M., CNA G said the resident required assistance from two staff members for transfers and was dependent on staff for cares. The CNA said this should be in the resident's care plan, but it was not. The care plan needed to be updated. During an interview on 11/21/24 at 10:15 A.M., the ADON said the resident required two staff members for transfers and sometimes used a mechanical lift. The ADON said one staff assist with ADLs was not accurate anymore. The ADON said the resident's care plan should say two staff assist with ADLs and mechanical lift as needed. During an interview on 11/21/24 at 11:50 A.M., the MDS Coordinator said the resident had a change in his/her ADL care and it should have been added to the care plan. The MDS Coordinator said he/she was aware the resident required assistance from two staff members for transfers. The MDS Coordinator said the care plan should have been updated to show the resident was a two person assist with ADLs. During an interview on 11/21/24 at 12:01 P.M., the DON said he/she would expect a decline in ADLs to be updated on the care plan. The DON said the MDS Coordinator was responsible, but while the MDS Coordinator was gone, he/she tried to keep up with the care plan updates and had a hard time unfortunately. The DON said the resident's care plan for one staff assist was not accurate for the resident at this time. During an interview on 11/21/24 at 1:03 P.M., the Administrator said ADL declines should be on the resident's care plan. The Administrator said the nurses should notify the MDS Coordinator in the morning meeting and the MDS Coordinator should update the care plans. The Administrator said the responsibility of care plans ultimately falls on the DON. 4. Review of Resident #8's Admission MDS, dated [DATE], showed care area triggered for pressure ulcers and should be on the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -At risk for pressure ulcers; -No pressure ulcers; -Pressure reducing devices in chair and bed; -Used a wheelchair; -Required partial to moderate assist for toileting, shower/bathe self; and personal hygiene. Review of the resident's weekly skin assessment, dated 10/03/24, showed staff documented a new unstageable pressure ulcer (wound can not be staged because the wound is covered by necrotic tissues and eschar (dead tissue that eventually sloughs off healthy skin after an injury) on his/her right heel measured 5 centimeters (cm) x 3 cm with eschar. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed orders: -On 10/4/24 for heel protectors to feet and/or float heels on pillow every day and night shift for wound care; -On 10/5/24 to apply skin prep to right heel daily. Review of the resident's care plan, dated 11/15/24, showed the care plan did not contain direction for staff in regard to the resident's risk for developing pressure ulcers or current pressure ulcers. During an interview on 11/21/24 at 10:13 A.M., CNA G said pressure ulcers should be on the care plan and should include what cares need to be done for the resident. The CNA said interventions like heel protectors, pillows, or other items to help with pressure relief should be listed on the care plan. CNA G said he/she did not know the resident's care plan did not contain interventions for pressure relief. The MDS Coordinator is responsible for updating the care plans. During an interview on 11/21/24 at 10:15 A.M., Licensed Practical Nurse (LPN) E said pressure ulcers should be on the care plan and he/she did not know the care plan did not address the resident's pressure ulcer. LPN E said anyone can update the care plans, but it is usually nurses that update it, and pressure ulcers should be on the care plan. LPN E said he/she believed the resident's pressure ulcer started around the first part of October 2024, so it should be on the care plan. During an interview on 11/21/24 at 10:18 A.M., the ADON said pressure ulcers should be on the care plan if the resident has one or if they are at risk for developing one. The ADON said the care plan should contain what treatments and pressure relief interventions are used. He/she said typically the MDS Coordinator or DON update the care plans, but any nurse can add small changes. The ADON did not know the care plan did not contain information in regard to the resident's pressure ulcer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Meramec Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Mattox Drive Sullivan, MO 63080	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 10:50 A.M., the DON said the MDS Coordinator had been pulled to work the floor for two to three months, so he/she had been helping with care plans. The DON said pressure ulcers should be on the care plan, and he/she did not know the resident's new pressure ulcer had not been added. The DON said it is important to be on the care plan so that the whole team can be aware of what the treatments are, and he/she takes full responsibility for it not being on there. During an interview on 11/21/24 at 10:50 A.M., the Administrator said pressure ulcers should be on the care plan, and he/she did not know the resident's care plan had not been updated. The Administrator said it is important to be on the care plan so the whole team can be aware of what the issue is and so everyone can be involved and treatments are carried out for the resident. The Administrator said the responsibility of care plans ultimately falls on the DON. During an interview on 11/21/24 at 11:51 A.M., the MDS Coordinator said he/she has been the MDS coordinator since May 2024, but had been pulled to work night shift, so the DON had been updating care plans. The MDS Coordinator said pressure ulcer prevention and if a resident actually has a pressure ulcer should be on the care plan. He/she said it would be important so everyone is aware to turn and reposition, to make sure the resident is clean and dry, to ensure nutritional needs are addressed and if they need boots or any other devices. The MDS Coordinator said he/she did not know the resident's pressure ulcer was not on the care plan, but it should be and he/she was working nights and missed it. 5. Review of Resident #11's Quarterly MDS, dated [DATE], showed staff assessed the resident had a significant weight loss and received a mechanically altered diet. Review of the Dietitian Consult note, dated 08/09/24, showed the Registered Dietician (RD) documented the resident's August weight at 180 pounds (lbs), which is significantly decreased. Will recommend a house supplement with lunch. Review of the resident's November 2024 POS showed an order, dated 08/14/24, for staff to provide the resident with a house supplement at lunch daily. Review of the resident's care plan, revised 10/29/24, showed it did not contain direction for staff in regard to a house supplement at lunch. Observation on 11/18/24 at 12:48 P.M., showed unknown staff assisted resident at lunch. The resident was in his/her wheelchair at the table for residents who required staff assistance. The resident did not receive his/her lunch supplement. Observation on 11/19/24 at 12:21 P.M., the ADON sat down beside the resident at the table for residents who required assistance from staff in the lunch room. The ADON assisted the resident with bites of food and drinks. The resident did not receive a lunch supplement. During an interview on 11/21/24 at 10:07 A.M., CNA G said he/she did not know the resident got a house supplement at lunch. The CNA said it should be care planned if a resident gets a house supplement. (continued on next page)

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	265554	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meramec Nursing	940 Mattox Drive Sullivan, MO 63080

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 10:09 A.M., the ADON said he/she did not know the resident was supposed to have a supplement for lunch, because he/she does not check the orders everyday. The ADON said the supplement should be on the resident's care plan. The ADON said he/she is not certain if it is on the resident's care plan. During an interview on 11/21/24 at 11:54 A.M., the MDS Coordinator said interventions for weight loss should be on the resident's care plan. The MDS Coordinator said he/she did not know the resident had an order for a supplement at lunch for the past three months. During an interview on 11/21/24 at 12:06 P.M., the DON said the supplement should have been added to the resident's care plan. The DON said he/she did not know why it had not added to the care plan, it had probably been missed. During an interview on 11/21/24 at 1:02 P.M., the Administrator said the resident's supplement should be on the care plan. The Administrator said the MDS Coordinator is responsible and so is the DON, who signs off on the resident's care plan. 45489 50361

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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** 33477 Based on observation, interview, and record review, the facility staff failed to ensure the residents' environment remained free of accident hazards when facility staff failed to provide safe mechanical lift for two (Residents #1 and #4) out of two sampled residents and failed to store razors/sharps and hazardous chemicals in a safe manner not accessible to residents. The facility census was 47. 1. Review of the facility's undated policy, How to Use a Mechanical Lift, showed staff should spread the base of the lift to its widest possible position to maximize stability when raising the resident. When transferring a resident from the bed the legs of the base should be open and locked prior to attaching the resident sling. 2. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/31/24 showed the resident was dependent on staff for chair/bed-to-chair transfers. Review of Resident #1's care plan, dated 12/01/23, showed staff documented the resident required the use of a mechanical lift for transfers. Observation on 11/18/24 at 12:06 P.M., showed Certified Nurse Aide (CNA) R and CNA U entered the resident's room with a mechanical lift and a tilt-in-space (wheelchair that can tilt backward) wheelchair. CNA R placed the lift under the bed with the legs of the lift closed, raised the resident, and moved the lift in front of the wheelchair without the base of the lift spread. 3. Review of Resident #4's quarterly MDS, dated [DATE] showed the resident was dependent on staff for chair/bed-to-chair transfers. Review of Resident #4's care plan, dated 07/20/23, showed staff documented the resident required assistance from two staff members for transfers. Observation on 11/18/24 at 3:22 P.M., showed CNA R and CNA T entered the resident's room. The CNAs lifted the resident in the mechanical lift with the legs of the lift in the opened position, moved the lift around the chair and closed the legs of the lift. The CNAs pushed the lift under the bed and lowered the resident to the bed with the legs of the lift closed. 4. During an interview on 11/18/24 at 12:19 P.M., CNA R said the legs of the lift should be open while moving the resident and closed when the lift is under the bed. The CNA said the legs of the lift should be open when it is being moved. The CNA said they were in their zone and that's why they did not open the legs of the lift. During an interview on 11/21/24 at 8:47 A.M., the Assistant Director of Nursing (ADON) said the legs of the lift should be open at all times. The legs of the lift should be open all the way anytime the resident is suspended in the air. The ADON said if the legs of the lift are not open all the way the resident could fall or the lift could tip over. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 12:17 P.M., The Director of Nursing (DON) said the legs of the lift should be closed during transfers and only open when maneuvering around a wheelchair. The DON said the legs of the lift should remain closed when under the bed and when the lift is turned. To put a resident in a chair staff may have to open the legs of the lift to get around the wheelchair. The DON said if the legs of the lift are open the lift is at risk for tipping over. During an interview on 11/21/24 at 1:124 P.M., the Administrator said the legs of the hydraulic lift should be open for stability during transfers. He/she said if staff are not opening the legs of the lift it could cause it to tip or the resident could fall and sustain injuries. The Administrator said staff have been in-serviced on this topic many times and he/she is unsure why they are performing unsafe transfers. 5. Review of the policies provided by the facility from 11/19/24 through 11/21/24, showed the records did not contain a policy related to the storage of razors/sharps and hazardous chemicals. Review of the product labels for the bottles of quaternary ammonium based disinfectant spray and all-purpose cleaner with bleach, showed warnings which directed the products were hazardous to humans, could cause eye and skin irritation, and were harmful if swallowed. Observations on 11/19/24 at 11:55 A.M. and 1:50 P.M. and on 11/20/24 at 9:20 A.M., showed the door to the 100 hall shower room unlocked and the room unattended by staff. Observation showed an opened box of shaving razors, a 12.5 ounce (oz.) bottle and a 32 oz. bottle of quaternary ammonium based disinfectant spray and a 34 oz. spray bottle of all-purpose cleaner with bleach stored unsecured in the room. Observation showed residents near by on the hall. During an interview on 11/20/24 at 9:20 A.M., the Maintenance Director said the razors and cleaning chemicals should be stored in a locked cabinet when not in use by staff and staff are trained on this requirement. The Maintenance Director said all staff are responsible for the proper storage of razors and chemicals and, while he/she looks as he/she goes around the building, he/she did not know if anyone had been assigned to monitor the storage of sharps and chemicals routinely. The Maintenance Director said the facility did have at least one resident that is confused and wanders. During an interview on 11/21/24 at 8:00 A.M., the Administrator said sharp items, such as razors, and hazardous chemicals should be stored behind a locked door and the maintenance director is responsible to monitor the storage of sharps and chemicals at least weekly. The Administrator said he/she did not know staff left razors and chemicals unsecured in the shower room. 50361

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48982 Based on observation, interview, and record review, facility staff failed to reconcile narcotics at the change of shift when the medication cart changed from one staff member to another for four of four medication carts. The facility census was 47. 1. Review of the facility's policy titled Controlled Substance administration and Accountability, revised 04/07/22, showed the facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure. All controlled substances obtained from the medication cart or cabinet are recorded on the designated usage form, written documentation must be legible with all information provided. Areas without automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for 24 hour recording of controlled substances. The amount on hand is checked against the amount used from the documentation records. The entire amount of controlled substance obtained or dispensed is accounted for. 2. Review of the facility's Nurse Medication Cart Liquids on-coming and off-going narcotic count sheet, dated 11/1/24 through 11/21/24, did not contain two licensed staff signatures for narcotic counts at shift change from 11/2/24 to 11/21/24. 3. Review of the facility's Nurse Medication Cart Pills on-coming and off-going narcotic count sheet, dated 11/1/24 through 11/21/24, did not contain two licensed staff signatures for narcotic counts at shift change from 11/2/24 to 11/21/24. During an interview on 11/20/24 at 11:00 A.M., Licensed Practical Nurse (LPN) E said he/she is the charge nurse and responsible for the nurse cart. LPN E said the proper way to count narcotics is with two licensed staff members, the off-going and on-coming staff person, to ensure the narcotic count is correct. LPN E said not all agency staff have access to the narcotic count computer system. 4. Review of the facility's 100/200 Hall Medication Cart Liquids, on-coming and off-going narcotic count sheet, dated 11/1/24 through 11/21/24, did not contain two licensed staff signatures for narcotic counts at shift change from 11/2/24 to 11/21/24. 5. Review of the facility's 300 Hall Medication Cart Liquids, on-coming and off-going narcotic count sheet, dated 11/1/24 through 11/21/24, did not contain two licensed staff signatures for narcotic counts at shift change from 11/2/24 to 11/21/24. 6. During an interview on 11/19/24 at 2:50 P.M., LPN F said the facility staff count narcotic cards with the computer system. He/She said the agency staff do not have access to the computer system to count or sign out a narcotic. LPN F said he/she does not count with the off-going licensed staff and just compares the computer count against the remaining amount in the cards to determine if there is a discrepancy. LPN F said the charge nurse or Certified Medication Technician (CMT) do not have access to a narcotic count log. LPN F said two licensed staff members should count narcotic medications with the change of the cart at the end of the shift. LPN F it should be the off-going and on-coming licensed staff counting narcotics to ensure when the staff accept the keys to the count is correct. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 3:10 P.M., CMT J said he/she is a day shift CMT and follows agency staff each shift. CMT J said he/she does not count narcotics with the off-going nurse due to agency staff not having access to the computer system to count. CMT J said he/he compares what the computer says to the amount in the cards. CMT J said there is no way to see a shift narcotic count. During an interview on 11/19/24 at 3:45 P.M., the Assistant Director of Nursing (ADON) said the facility changed from a paper narcotic count log to the computer system around June 2024 when the new company bought the facility. The ADON said not all agency staff have access to the narcotic count portion of the computer system and they do not use paper logs. The ADON said there is no way to pull a 24-hour narcotic count report showing the off-going and on-coming staff responsible. The ADON said the proper way to count narcotics is with two licensed staff members, the off-going and on-coming person, and both sign the narcotic count log ensuring the count is correct. During an interview on 11/20/24 at 5:30 A.M., LPN O said he/she is an agency nurse who works at the facility occasionally. LPN O said he/she did not have access to the computer narcotic counting system until a few days ago. LPN O said prior to the past few days he/she did not complete shiftly narcotic counts due to not having computer access. LPN O said the proper way to count narcotics is with two licensed staff, one being the off-going and one being the on-coming staff person. During an interview on 11/20/24 at 5:45 A.M., CMT P said not all agency staff have access to the computer narcotic count system and he/she is not always able to count with the off-going staff. During an interview on 11/20/24 at 1:30 P.M., the DON said narcotic counts should be completed with the computer narcotic count system and the card. The DON said not all agency staff have access to the narcotic count system and in order for the count to be correct they would need access. The DON said the facility does not keep paper narcotic count logs anymore and this changed when the facility changed ownership a few months ago. During an interview on 11/20/24 at 1:40 P.M., the Administrator said the facility changed ownership in June 2024 and at that time converted to a computer narcotic count system. The Administrator said he/she is aware not all agency staff have access to the narcotic computer count system and he/she is working to get them access. The Administrator said the proper way to count narcotics is with the off-going and on-coming licensed staff members.

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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. 37131 Based on observation, interview, and record review, facility staff failed to implement Enhanced Barrier Precautions (EBP) to prevent the spread of bacteria and other infection causing contaminants during the provision of care for two residents (Residents #40 and #53) out of a sample of two residents. Staff failed to perform appropriate hand hygiene during incontinence care for two residents (Residents #1 and #4) out of a sample of 12. The facility census was 47. 1. Review of the facility's policy titled Enhanced Barrier Precautions, revised 12/12/23, showed the facility will implement EBP for the prevention of transmission of multidrug-resistant organisms (MDRO). EBP refers to the use of gown and gloves for use during high-contact resident care activities for resident known to be colonized or infected with a MDRO as those at increase risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Make gowns and gloves available immediately outside the resident's room. The Infection Preventionist (IP) will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care urinary catheters, central lines, feeding tubes, tracheostomy and wound care. 2. Observation on 11/18/24 at 1:00 P.M., showed outside of Resident #40's room an EBP stop sign with instruction for staff to wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device and wound care. Observation on 11/18/24 at 1:02 P.M., showed Registered Nurse (RN) D, RN U and Certified Nurse Aide (CNA) C entered the resident's room to perform perineal care. The resident had an indwelling catheter. RN D, RN U and CNA C entered the resident's room, washed hands and applied gloves. Observation showed the staff provided perineal care and did not wear gowns throughout the care. Observation showed the resident's room or outside the room did not contain gowns. During an interview on 11/18/24 at 1:08 P.M., CNA C said staff provided perineal care to the resident. The CNA said he/she did not know if the resident was on EBP or what EBP was. The CNA said he/she did not know if he/she was supposed to wear a gown when he/she provided care for the resident. The CNA said no one had taught him/her about EBP. During an interview on 11/18/24 at 1:13 P.M., RN D said EBP was required for the resident if staff was emptying his/her catheter bag, but not for perineal care. The RN said staff had EBP training about six months ago. The RN said he/she provided perineal care. 3. Observation on 11/19/24 at 10:00 A.M., showed outside of Resident #53's room an EBP stop sign with instruction for staff to wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device and wound care. (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 11/19/24 at 10:05 A.M., showed CNA S applied gloves and transferred the resident from the wheelchair to the bed and placed a catheter bag on his/her pant leg. The CNA removed the resident's pants and brief and moved the catheter bag to the bed frame. The CNA did not wear a gown. During an interview on 11/19/24 at 10:19 A.M., CNA S said EBP was required when a resident had a colostomy bag, catheter, or a wound. The CNA said staff should wear a gown with a resident who requires EBP. The CNA said they were nervous and that is why they did not wear a gown to provide care. 4. During an interview on 11/20/24 at 3:00 P.M., the IP/Assistant Director of Nursing (ADON) said staff should wear a gown and gloves when providing perineal care for residents with a catheter. The IP said he/she does not know why staff did not wear gowns. The IP said staff has been inserviced on handwashing, personal protective equipment (PPE), and EBP. The IP said staff should wear a gown and gloves when providing care for residents who require EBPs. He/She said staff should have had gowns on before before they removed resident #53's brief. During an interview on 11/21/24 at 12:15 P.M., the Director of Nursing (DON) said staff have been educated on EBP and know they should wear gowns and gloves when they provide care. The DON said staff should have worn gowns and gloves during perineal care. The DON said EBP should be used for residents who have a catheter, a wound, and MDROs. There are informational signs outside of the residents' doors and staff are directed to use a gown and gloves when providing direct patient care. He/she said EBP is for the residents' protection. Staff were educated and continue to receive education weekly about EBP. During an interview on 11/21/24 at 1:08 P.M., the Administrator said staff should wear a gown, gloves and mask for care with residents on EBP. The administrator said staff should have worn a gown when providing perineal care due to the residents' catheter. The Administrator said if the staff does not wear a gown, there is a risk of infection. The Administrator said staff have been trained multiple times and he/she doesn't know why staff did not wear gowns. 5. Review of the facility's policy titled Hand Hygiene, revised May 2022, showed the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (applying) gloves and immediately after removing gloves. 6. Observation on 11/18/24 at 12:06 P.M., showed CNA R entered Resident #1's room with perineal care supplies, performed hand hygiene and applied clean gloves. The CNA cleaned the resident's bottom and removed the lift pad. With the same gloves on the CNA placed a clean brief, cleansed the resident's perineal area, removed an incontinence pad from under the resident, put a lift pad under the resident, and put on a clean brief and pants. The CNA removed his/her gloves, did not perform hand hygiene, and covered the resident with a blanket and lowered the bed. During an interview on 11/18/24 at 12:19 P.M., CNA R said gloves should be changed and hands should be washed every time a resident is touched. The CNA said he/she should have washed his/her after providing care. The CNA said he/she did not perform hand hygiene because she/she was nervous and in the zone. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Observation on 11/18/24 at 3:22 P.M., showed CNA T entered Resident #4's room, performed hand hygiene and gathered supplies for perineal care. The CNA tucked the lift pad under the resident and rolled him/her while he/she removed the resident's pants and soiled brief. The CNA used wipes to clean the resident's back side, rolled the resident over, and with the same gloves on, undressed the resident, cleansed the resident's perineal area, and touched the resident's blanket. The CNA removed gloves, performed hand hygiene, applied barrier cream to the resident's bottom, removed gloves, did not perform hand hygiene and touched the resident's blanket. 8. During an interview on 11/20/24 at 3:18 P.M., the ADON/IP said staff should change their gloves and wash their hands when providing perineal care, when moving from dirty to clean tasks, when their gloves are soiled, and before and after care. During an interview on 11/21/24 at 12:12 P.M., the DON said hand hygiene should be done when moving from a dirty to clean task, and before and after perineal care. If hand hygiene is not completed, staff could be spreading bacteria to other residents or staff. During an interview on 11/21/24 at 1:08 P.M., the Administrator said staff should perform hand hygiene all the time when providing perineal care, before and after care, when moving from a dirty to clean tasks and anytime they change gloves. If staff do not perform hand hygiene appropriately, they could spread bacteria. 50361