STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265565	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Health and Rehabilitation Center	1300 Broadway Pleasant Hill, MO 64080

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303 Based on interview and record review, the facility failed to ensure a resident was included on his/her care plan meetings and care plan meeting invitations for two sampled residents (Resident #59 and #75) out of 22 sampled residents. The facility census was 80 residents. Review of the policy Person Centered Care Plans effective date 8/15/18 showed: -Preparation for Care Plan Committee Meetings: --The Registered Nurse or other designee should provide a list of resident/guest(s) names, dates, and times for care plan meetings two weeks in advance to other team members. This list also includes information as to the type of care plan review for each resident/guest, admission, quarterly, annual, or significant change in status reviews. --The Social Service Director (SSD, or other designee, should inform the resident/guest and families of the scheduled meeting by mailing the Notice of Schedule Plan of Care Conference to family members or legal representatives, as meeting notice. Family members and legal representatives should only be invited to attend, when permitted by the resident/guest, or when the party is legally responsible for making the health care decisions for the resident/guest. --The Interdisciplinary team (IDT) members should prepare for the care plan meeting by completing an assessment of the resident/guest and initiating care plan entries for problems or concerns related to the resident/guest as appropriate. -Conducting the Person-Centered Care Plan Meeting: --The team, including the resident/guest and their desired representatives, when possible, should present findings from assessments, using information from the Resident Assessment Instrument (RAI - helps the facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan and discuss suggested new goals or approaches, as appropriate. Existing goals and approaches should be reviewed and revised as needed. Any input gained from the resident/guest should be recorded in the plan of care and the resident/guest participation should be recorded in the electronic medical record (EMR). (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: 265565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--When the resident/guest is unable to attend, but able to comprehend the plan of care, a review of the plan should be conducted by the care plan designee. The resident/guest participation should be recorded in the EMR. --The care plan team should develop a comprehensive care plan for each resident/guest that includes measurable objectives and timetables to meet a resident/guest(s)medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and the resident/guest(s) goals and preferences, future discharge. --Each participant in the care plan meeting should document their involvement. 1. Review of Resident #59's undated Face Sheet showed his/her most recent admission was 12/14/23. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 10/7/24 showed the resident had some cognitive impairment that needed support. During an interview on 10/28/24 at 8:28 A.M. the resident said he/she was not aware of care plan meetings or involved in the setting of goals, and had not been invited to care plan meetings. Resident had not seen his/her care plan. He/She had two sons that were retired but did not provide help. He/She would like to participate in the care plan process. Review of the resident's care plan meeting invitation binder on 10/30/24 at 11:06 A.M. showed: -Care plan meeting invitations for 5/28/24, 8/7/24, and 11/13/24 were addressed to the resident's family member. No care plan meeting invitations were addressed to the resident. -No documentation the resident was presented a copy of these invitations to his/her care plan meetings. -No documentation of who attended the care plan meetings. 2. Review of Resident #75's undated Face Sheet showed his/her most recent admission was 4/7/24. Review of the resident's quarterly MDS dated [DATE] showed the resident was cognitively intact. During an interview on 10/28/24 at 11:50 A.M. the resident said he/she had not been informed of care plan meetings, had not been invited to care plan meetings, or involved in the setting of goals but would like to be involved. He/She had not seen his/her individualized care plan. Review of the resident's care plan meeting invitation binder on 10/30/24 at 8:43 A.M. showed: -Care plan meeting invitations for 6/14/24, 7/31/24, and 10/10/24 were addressed to the resident's family member. No care plan meeting invitations were addressed to the resident. -No documentation the resident was presented a copy of these invitations to his/her care plan meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation of who attended the care plan meetings. 3. During an interview on 10/30/24 at 11:06 A.M. the SSD said: -Care plan meeting invitations were sent to the family. -Care plan meeting invitations are not sent out or given to the residents. -The Interdisciplinary Team (IDT) would speak to the resident to ask if there were concerns. -A care plan conference form would be signed to document the meeting by all who attended the meeting. -A care plan conference form was not located for Resident #59 or #75. During an interview on 11/01/24 at 08:43 AM. the MDS nurse said: -The Social Service Director would send the care plan meeting invitations. -The facility tries to include the resident and/or the responsible party. -The care plan meeting was attended by the MDS nurse, SSD and Business Office Manager (BOM), Activities Director (AD) would be there if there were an activity concern. The dietary manager was new and not attending at this time. -The care plan meetings were to be documented in the chart. -The SSD usually made a note documenting the care plan meeting. -He/She felt a skilled resident was involved in goal setting. -The IDT would ask a long-term care resident if they had concerns or wanted something different. -He/She reviewed the baseline care plan with new residents. -He/She did not review the comprehensive care plans with residents. During an interview on 11/01/24 at 11:31 A.M. the Director of Nursing (DON) said: -He/She expected residents to participate in the development and implementation of the person-centered care plan. -He/She expected residents to be involved in the establishment of goals. -He/She expected the residents were able to review their care plans. -He/She expected a member of the IDT would document the care plan meeting in the clinical chart. This was usually the SSD.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on interview and record review, the facility failed to obtain a signature for the authorization of the opening of a resident trust account for one sampled resident (Resident #50) and failed to obtain authorization signatures from sampled three residents (Residents #100, #41 and #62) to allow Supplemental Insurance Company A to withdraw funds from the accounts of those residents. This practice affected at least four residents who had resident trust accounts at the facility. The facility census was 80 residents. Review of the facility's Business Office and Internal Controls Policy and Procedure Manual, dated 10/22 showed: -Upon written authorization from the resident/guest or their agent, the facility must hold, safeguard, manage and account for the personal funds deposited with the facility. -Funds may be expended from the facility's Resident Trust Petty Cash or by a Resident Trust Check Request. -Anytime a transaction is made from the Resident Trust Fund, by request or by cash, it must be fully documented, supported by voucher or invoice, and approved by the resident, legal guardian, conservator or Power of Attorney (POA-- a legal document that allows someone to act on another person's behalf). 1. Review of Resident #50's authorization form (to open a resident trust account) showed the absence of the resident's signature or a signature from the resident's POA. The resident trust account was opened on 4/5/23. Review of written communication from the facility to the resident's POA dated 4/3/23 showed the POA returned the form back to the facility on [DATE] unsigned. During an interview on 10/29/24 at 10:58 A.M., the Financial Specialist said he/she did not believe any other outreach has been done to the resident's POA, since April of 2023. 2. Review of Resident #100's Resident Trust account records, showed: -A check for $636.00 dated 8/6/24, was written to Supplemental Insurance Company A for dental insurance premium. -A check for $159.00 dated 8/6/24, was written to Supplemental Insurance Company A for vision insurance. -No signatures by Resident #100 to allow Supplemental Insurance Company A to be able to obtain that money. During an interview on 10/29/24 at 9:52 A.M., the Financial Specialist said: (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #100 had a withdrawal of $636.00 on 8/6/24 for insurance premiums which were $159.00 each month for four months (4/24 through 8/24). -Another check was written for $159.00 on 9/3/24. -Another check was written for $159.00 on 10/1/24 -There were not any signatures by the resident in 4/24, at the beginning of the residents purchasing of services from Supplemental Insurance Company A and no signatures to authorize any transactions in 8/24. 3. Review of Resident #41's Resident Trust Account records showed: -On 8/2/24, a check for $236.00 dated 8/2/24, was written to Supplemental Insurance Company A for vision insurance, -On 8/2/24, a check for $636.00 dated 8/2/24, was written to Supplemental Insurance Company A for dental Insurance, - Review of Resident #41's Resident Trust records with the Financial Specialist, showed the absence of signature from Resident #41 on any of the forms which were dated August 2024 4. Review of Resident #62's Resident Trust Account records showed: -On 8/2/24, a check for $708.00 dated 8/2/24 was written to Supplemental Insurance Company A for vision insurance -On 8/2/24, a check for $636.00 dated 8/2/24 was written to Supplemental Insurance Company A for dental Insurance -The absence of a signature by Resident #62 to authorize Supplemental Insurance Company A to have those checks written. During an interview on 11/1/24 at 10:08 A.M. the Financial Specialist said: -After he/she reviewed the resident trust records of Residents #100, #41 and #62, he/she did not see there were signatures from any of those residents to authorize payments to Supplemental Insurance Company A. -Supplemental Insurance Company A signs up the residents but the company did not provide facility personnel with copies of the signed paperwork with the resident's signature. -The facility is supposed to obtain signatures from the residents when they first sign up with Supplemental Insurance Company A.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to ensure the correct code status was in place for one sampled resident (Resident #28) out of 22 sampled residents. The facility census was 80 residents. A policy related to advance directives was requested and was not received by the facility. 1. Review of Resident #28's face sheet showed he/she admitted to the facility on [DATE] with a diagnosis of Encounter for Other Orthopedic Aftercare. NOTE: The face sheet also showed that the resident did not have an advance directive or code status in place. Review of the resident's Physician Order Sheet (POS) dated [DATE] showed no order for an advance directive or code status. Review of the resident's care plan dated [DATE] showed the resident's advance directive or code status was not in the care plan. Review off the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated [DATE] showed the resident was cognitively intact. Review of the resident's Electronic Medical Record (EMR) on [DATE] at 10:34 A.M. showed the resident did not have an advance directive in place and no documentation of the resident's desire for a Do Not Resuscitate (DNR - an order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest) code status. Review of the resident's paper chart on [DATE] at 2:22 P.M. showed the resident did not have an advance directive in place and no documentation of the resident's desire for a DNR code status. During an interview on [DATE] at 9:34 A.M. the resident said he/she had a code status of DNR. During an interview on [DATE] at 9:35 A.M. Family Member A said: -The resident was a DNR. -The resident's DNR status should be in the facility records. During an interview on [DATE] at 8:59 A.M. the Social Services Designee (SSD) said the resident was a full code, so the facility did not have any record of the resident's advance directive or desire for a DNR code status. During an interview on [DATE] at 8:03 A.M. Certified Nursing Assistant (CNA) A said: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility usually received a resident's advance directive and code status upon admission. -The nurses were responsible for ensuring the completion of the advance directive. -If a resident stated that they were supposed to be a DNR, then he/she would get the nurse or SSD. -A resident's advance directive could be found in the EMR or in a paper chart. -If a resident is a DNR then there should be an order in place. -He/She thought the resident was a full code (indicates the healthcare team should perform CardioPulmonary Resuscitation (CPR) - if needed). -The resident's advance directive and code status should be on his/her care plan. -He/She was unaware that the resident was supposed to be a DNR. During an interview on [DATE] at 8:14 A.M. Registered Nurse (RN) A said: -Nurses were responsible for ensuring the resident's correct advance directive and code status was in place upon admission. -A resident's advance directive could be found in the EMR or in a paper chart. -If a resident requested to be a DNR then he/she would discuss his/her code status with the resident to ensure that is what the resident wanted and get an order from the doctor. -An order should be in place for a resident who is a DNR. -He/She thought the resident was a full code. -If the face sheet showed There are no Advance Directives selected for this resident then that indicated the resident's code status was not in the EMR. -He/She was unaware that the resident did not have an advance directive in place and that the resident was supposed to be a DNR. -A resident's advance directive and code status should be on his/her care plan. During an interview on [DATE] at 11:36 A.M. the Director of Nursing (DON) said: -Nurses were responsible for obtaining a resident's advance directive and code status upon admission. -Advance directives and code status should be on all resident care plans. -If a resident wanted to be a DNR, then he/she would expect the nurses to ensure the resident could make his/her own decisions, get an order, and ensure the appropriate documentation was in place. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a banner in the facility's electronic medical record system that indicated what a resident's code status was. -There would only need to be an order in place in the resident's POS if the resident was a DNR. -He/She thought the resident was a full code. -He/She was unaware that the resident's advance directive had not been completed and that the resident was supposed to be a DNR.

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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** 51305 Based on interview and record review, the facility failed to notify the physician when medication could not be obtained from the pharmacy for one sampled resident (Resident #61) out of 22 sampled residents. The facility census was 80 residents. Review of the facility Medication Shortages/Unavailable Medications, dated 1/1/13, showed: -When the facility discovers it has an inadequate supply of medication to administer to a resident then the facility staff should immediately initiate action to obtain the medication from the pharmacy. -If facility nurse is unable to obtain a response from the attending physician/prescriber in a timely manner, facility nurse should notify the nursing supervisor and contact facility's Medical Director for orders/direction, making sure to explain the circumstances of the medication shortage. 1. Review of Resident #61's Face Sheet showed the resident was admitted on [DATE] with the following diagnoses: -Alcohol-induced chronic pancreatitis (inflammation of the pancreas). -Alcohol abuse with other-induced disorder. Review of the resident's Physician Order Sheet (POS) dated 9/19/24 showed the following physician's ordered medication: -Acamprosate 333 milligrams (mg) two tablets three times daily at 9:00 A.M., 3:00 P.M. and 9:00 P.M. by mouth for alcohol abuse with other alcohol-induced disorder. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 9/26/24 showed the resident was cognitively intact. Review of the resident's Medication Administration Record (MAR) dated 10/2024 showed: -Acamprosate 333 mg two tablets three times daily at 9:00 A.M., 3:00 P.M. and 9:00 P.M. by mouth for alcohol abuse with other alcohol-induced disorder. -The medication was not administered by staff a total of 21 days out of 31 days in this month. -The staff documented the medication was unavailable from the pharmacy. -No documentation the resident's physician wasn notified the medication was not available and not administered to the resident. (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 Care Plan, dated 10/2/24, showed: -The resident had an alcohol induced chronic Pancreatitis. -The staff were to monitor and record any complaints of pain: character, onset, pattern, location, severity, duration, aggravating factors, and alleviating factors. -The staff were to monitor and record any non-verbal signs of pain: guarding, moaning, restlessness, grimacing, diaphoresis, and withdrawals. During an interview on 10/31/24 at 2:05 P.M., the resident said: -He/She did not need the Acamprosate medication and he/she did not want to take it. -He/She had no side effects of alcohol withdrawal by not taking the medication. During an interview on 10/31/24 at 2:21 P.M., Licensed Practical Nurse (LPN) C said: -If the medication became unavailable then the Certified Medication Technician (CMT) or a nurse could click the resupply button in the resident's electronic record and re-order it from the pharmacy. -The CMT or the nurse could call the pharmacy to see how long it would take to get the medicine. -The CMT should notify the nurse so the nurse could call and notify the physician immediately when it cannot be filled by the pharmacy. -He/She was not told by any CMTs the medication had not been received by the pharmacy. During an interview on 11/1/24 at 8:55 A.M., CMT A said: -If a medication was unavailable then he/she would notify the charge nurse. -The charge nurse was responsible for notifying the physician. During an interview on 11/1/24 at 11:36 A.M., the Director of Nursing (DON), Regional Nurse Consultant (RNC), and Regional Quality Assurance Nurse (RQAN), the DON said: -He/She expected the charge nurse would be notified that the medication had not been received by the pharmacy. -He/She would contact the pharmacy about obtaining the resident's medication. -He/She would not let a resident go more than one day without a medication. -He/She expected the charge nurse to call and notify the physician if a medication was not available from the pharmacy. -He/She was unaware the resident had not received his/her medication.

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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. 51305 Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) (form CMS-10055) and/or the Notice of Medicare Provider Non-Coverage (NOMNC, form CMS-10123) for three sampled residents (Resident #78, #139 and #102) out of three sampled residents who were discharged from Medicare part A services. The facility census was 80 residents. Record review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C-09-20), dated 1/9/09, showed the following: -The Notice of Medicare Provider Non-Coverage (NOMNC, form CMS-10123) was issued when all covered Medicare services end for coverage reasons. -If the skilled nursing facility (SNF) believed on admission or during a resident's stay that Medicare would not pay for skilled nursing or specialized rehabilitative services and the provider believed that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by the use of either the SNFABN (form CMS-10055) or one of the five uniform denial letters. -The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have. -If the SNF provided the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider had met the obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination. 1. Review of Resident #78's SNF Beneficiary Protection Notification Review form completed by Financial Specialist showed: -The resident discharged from Medicare Part A services on 6/23/24 and stayed at the facility. -The NOMNC had not been provided to the resident or the resident's responsible party because he/he had been using the incorrect form. 2. Record review Resident #138's SNF Beneficiary Protection Notification Review form completed by Financial Specialist showed: -The resident discharged from Medicare Part A services on 6/30/24 and stayed at the facility. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The NOMNC had not been provided to the resident or the resident's responsible party because he/he had been using the incorrect form. 3. Review of Resident #102's SNF Beneficiary Notification Review form completed by Financial Specialist showed: -The resident discharged from Medicare Part A services on 7/26/24 and went home. -The NOMNC had not been provided to the resident because the resident requested to go home. Review of the resident's electronic medical record showed no documentation the resident requested to self-discharge off Medicare Part A services. During an interview on 10/31/24 at 1:40 P.M. the Financial Specialist said: -He/She was responsible for providing the NOMNCs and SNF ABNs to the residents. -The residents were given a 48-hour notice prior to the Medicare Part A discharge date . -He/She would call the resident's responsible party and notify them over the phone 48 hours prior to the Medicare Part A discharge date . -In certain situations, the NOMNC and ABN will be given in advance. -He/She had been giving out the wrong NOMNC. -He/She thought the Medicare Part B form was the NOMNC form. -He/She had been trained to use the Medicare Part B form as the NOMNC form upon hire. -He/She gave the ABN form to the resident and/or resident responsible party. -He/She gives the form to every resident who is discharged or stay in the facility. -Resident #102 requested to discharge to home so the no forms were provided to the resident. -He/She could not locate any information in the resident electronic medical record showing the resident decided to discharge home.

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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** 19916 Based on observation and interview, the facility failed to maintain the following resident rooms clean and free from a buildup of dust and food debris on the floors and walls: resident rooms 508, 207, 202, 201, 200, 301, 303, 302, 300, 403, 404, 401, 105, and 107. This practice potentially affected 24 residents who resided in those rooms. The facility census was 80 residents. 1. Observations with the Maintenance Director on 10/30/24, showed: -At 1:36 P.M., there was a heavy buildup of cobwebs (a web spun by certain spiders, often found in the corners of disused rooms) between the climate control unit and the night stand in resident room [ROOM NUMBER]. -At 2:37 P.M., there was a heavy buildup of cobwebs which stretched between the floor and the climate control unit. -At 2:40 P.M., there was a heavy buildup of food crumbs in he corner between the bed and the window in resident room [ROOM NUMBER]. -At 2:43 P.M., there was a buildup of dust on the fans in resident room [ROOM NUMBER]. -At 2:44 P.M., there was a buildup of debris including grass clippings and grime on the floor next to the climate control unit in resident room [ROOM NUMBER]. Observations with the Maintenance Director on 10/31/24, showed: -At 9:46 A.M., there was a buildup of debris such papers under the bed in resident room [ROOM NUMBER]. -At 9:48 A.M., there was the presence of debris under the beds in resident room [ROOM NUMBER]. -At 10:05 A.M., there was debris under the bed in resident room [ROOM NUMBER]. -At 10:14 A.M., a trash container with soiled items (adult briefs etc.) was stored in the 300 Hall shower room, which caused a pungent urine odor in that shower room. -At 10:31 A.M., there was an old plastic pink bedpan under the bed in resident room [ROOM NUMBER]. -At 10:34 A.M., there was a buildup of dust under the beds in resident room [ROOM NUMBER]. -At 10:47 A.M., there was a buildup of food crumbs and debris in the corner next to the bed closest to the door in resident room [ROOM NUMBER]. -At 11:21 A.M, there was a buildup of candy pieces behind the bed in resident room [ROOM NUMBER]. and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:27 A.M., there was dust and debris under the bed in resident room [ROOM NUMBER]. During an interview on 11/01/24 at 9:06 A.M., the Housekeeping Supervisor said: -He/She has been the housekeeping supervisor since 6/24. -After seeing the buildup of cobwebs in resident room [ROOM NUMBER] , he/she said that the housekeepers go into rooms where the residents do not want the housekeeper to move their items so it was harder for the housekeepers to get into areas to clean properly. -The trash container should not be in the shower room, instead the trash container should be in the soiled utility room. -He/She noticed the buildup of cobwebs, the dead insects and dust behind the night stand in resident room [ROOM NUMBER]. -He/She noticed the buildup of plastic bags and debris behind nightstand in resident room [ROOM NUMBER]. -He/She noticed the pieces of candy and the buildup of dust on the floor in resident room [ROOM NUMBER]. -He/She noticed the dust buildup on the fan in resident room [ROOM NUMBER] and the housekeepers should clean the fan once per week. -He/She expected the housekeepers to do as much they can without hurting themselves and his/her department was short of a housekeeper for a period of time earlier in 2024. During an interview on 11/01/24 at At 9:15 A.M., Nursing Assistant (NA) A said the trash container should be in the soiled utility room. During an interview on 11/1/24 at 2:17 P.M., the Administrator said he/she did not know why that pink bedpan was under the bed in resident 403 and he/she did not know how long that pink bedpan had been there.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on record review and interview, the facility failed to ensure the resident or resident representative was provided with the bed hold policy or educated on the bed hold policy when the resident was discharged to the hospital in a timely manner for two sampled residents (Resident #8 and #5) out of 22 sampled residents. The facility census was 80 residents. Review of the facility Transfer/Discharge and Therapeutic Leave policy and procedure updated June 26, 2019, showed: -A copy of the resident bed hold and admission policies/transfer to the hospital should be provided upon transfer by the assigned nurse to the resident or responsible party. 1. Review of Resident #8's Face Sheet showed the resident was initially admitted on [DATE]. Review of the resident's Nursing Notes showed: -10/26/24 at 11:19 A.M., showed the physician gave orders to send the resident to the hospital for further evaluation. The resident was unable to sign the bed hold. The nurse called the resident's responsible party again to notify of the resident being sent to the hospital. Nursing staff also notified the Director of Nursing (DON). Review of the resident's Electronic Medical Record showed there was no documentation showing the resident's Bed Hold form was completed or signed. The Bed Hold form was not in the electronic record or in the resident's paper chart. There was no documentation showing the facility sent the resident's bed hold document to the resident's responsible party or if he/she was informed/educated on the bed hold agreement. During an interview on 10/31/24 at 2:32 P.M., the Administrator said: -When the resident went to the hospital, he/she was unable to sign the bed hold form. -They did not send the bed hold to the resident's responsible party. -He/She was unable to find the bed hold document for the resident. 46519 2. Review of Resident #5's annual Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 10/11/24 showed the resident had moderately impaired cognition. Review of the resident's Electronic Medical Record (EMR) showed: -The resident had been hospitalized from 6/29/24 to 7/9/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had been hospitalized from 7/17/24 to 7/19/24. -No indication that the resident's Designated Power of Attorney (DPOA) had been enacted. -No documentation of a Bed Hold form was completed or signed for either discharge. During an interview on 10/30/24 at 12:21 P.M., the DON said: -He/She could not find the resident's physical bed hold forms, but there were notes related to the bed hold in the resident's EMR. -There should have been a physical bed hold form completed for the resident for both hospitalization s. -Normally the Social Services Designee (SSD) would follow-up the next day following a resident hospitalization to ensure completion of the bed hold form. During an interview on 10/30/24 at 1:05 P.M. the SSD said he/she did not have copies of the resident's bed hold forms from the last two hospitalization s. 3. During an interview on 11/1/24 at 8:03 A.M. Certified Nursing Assistant (CNA) A said the SSD was responsible for completing the bed hold forms. During an interview on 11/1/24 at 8:17 A.M. Registered Nurse (RN) A said: -The charge nurses were responsible for giving the bed hold forms to residents. -He/She was unsure of who ensured completion of the bed hold forms. -He/She had not been trained on the facility's bed hold process. During an interview on 11/1/24 at 9:17 A.M. the SSD said: -He/She had not followed up on the resident's bed hold forms. -He/She was not always good about completing the follow-up of the bed hold forms. -Some of the nurses were good about completing the bed hold forms and bringing them to him/her and some were not. During an interview on 11/1/24 at 11:36 A.M. the DON and the Regional Corporate Nurse said: -The charge nurses were responsible for completing the bed hold forms. -If the resident is not able to sign the bed hold upon leaving the facility, the nurse should complete the top of the form and send it with the resident to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not know if they keep a copy of the bed hold form and the Social Service Designee usually was responsible for ensuring the completion of the bed hold. -If the resident was not able to sign the Bed Hold, he/she would expect the Social Services Designee to notify the responsible party of the bed hold and document their response in the resident's medical record. -The bed holds had not been completed for Resident #5 because his/her family had declined the bed hold. During an interview on 11/1/24 at 12:15 P.M. the DON said Resident #5 would be the person that would decline the bed hold and not his/her family.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on observation, interview and record review, the facility failed to provide an ongoing, person-centered activities program based on care planned and assessed resident interests and abilities in order to meet the interests and support a residents physical and psychosocial wellbeing for one of 22 sampled residents (Resident #25). The facility census was 80 residents. Review of a facility policy titled Delegation of Activity Program Duties, dated 3/1/08, showed: -The facility was to provide an ongoing activities program designed to meet the physical, mental and psychosocial wellbeing of each resident. -The activities program should have occurred within the context of each resident's comprehensive assessment and care plan. 1. Review of Resident 25's face sheet, dated 6/20/24, showed: -An admitted [DATE]. -Diagnoses of Down Syndrome (a genetic chromosomal disorder causing developmental and intellectual delays) and a cognitive communication deficit. Review of the resident's facility Activity Assessment, completed 6/14/24, showed: -Activity interests of games, socialization, one-on-one activities, cognitive learning, arts and crafts, music, and exercise. -Goals of attending at least three activities weekly. -Interventions including providing reminders and assistance for activities and identifying activities suited for the resident's needs. Review of the resident's Care Plan, dated 9/17/24, lacked information about the resident's preferred activities, activity goals and activity interventions. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated comprehensive assessment conducted by the facility to determine the needs of the resident) dated 10/1/24, showed the resident: -Rarely or never understood others or was able to make themselves understood. -Had severely impaired decision-making capabilities. -Preferred to listen to music, do things with groups of people, participate in favorite activities, and spend time outdoors. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a provided Point of Care History Report for activity participation for the month of 10/24 showed the resident participated in activities on two days, 10/9/24 and 10/29/24. Observation on 10/28/24 at 8:31 A.M., showed the resident sitting in a chair near the nurse's station making non-lexical vocalizations (sounds that do not form words) and rubbing his/her legs repeatedly. Another unknown resident was attempting to comfort the resident. A bedside table with colored pencils and a coloring sheet was nearby but was not offered to the resident by staff. The resident was not invited to or assisted to participate in activities offered to other residents was made on 10/28/24. Observation on 10/29/24 at 8:37 A.M., showed the resident was sitting in a chair near the nurse's station making non-lexical vocalizations and looking down at the floor. Observation on 10/30/24 at 9:46 A.M., showed the resident was taken to a community movie. The resident was observed rubbing his/her legs repeatedly and looking at the floor during the film. Staff were in the room during the movie, no observations of staff interacting with the resident during this activity. During an interview on 10/31/24 at 1:30 P.M., the resident's family member said he/she has never seen the resident participating in activities at the facility and that the resident receives minimal mental or physical stimulation. During an interview on 10/31/24 at 1:45 P.M., Certified Medication Technician (CMT) B said he/she was unaware what activities the resident enjoyed but the resident had fidget toys and coloring items that were given to him/her to use. During observations on the day shift from 10/28/24 to 11/1/24, staff were not observed offering the resident any items for recreational use. During an interview on 11/1/24 at 8:27 A.M., the Activities Director said: -He/She completed an activity assessment to determine what residents enjoyed doing. -The resident could come to activities every once in a while, otherwise he/she would bring the resident a fidget toy to use. -He/She would expect staff to ensure the resident has something to occupy his/her time throughout the day and not sit in a chair near the nurse's station when the resident cannot participate in the planned activity. During an interview on 11/1/24 at 11:46 A.M., the Director of Nursing (DON) said: -He/She would expect staff to assess and offer a resident with appropriate activities that offer mental and physical stimulation. -He/She would expect staff to have offered the resident more than two activities in a month span. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would expect individualized activities to be offered to the resident throughout the day if there were group activities he/she couldn't participate in. -Activity preferences should have been care planned. -The MDS Coordinator was responsible for ensuring the residents care plan was complete and accurate.

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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** 19916 Based on observation, interview, and record review, the facility failed to maintain the hot water temperature at or below 120 F (degrees Fahrenheit) in the room of Residents #2 and #76 and in the room of Residents #26 and #77; failed to use a gait belt when assisting one sampled resident to ambulate (Resident #19) who was unsteady on his/her feet; and failed to ensure an initial smoking assessment was completed to establish a baseline for the ability of one resident to smoke, determine assistance as necessary, and ensure safe smoking habits were in place for one sampled resident (Residents #61) out of 22 sampled residents. The facility census was 80 residents. 1. Review of the temperature log dated 10/14/24, showed the following hot water temperatures: -In the 100 Hall the temperature was 102 F. -In the 200 Hall, the temperature was 102 F. -In the 300 Hall, the temperature was 104 F. -In the 400 Hall, the temperature was 105 F -In the 500 Hall, the temperature was 104 F. -The particular rooms on each hall were not identified. During an interview on 11/1/24 at 12:54 P.M., the Maintenance Director said he/she had not identified the particular rooms on each hall in hot water temperatures were checked. 2. Observation on 10/31/24 at 10:02 A.M., with the Maintenance Director, showed the temperature of the hot water heater for that hall, was set at 165 F and that hot water heater also served the laundry which was on that hall. During an interview on 10/31/24 at 10:03 A.M., the Maintenance Director said the hot water heater did not need to be set at that high of a temperature. 3. Review of Resident #2's quarterly Minimum Data Set (MDS--a federally mandated assessment tool completed by the facility for care planning) dated 8/20/24, identified the resident as: -A resident who needed minimal assistance for transfers and ambulation. -A resident who had moderate cognitive impairment. Review of Resident #76's quarterly MDS dated [DATE], identified the resident as -A resident who required substantial assistance for transfers and ambulation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A resident who was severely impaired in cognitive skills for daily decision-making. Observation on 10/31/24 at 9:54 A.M. with the Maintenance Director, showed the temperature of the hot water in the room of Residents #2 and #76 was between 126-128.2 F, after the water from the faucet was allowed to flow for two or more minutes. Observation on 10/31/24 at 1:54 P.M., with Certified Medication Technician (CMT) A showed the temperature of the hot water in the Resident #76's and #2's room, was 129.7 F. During an interview on 10/31/24 at 1:55 P.M., CMT A said he/she did not know the water in that room was so hot after he/she washed his/her hands. Observations on 11/1/24 at 9:35 A.M., showed the hot water temperature in Resident #76's and #2's room was 128.4 F. 4. Review of Resident #26's quarterly MDS dated [DATE] identified the resident as: -A resident who was required no assistance from a helper in transfers. and ambulation. -A resident who had severe cognitive impairment. Review of Resident #77's quarterly MDS dated [DATE], identified the resident as -A resident who needed minimal assistance for transfers and had not performed any ambulation in the 7 days prior to the date of the MDS. -Resident who had severe cognitive impairment. Observation on 10/31/24 at 9:56 A.M. with the Maintenance Director, showed the temperature of the hot water in the room of Residents #26 and #77, was between 126.5 F, after the water from the faucet was allowed to flow for two or more minutes. Observation on 10/31/24 at 1:58 P.M., showed the temperature of the hot water in the Resident #26's and #77's room, was 129.5 F. Observations on 11/1/24 at 9:32 A.M., showed the hot water temperature in Resident #26's and #77's room was 130.0 F. 5. During an interview on 10/31/24 at 2:03 P.M., CMT A said: - Neither Resident #76 nor Resident #2 were able to get to the handwashing faucet on their own because both residents needed assistance in ambulating. - Resident #26 was able to ambulate without assistance but did not have enough cognitive ability to be able to mix the hot and cold water. - Resident #77 was able to ambulate to the handwashing faucet and had the cognitive ability to mix the hot and cold water at the faucet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	** At the times of the observations no residents attempted to go towards the handwashing faucet. During an interview on 10/31/24 at 2:07 P.M., Licensed Practical Nurse (LPN) A said: - Residents #76 and #2 were not able to get to the handwashing faucet on their own, because they needed assistance in transfers. - Resident #26 was capable of getting to the handwashing faucet on his/her own, but only had the cognitive ability to mix the hot and the cold on some days and on other days. He/she was not able to mix the hot and cold water. - Resident #77 had the cognitive ability to mix the hot and cold water on his/her own. 21003 6. A policy for gait belt use was requested but not received from the facility at the time of exit. Review of Resident #19's Face Sheet showed the resident was admitted on [DATE], with diagnoses including Parkinson's Disease (a movement disorder of the nervous system that worsens over time) and blindness. Review of the resident's MDS dated [DATE], showed: -The resident was alert and oriented with minimal confusion. -Had had no functional impairment in range of motion and used a walker for mobility. -Was dependent for toileting and required moderate assistance for upper and lower body dressing. -Needed supervision to touching assistance to go from a siting to lying position, lying to sitting, sitting to standing, transfer to/from bed to chair, and transfer to/from the toilet. -Had no falls during the look back period. Review of the resident's Nursing Notes showed the resident had a recent unwitnessed non-injury fall on 10/28/24 and the resident sustained a skin abrasion to his/her right elbow. Review of the resident's Care Plan dated 4/12/27 and revised on 10/28/24, showed the resident required staff assistance with all cares due to visual disturbances and tremors, It also showed the resident had the potential for falls related to poor safety awareness and blindness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/30/24 at 1:15 P.M., showed the resident was laying down on his/her bed in his/her room. Certified Nursing Assistant (CNA) B entered the resident's room and assisted the resident to sit up on the side of his/her bed. CNA B then pulled the resident's walker up to him/her and the resident was able to hold onto the walker as CNA B assisted the resident to stand without using a gait belt. Once the resident was standing, he/she said he/she needed to go to the bathroom and CNA B provided standby assist and direct assistance of the resident as he/she walked with his/her walker to the bathroom, as the resident became unsteady while walking. LPN B, who was watching CNA B assisting the resident to walk, went to get a gait belt and gave it to CNA B to put on the resident. The resident was in the bathroom at this time. During an interview on 10/30/24 at 1:24 P.M., LPN B said: -The resident normally was able to ambulate without any assistance with his/her walker, but he/she was having more shaking related to his/her Parkinson's disease today and needed the assistance to walk. -He/She went to get the gait belt when he/she did not see the resident wearing one while CNA B was assisting him/her. -CNA B should have placed a gait belt on the resident because he/she was physically assisting him/her with walking to the bathroom. During an interview on 10/30/24 at 1:58 P.M., CNA B said: -He/She went to the resident's room to feed him/her because the resident was shaking more and did not want to go to the dining room. -He/She assisted the resident to transfer to his/her walker and to the bathroom because he/she was unsteady on his/her feet. -He/She did not have a gait belt available at the time and there was no gait belt in the room so he/she did not use one. -He/She knew he/she should have used a gait belt when assisting the resident to stand and walk. During an interview on 11/1/24 at 11:36 A.M., with the Director of Nursing (DON), Regional Nurse Consultant (RNC), and Regional Quality Assurance Nurse (RQAN), the DON said: -If the resident is ambulating independently, they would not need to wear a gait belt if they were only providing stand by assistance only. -If the nursing staff provide any hands on assistance with ambulation, they are to use a gait belt. -The nursing staff do not carry gait belts with them. -Each resident has a gait belt in their room that is designated for use with that resident and the gait belts are hanging in each resident closet. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Hill Health and Rehabilitation Center	1300 Broadway Pleasant Hill, MO 64080

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was made aware that the nursing aide had not worn a gait belt when assisting the resident and the nursing staff should have worn one. 51305 7. Review of the facility Smoking policy and procedure, dated 10/29/17 showed: -The facility must comply with federal, state, and local regulations regarding smoking in healthcare facilities. -There was no documentation showing how often staff were to complete smoking assessments for residents to ensure they could smoke safely. Review of Resident #61's Face Sheet showed the resident was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation) and tobacco use. Review of the resident's admission Progress Note dated 9/19/24 showed the resident was a current every day smoker. Review of the resident's admission MDS dated [DATE] showed the resident: -Was cognitively intact. -Used tobacco products. Review of the resident's Care Plan dated 10/2/24, showed: -The resident smoked cigarettes. -The staff were to instruct the resident about smoking schedule and rules. -The resident was to be observed while smoking by staff. Review of the resident's electronic medical record on 10/29/24 showed: -No documentation the facility staff had completed an initial smoking assessment. -There was no documentation showing the resident was able to safely smoke and abide by the facility smoking policy. During an interview on 10/28/24 at 11:42 A.M., the resident said he/she goes outside and smokes cigarettes five times a day. During an interview on 10/31/24 at 2:21 P.M., LPN C said: -Upon admission, he/she would ask the resident if he/she smoked cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If the resident said yes, he/she would notify the Social Services Director (SSD) to complete a smoking assessment on the resident. -The SSD was responsible for completing all smoking assessment on the residents. -The smoking assessments were completed upon admission, quarterly or if there was a change in the resident's condition. -Resident #61 should have had a smoking assessment completed. -All residents that smoke cigarettes have a contract that was signed by the resident stating that he/she agreed to follow the facilities rules about smoking. During an interview on 11/1/24 at 9:16 A.M., the SSD said: -If a resident smoked cigarettes, he/she signed a contract agreeing to the rules. -Nurses were responsible for completing residents smoking assessments. -A resident would be assessed by the nurse to see if he/she could hold and light a cigarette safely. -The smoking assessments were done upon admission and every quarter. -The Director of Nursing or any nurse were responsible for the completion of the smoking assessment. -Resident #61 should have had a smoking assessment completed. During an interview on 11/1/24 at 11:36 A.M., the DON, RNC, and RQAN, the DON said: -A smoking assessment was needed to make sure the resident was able to smoke cigarettes without any concerns or if he/she would need some kind of protection like a smoking apron. -He/She would use the assessment to determine if the resident can smoke cigarettes safely. -The smoking assessments were completed upon admission and annually. -The nurses or nursing management were responsible for completing the smoking assessments. -The smoking assessments were completed by the interdisciplinary Team (IDT). -All assessments are kept electronically in the resident's medical record. -The RNC said: -If the resident was a smoker at the time of admission, he/she should have had a smoking assessment completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 33409 Based on observation, interview and record review, the facility failed to ensure to have a comprehensive physician's order for colostomy (or ostomy is a surgical procedure that creates an opening in the large intestine, or colon, through the abdominal wall. The opening, called a stoma, allows stool to drain into a bag or pouch attached to the abdomen) care to include type and size of ostomy supplies needed, failed to have a comprehensive care plan for colostomy care and type of supplies needed for one sampled resident (Resident #3) out of 22 sampled residents. The facility census was 80 residents. Review of the facility's Colostomy Care policy dated 10/1/10 showed: -Care of the colostomy site helps prevent skin irritation around the sire and leakage of the drainage bag. 1. Review of of Resident #3's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 8/29/24 showed: -Was cognitively intact, able to make his/her needs and wants known. -Had a colostomy upon admission. Review of the resident's care plan revised on 9/12/24 showed: -The resident had potential complication for his/her colostomy. -Care staff were to change colostomy pouch and wafer (is a skin barrier piece of the pouching system that sticks to skin around the stoma to attach the collection pouch) per schedule and as needed. -Care staff were to empty /rinse colostomy collection pouch as needed. -Provide colostomy care per schedule. -NOTE: No documentation on the type ostomy system needed or size wafer needed. Review of the resident Physician order Sheet (POS) 9/29/24 to 10/29/24 showed: -Nursing staff were provided routine Colostomy care every shift. Order was dated 8/5/24. -Note: Did not have detail order for colostomy to include monitoring, when to change the colostomy pouch and wafer, the care of stoma, size of wafer and type collection bag required (These can be one-piece or two-piece systems). Review of the resident's Medication Administration Record (MAR) 10/1/24 to 10/29/24 showed: (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Physician order for nursing staff were provided routine Colostomy care every shift: -Had nursing initial of care provided each shift. -Note: No specific detail order or documentation related to monitoring of colostomy site and type and size of supplies required. Observation on 10/28/24 at 8:28 A.M., the resident showed had a colostomy located on left lower stomach area. Observation on 10/29/24 at 11:00 A.M., of the resident wound showed: -The colostomy collection pouch had loose brownish green stool. -Wound Nurse said the resident had colostomy due to placement of his/her wounds. During an interview on 11/1/24 at 8:40 A.M., Certified Nursing Assistant (CNA) E said: -The resident's colostomy care he/she would clean area and change bag and/or wafer as needed. -He/She would use a tape measure to measure the stoma for the size opening of the wafer needed to be and cut to fit. -Nursing would be responsible for ensure to have physician orders for the care and monitoring of the resident colostomy. -He/She had not cared for the resident colostomy, was not sure type or kind of colostomy the resident had. During an interview on 11/1/24 at 8:46 A.M., CNA B said: -The nursing staff would be responsible for replace the resident's colostomy wafer. The CNA would then clean and empty the collection pouch as needed. -He/She was not sure were to find documentation on type or size of supplies needed for the resident colostomy. Review of the resident's medical record on 11/01/24 at 9:02 A.M., with Registered Nurse (RN) B showed: -The resident POS did not have a detail colostomy's order to include the type and size colostomy supplies needed or when to change colostomy wafer and collection pouch. -The resident's care plan should include how to care for colostomy site and supplies required. -He/She would expect to have detail physician order for colostomy care and monitoring. During an interview on 11/01/24 at 11:03 A.M., MDS Coordinator said: (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Would expect to have physician order for the resident colostomy and a comprehensive care plan. -He/She would be responsible for the review and updating care plan as needed. -He/She would review the resident's physician order and nursing assessments to be able to complete or update care plans. During interview on 11/1/24 at 11:36 A.M., Director of Nursing (DON) said: -He/She would expect to have a comprehensive physician order for a resident with colostomy. -The physician order should include but not limited: the monitoring of the stoma site, size or type of colostomy supplies needed and when to change colostomy wafer and collection bag.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46519 Based on observation, interview, and record review, the facility failed to ensure appropriate care for one sampled resident (Resident #60) with a Percutaneous Endoscopic Gastronomy (PEG) tube (a tube that is passed into a person's stomach through the abdominal wall, most commonly used to provide a means of feeding when oral intake is not adequate) out of 22 sampled residents. The facility census was 80 residents. Review of the facility's policy titled Tube Feeding-Kangaroo E-Pump dated 2/1/18 showed: -Staff were expected to label the feeding formula including rate, time, and initials. -Staff were expected to label the flush bag with the date, time, and initial amount of water. -Staff were expected to follow the manufacturer guidelines related to hang times for the tube feeding. 1. Review of Resident #60's face sheet showed he/she admitted to the facility with the following diagnosis: -Gastrostomy Status. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/19/24 showed: -The resident was non-verbal and could not make himself/herself understood. -The resident received tube feeding. -The resident received 51% or more of his/her daily nutrition through tube feeding. Review of the resident's Physician Order Sheet (POS) dated October 2024 showed: -Tube feeding per pump pole flush and feed, Jevity 1.2 (a high-protein, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) at 55 milliliters (ml) per hour to equal 1495 ml for 23 hours/ flush set at 100 ml for 23 hours. -An order for the staff to ensure the resident's head of bed (HOB) was elevated to 45 degrees at all times due to tube feeding. Observation on 10/28/24 at 11:01 A.M. of the resident showed: -The resident's HOB was at approximately 30 degrees. -The resident's water flush bag was not labeled. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/29/24 at 8:47 A.M. of the resident showed: -The resident's HOB was at approximately 30 degrees. -The resident's tube feeding was not labeled with a start time. -The resident's water flush bag was not labeled. Observation on 10/29/24 at 12:03 P.M. of the resident showed the resident's HOB was at approximately 30 degrees. Observation on 10/30/24 at 8:56 A.M. of the resident showed: -The resident's HOB was at approximately 30 degrees. -The resident's water flush bag was not labeled. Observation on 10/31/24 at 8:43 A.M. of the resident showed: -The resident's HOB was at approximately 30 degrees. -The resident's water flush bag was not labeled. During an interview on 11/1/24 at 8:03 A.M. Certified Nursing Assistant (CNA) A said resident's who have tube feeding running should have their HOB elevated to 30 degrees. During an interview on 11/1/24 at 8:19 A.M. Registered Nurse (RN) A said: -When tube feeding was hung the bottle should be labeled with name, date, and volume. -He/She was unsure if the water flush bag needed to be labeled. -If he/she were to walk into a resident's room with tube feeding and the bottle was not labeled appropriately, then he/she would hang a new bottle of tube feeding. -He/She was unsure of the resident's order for positioning. -He/She was unsure if the facility had a specific policy related to tube feeding HOB positioning, but resident's HOB needed to be positioned at least at 30 degrees. -If the resident's order stated that the resident's HOB needed to be at 45 degrees, then that is how the resident's HOB should be positioned. -He/She had not been into the resident's room at that point in time and he/she was unsure how the resident had been currently positioned. During an interview on 11/1/24 at 11:36 A.M. the Director of Nursing (DON) said: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She expected the tube feeding set to be labeled with the date and start time. -He/She expected staff to change out the tube feeding set if the tube feeding set was not labeled appropriately. -Resident's who have continuous tube feeding should have their HOB elevated at 45 degrees. -He/She expected staff to follow the physician's order for how the resident's HOB should be set at. -The resident's order needed to be updated to show the HOB could be between 30 to 45 degrees. -The nurses were responsible for ensuring the correct HOB positioning of the resident.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33409

Based on observation, interview and record review, the facility failed to ensure physician's orders for a Continuous Positive Airway Pressure (CPAP a form of positive airway pressure ventilation in which a constant level of pressure greater than atmospheric pressure is continuously pumped into the lungs during spontaneous breathing) machine was on their Physician's Order Sheet (POS), care plan for one sampled resident (Resident #37); and failed to ensure respiratory face masks and tubing were kept covered when not in use for three sampled residents (Resident #68, #81, and #59) out of 22 sampled residents. The facility census was 80 residents.

Review of the facility's Policy Continuous Positive Airway Pressure revised 6/15/16 showed:

-CPAP should be administered under order of the attending physician.

-Obtain physician order for the rate of flow/pressure setting for CPAP and frequency of use.

-Mask/nasal pillows and flexible tubing should be washed, per manufacturers guidelines with mild soap and water, rinse thoroughly and air dry.

Review of the facility's Policy Oxygen Administration dated 12/8/05 showed:

-Oxygen (O2) cannula/mask should be stored in plastic bag when not in use.

-Obtain physician order for the rate of flow and route of administration of oxygen (i.e. by tank, concentrator, nasal cannula, mask, etc.).

1. Review of Resident #37's Admission Face sheet showed the resident had a diagnosis of:

-Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation).

Review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 8/19/24 showed he/she:

-Was cognitively intact, able to make his/her needs and wants known.

-Had no documentation that the resident required the use of a CPAP machine.

Review of the resident's Care Plan dated 9/17/24 showed the resident:

-Was receiving Oxygen Therapy.

-Intervention include administer oxygen therapy as needed and ensure that supplies were always available.

-NOTE: Did not have a care plan for the use and the care of CPAP machine and mask.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's POS dated 10/1/24 to 10/31/24 showed he/she had the following orders: -Did not have a detailed physician's order for use and monitoring/care of the residents CPAP machine and supplies. -No documentation of the resident's use of the CPAP machine at bedtime or as needed. Review of the resident's Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated 10/1/24 to 10/31/24 showed: -Did not have a detailed physician's order for use and monitoring/care of the residents CPAP machine and supplies. -No documentation of the monitoring of the resident's use of the CPAP machine at bedtime or as needed. Observation on 10/28/24 at 8:20 A.M., showed the resident had a CPAP machine next to the bed on the dresser with a face mask laid on the resident bed uncovered. Observation on 10/29/24 at 12:33 P.M. showed: -A CPAP machine sitting on the dresser. Observation on 10/30/24 at 12:56 P.M., showed the resident had a CPAP machine sitting on the dresser, mask laid on bed uncovered. During an interview on 10/30/24 at 2:23 P.M. the resident said: -He/She wore the CPAP at night. During an interview on 11/1/24 at 8:16 A.M., Certified Medication Technician (CMT) A said: -The resident use CPAP at night. During an interview on 11/1/24 at 8:40 A.M., Certified Nursing Assistant (CNA) E said: -CPAP should have a physician order, he/she would refer to the nursing staff about the physician order and care for a CPAP machine. During an interview on 11/01/24 at 8:56 A.M., Registered Nurse (RN) B said: -He/she would expect to have physician's order for use of CPAP. Review of the resident's electronic record on 11/1/24 at 9:02 A.M., with RN B showed: -He/she did not find a physician order for Resident #37 use of CPAP machine and care of mask or supplies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-RCN said he/she did not find a physician order for CPAP. -RCN said he/she would expect to have detail physician order for use of CPAP machine and care for mask. Care plan updated with use and monitoring of the CPAP machine and supplies. During an interview 11/01/24 at 11:36 A.M., the Director of Nursing (DON) said: -Would expect to have a physician order for Resident#37 use of CPAP machine to include the settings, supplies needed for CPAP machine and the cleaning of face mask. -Would expect to have care plan to include resident use of a CPAP. 50579 2. Review of Resident #81's quarterly MDS assessment, dated 10/16/24, showed: -Diagnoses of COPD and chronic respiratory failure. -The resident received oxygen therapy but did not use a CPAP device. Review of the resident's POS, dated 11/1/24, showed no orders for oxygen administration or the use of a CPAP machine. Review of the resident's Care Plan, dated 10/21/24, showed: -The resident received oxygen therapy. -Staff were to change tubing per protocol. -No specifications to the rate or frequency of oxygen to be administered. Observation on 10/28/24 at 9:13 A.M., showed: -The resident in his/her room with oxygen being administered through a nasal cannula at 2 liters per minute. -A CPAP device near the resident's bed, with tubing that ran across the ground and a mask that rested uncovered on a tote near the resident's bed. -No dates on the oxygen tubing or CPAP mask/tubing. -No bags or areas to place the mask or tubing when not in use. 21003 3. Review of Resident #68's Face Sheet showed the resident was admitted on [DATE], with a diagnosis of sleep apnea (a sleep disorder that causes breathing to repeatedly stop or become shallow during sleep). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS dated [DATE], showed the resident: -Was alert and oriented without confusion. -Had a specialized treatment- a non-invasive ventilator (CPAP/bilevel positive airway pressure (BiPAP, a noninvasive breathing machine that helps people breathe when they have medical conditions that make it difficult). Review of the resident's POS dated 10/2024, showed physician's orders for: - CPAP/BiPAP setting and ensure distilled water is full in the reservoir at bedtime daily at 9:00 P.M. Review of the resident's Care Plan updated on 10/25/24, showed the resident had sleep apnea and used a CPAP/BiPAP at bedside. Interventions showed staff would: -Administer oxygen therapy as ordered. -Change the tubing per protocol. Observation on 10/28/24 at 8:39 A.M., showed the resident was not in his/her room. There was a CPAP/BiPAP machine sitting on the nightstand beside the resident's bed. The resident's face mask and tubing was left uncovered and laying on top of the resident's bed. There was a brown substance on the linen on the bed that was next to the face mask. Observation on 10/29/24 at 9:54 A.M., showed the resident was laying on his/her bed and nursing staff was preparing to provide care to him/her/ On the nightstand beside the resident's bed was his/her CPAP/BiPAP machine and the face mask and tubing was laying on top of it, uncovered. Observation and interview on 10/29/24 at 10:24 A.M., showed the resident's CPAP/BiPAP machine was still on his/her nightstand and the face mask and tubing was still laying on the machine, uncovered. The resident said he/she used the CPAP/BiPAP when he/she was sleeping at night and when he/she awoke, he/she placed the face mask on the machine. He/She said he/she did not usually have a bag for the face mask. 51303 4. Review of the resident undated Face Sheet showed his/her most recent admission was 12/14/2023 with a diagnosis of COPD. Review of resident's quarterly MDS dated [DATE] showed: -The resident had some cognitive impairment that needed support from staff. -He/She was receiving oxygen. Review of resident's POS for 10/1/24 to 10/29/24 showed an order for oxygen at 2 to 4 liters per minute per nasal cannula as needed for shortness of breath. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER: Pleasant Hill Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1300 Broadway Pleasant Hill, MO 64080	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident's care plan showed a problem of oxygen therapy with interventions to include: -Administer oxygen therapy as ordered. -Change tubing per protocol. Observation on 10/28/24 at 8:28 A.M. showed the oxygen tubing for the E-tank (a portable oxygen tank) was draped over the wheelchair and not bagged. Observation on 10/29/24 at 12:59 P.M. showed the oxygen tubing for his/her concentrator in the room drapped over the bedside table and was not bagged. Observation 10/30/24 at 9:09 showed the resident up in wheelchair with oxygen tubing to his concentrator on. The external filter to the concentrator was missing, and the concentrator had a buildup of dust and grime. Oxygen tubing for the E-tank was draped over wheelchair and not bagged. 5. During an interview on 10/29/24 at 10:16 A.M., CNA A said: -The CPAP face mask and oxygen tubing should be in a bag when it is not in use and they (staff) should label and date the bag. During an interview on 11/01/24 at 11:36 A.M., with the DON, Regional Nurse Consultant, and the Regional Corporate Quality Assurance (QA) Nurse, the DON said: -Oxygen tubing, face masks and CPAP/BiPAP supplies should be stored in dated bags when not in use to prevent contamination. -An order should be in the resident's record for oxygen therapy, CPAP use and changing the oxygen tubing and storage bags. -The night shift nurses were responsible for changing out the tubing weekly at night. -CPAP masks should be bagged when not in use and there should also be an order showing when the mask and bags are to be changed. -He/She expected the filters and concentrators were cleaned weekly on Wednesdays by night shift.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to follow physician's orders for assessing the resident's dialysis (a procedure that removes waste products and excess fluid from the blood when the kidneys are unable to function properly) shunt (a surgically created connection between an artery and a vein that allows for direct access to the bloodstream for dialysis) site twice daily, failed to ensure dialysis communication was received and documented after each dialysis treatment for continuum of care, and failed to include in the care plan the location and type of dialysis access and complete interventions on dialysis care needs for two sampled residents (Resident #68 and #75) out of 22 sampled residents. The facility census was 80 residents. Review of the facility Hemodialysis policy and procedure dated 11/1/01, showed: -Physician's orders for care of the hemodialysis resident should include information regarding visits to a dialysis center, along with care of the access site. -Process for monitoring included palpate for a thrill and monitor the site for pain, swelling, redness or drainage, notify the physician if abnormalities are found. -Obtain dry weights from the dialysis center. -Obtain lab work from the dialysis center when performed. -The policy did not show any procedure for continuum of care/routine communication with the dialysis center per treatment. 1. Review of Resident #68's Face Sheet showed the resident was admitted on [DATE], with diagnoses including kidney disease and renal failure (occurs when the kidneys are no longer able to filter waste and excess water from the blood, or maintain the body's chemical balance) with dialysis use. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/14/24, showed the resident: -Was alert and oriented without confusion. -Received a specialized treatment-dialysis. Review of the resident's Physician's Order Sheet (POS) dated 10/2024, showed: -The resident attended dialysis on Monday, Wednesday and Friday at 4:00 AM (10/11/24). -Assess the resident's dialysis shunt for assess for bruit (a whooshing or rumbling sound caused by turbulent blood flow through a dialysis shunt) and thrill (vibration felt over a dialysis shunt, caused by blood flowing through it) every shift. If not contact physician immediately. Monitor for bleeding. If bleeding present, contact physician (7/3/24). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Remove dressing from dialysis access site day after treatment once daily on Tuesday, Thursday and Saturday (8/28/24). -Complete dialysis communication and send with resident on dialysis days (3/2/24). Review of the resident's Care Plan dated 5/12/23 and updated on 10/25/24, showed the resident had kidney disease and required dialysis. Interventions showed: -The resident at times refused dialysis. -Apply pressure promptly if bleeding. -Assess the resident's intake and output. -Check the resident's bruit and thrill as ordered. -Place a clean dry dressing over site (if bleeding) and hold pressure until emergency services arrives. -Do not obtain blood pressure where the access site is located. -Obtain weights and labs from dialysis. -Provide and coordinate transportation to and from dialysis. -The care plan did not show where the resident received dialysis or on what days he/she received it, what type of dialysis access the resident had and where it was located, how to care for the site and signs or symptoms of infection/adverse reactions to observe for and what to do if adverse reactions occurred. Review of the resident's documentation of handwritten Dialysis Communication forms (for both the facility and dialysis vendor) from 12/2023 to 4/2024, showed: -The facility's Dialysis Communication forms showed the facility's assessment of the resident's vital signs, frequency of dialysis, scheduled dialysis time, resident vital signs (pulse, respiration, blood pressure, temperature), medication sent with the resident, meal provision, transportation, time and facility contact number. -The dialysis clinic documented (on their own vendor form) the resident's vital signs (blood pressure, pulse, temperature, weight), mentation, medications given and labs drawn on the form pre-dialysis treatment and post dialysis treatment. It also included any complications experienced at each visit. -There were no handwritten dialysis communications forms documented after 4/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Dialysis Communication forms in the resident's electronic record showed the resident's name, date the communication was completed and recorded description and observation details. Observation details included the dialysis clinic, frequency of dialysis, scheduled dialysis time, resident vital signs, medication sent with the resident, meal provision, transportation, time and facility phone number. There was a section for the dialysis center to complete the resident's pre-weight, post weight, problems with the dialysis access site, whether the treatment was completed without incident, documentation of any lab work completed, medications given at dialysis, dietary recommendations and any recommendations/follow up. The documentation showed: -The facility completed the dialysis communication form to include the resident's vital signs and medications sent with the resident and any further comments on 9/16/24, 9/24/24, 9/25/24, 9/30/24,10/8/24, 10/14/24, 10/18/24, and 10/28/24 (8 visits), out of 17 visits from 9/16/24 to 10/25/24. -There was no documentation showing return communication from dialysis that showed the resident's pre-weight, post weight, problems with the dialysis access site, whether the treatment was completed without incident, documentation of any lab work completed, medications given at dialysis, dietary recommendations and any recommendations/follow up on any of the resident's communication forms out of 17 visits documented from 9/16/24 to 10/25/24. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 9/2024 and 10/2024, showed: -Physician's orders to send the dialysis communication with the resident on dialysis days (Monday, Wednesday and Friday). -Documentation showed the facility staff sent the dialysis communication form on 9/2/24, 9/4/24, 9/6/24, 9/9/24, 9/11/24, 9/13/24, 9/16/24, 9/18/24, 9/20/24, 9/23/24, 9/25/24, 9/27/24, 9/30/24, 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24, 10/14/24, 10/16/24, 10/18/24, 10/21/24, 10/23/24, 10/25/24, and 10/28/24. There was no documentation return communication was obtained from dialysis on any of the dates. -Physician's orders to assess the resident's dialysis access site for bruit/thrill every shift and monitor for bleeding. If not present or if bleeding present, contact physician immediately. --Documentation showed during 9/2024, that nursing staff followed the physician's orders except on 9/9/24, 9/13/24, 9/19/24, 9/20/24, 9/23/24, 9/24/24 and 9/30 where on these dates documentation showed the nurse only checked the thrill and bruit on the night shift. On 15 occasions the nurse documented a zero, indicating there was no thrill or bruit, but there was no documentation showing the physician was notified of this on those dates. --Documentation showed during 10/2024, that nursing staff followed physician's orders except on 10/2/24, 10/3/24, 10/7/24, 10/14/24, 10/17/24, 10/18/24, 10/21/24, and 10/27/24. On these dates, the nursing staff documented that the order was not followed due to the resident being unavailable. All of the dates showing the physician's orders were not followed occurred on the day shift except on 10/21/24 (night shift documented the resident was out of bed). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/29/24 at 10:24 A.M., showed the resident was laying in bed with a blanket covering him/her. There was an area on his/her upper left inner arm that was covered with a bandage. There was no swelling or redness surrounding the area. The resident said this was his/her dialysis access site. He/She said: -He/She had dialysis on Monday, Wednesday and Friday and his/her chair time was for 4:00 A.M. -He/She was comfortable with his/her treatments and had not had any issues with his/her access site. -On the days he/she went to dialysis, nursing staff took his/her vital signs, but at dialysis, they also took his/her vital signs and weights before and after his/her dialysis treatment. -Upon returning from dialysis, the nurse did not normally check his/her shunt site, complete vital signs or weigh him/her, but the Certified Medication Technician (CMT) came in at night to take his/her blood pressure. -He/She thought the dialysis center usually provided the facility with the documentation of his/her pre and post dialysis information, labs (when available) and communication after his/her dialysis treatments. Observation and interview on 10/30/24 at 10:50 A.M., showed the resident had just returned from dialysis and was in his/her room laying on his/her bed without a shirt on. There was a white 4x4 dressing covering his/her dialysis access site. At 11:53 A.M., Licensed Practical Nurse (LPN) A knocked on the resident's door and entered the resident's room and said he/she was going to check the resident's dialysis site. He/she put on gloves and used his/her fingers to feel on and around the resident's dialysis access site. LPN A said he/she was feeling for a pulse or vibration in the area. He/She then took the stethoscope and put it on the site and said he/she was listening for the swishing sound to identify the site was patent. LPN A said: -When the resident returned from dialysis the nurse was supposed to check the resident's access site to feel for the bruit and listen for the thrill. -He/She did not hear the swishing sound nor did he/she feel the vibration at the resident's access site, but this was because the resident has low blood pressure which was not abnormal for him/her. -If they are unable to hear or feel the thrill and bruit, they were supposed to notify the dialysis center and physician even though this is expected due to the resident's condition. -With Resident #68, because the resident's blood pressure is normally low, they rarely are able to successfully feel and hear the resident's blood going through the access site when he/she comes back from dialysis, but the residents primary care physician and dialysis physician are both aware of the resident's low blood pressure and he/she received Midodrine that was administered several times daily to keep his/her blood pressure up and they take his/her blood pressures several times daily. He/She said in spite of this, they are still supposed to check the site and report any abnormality to the physician. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was supposed to document the findings in the resident's MAR on the day/time they make the observation. -The resident was supposed to have his/her access site checked twice daily during the day and evening shift. She said the resident may not have his/her access site checked on the day shift due to the time he/she returned from the dialysis center, but it was checked at least once daily and they check it on the night shift. They document their monitoring on the resident's MAR. -The nurses were supposed to complete the communication section of the resident's dialysis communication form prior to the resident going to dialysis and some of the residents will bring back communication forms from their dialysis that showed the vendor's documentation of the resident's pre and post weights, vital signs medications given and how much fluid was pulled off and if there were any complications during dialysis treatments. -Resident #68 never brought back any documentation/communication from dialysis so he/she did not know any information about how the resident's dialysis treatment went or what his/her vital signs or weights were. -If the nursing staff have any concerns regarding dialysis, they can/will call the dialysis center to request information. -The resident's dialysis center will contact them if they have any concerns or need to notify them of any change in care, medications, or labs. -They do not contact the resident's dialysis center after each dialysis visit to obtain information regarding the resident's dialysis treatments or information regarding his/her weights, medications given during dialysis, vital signs or fluids pulled at each treatment. -He/She was going to notify the physician of the result he/she obtained when trying to check the resident's thrill and bruit today. During an interview with the Corporate Nurse on 10/29/24 at 1:59 P.M., showed: -The handwritten dialysis communication forms were in the dialysis book, but he/she was not sure all of the communications were in there for the resident and they may not all be there. -The dialysis communication forms for the resident should be and were in the resident's electronic record. -The return communication from dialysis should be in the resident's electronic record. During an interview on 11/01/24 at 11:36 A.M., with the Director of Nursing (DON), the Regional Nurse Consultant, and the Regional Quality Assurance (QA) Nurse, the DON said: -He/She would expect residents to be assessed upon return from dialysis and the thrill and bruit should be checked every shift. (continued on next page)

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	265565	A. Building B. Wing	11/01/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation of the staff monitoring of the resident's thrill and bruit should be on the resident's MAR. -They would not take the resident's vital signs unless there was an issue. -He/She does expect the nurse to follow the physician's order for assessing the thrill and bruit. -If the dialysis center does not return their assessment upon the resident's return, the nurse should call and ask the dialysis center if there is any information they need to know regarding the resident's treatment. -Usually the dialysis center will reach out to the facility if there are issues during dialysis, but they do not normally receive documentation from dialysis showing their pre and post dialysis communication. -They do expect the dialysis center to return documentation regarding their post assessment after treatment but they have had problems with the dialysis center being compliant with their requests for their communication. -They have called to try to get information from the dialysis center about the resident's treatments but they do not call to request the resident's information after each dialysis treatment. -When nursing staff have called to request information, he/she would expect nursing staff to document (when they have called to request information or when the dialysis center has refused to provide information) their communication in the resident's medical record. -They were aware that the resident has low blood pressure and may not be able to get an accurate assessment of his thrill and bruit. -With this resident, it is important to know what the resident's post dialysis assessment was after treatments. -He/She would expect the nurse to notify the physician and document the notification and response in the resident's medical record. -He/She would expect the resident's care plan to reflect that the resident has low blood pressures that may affect the ability to get the thrill and bruit. 51303 2. Review of Resident #75's undated Face Sheet showed he/she was admitted [DATE] with the following diagnoses: -End state renal disease (ESRD - the final, permanent stage of chronic kidney disease where the kidney function has declined to the point that the kidneys can no longer function on their own). -Hypertensive chronic kidney disease with stage 4 chronic kidney disease or end stage renal disease. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependence on renal dialysis. Review of resident's quarterly MDS dated [DATE] showed he/she had intact cognition and received dialysis. Review of the resident's POS dated for 9/29/24 to 10/29/24 showed: -Order dated 4/7/24 assess dialysis site after dialysis for bruit and thrill, If not present call physician, monitor for active bleeding if present call physician once a day on Monday, Wednesday and Friday at 4:00 P.M. -Order dated 8/1/24 Dialysis shunt assess for bruit and thrill every shift, if not present contact physician immediately, monitor for bleeding, if bleeding present contact physician every shift day and night shift. -Lacked a physician's order for the dialysis provider's location, scheduled days, and time of treatment. Review of resident's comprehensive care plan for renal disease and requires dialysis with a start date of 1/10/24 and edited 10/5/24 showed an intervention to obtain weights and labs from dialysis. Care plan failed to show the dialysis provider location, day, and time of treatment. The care plan lacked the location of shunt and not to provide treatments such as blood pressure or lab from his/her left arm and lacked documentation of the coordination of care between the facility and the dialysis provider. Review of the resident's Dialysis Communication Binder on 10/29/24 at 10:56 A.M. showed: -No documentation found for January 2024. -No documentation found for 2/1/24; 2/3/24; 2/6/24; 2/8/24; 2/20/24; 2/13/24; 2/15/24. -No documentation found for 3/3/24; 3/6/24; 3/8/24; 3/13/24; 3/17/24; 3/20/24; 3/22/24; 3/24/24; 3/27/24; 3/29/24 or 3/31/24. -No documentation found for April 2024. -No documentation found for 5/1/24; 5/3/24; 5/5/24; 5/12/24; 5/15/24; 5/19/24; 5/22/24; 5/26/24; or 5/31/24. -No documentation found for 6/2/24; 6/5/24; 6/9/24; 6/14/24; 6/16/24; 6/19/24; 6/23/24; 6/28/24; 6/30/24. -No documentation found for 7/5/24; 7/8/24; 7/12/24; 5/17/24; 7/26/24; 7/29/24; 7/31/24. -No documentation in binder after 8/7/24. Review of the resident's Dialysis Communication forms provided by the Director of Nursing (DON) on 10/30/24 at 8:43 A.M. showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documented vitals pre-dialysis and lacked information completed by the dialysis center on 9/11/24, 9/13/24, 9/18/24, 9/23/24, 9/27/24, 10/2/24, 10/7/24, 10/11/24, 10/16/24, and 10/21/24. -Had pre-dialysis vitals but lacked information completed by the dialysis center on 9/16/24, 9/25/24, 9/30/24, 10/4/24, 10/8/24, 10/14/24, 10/18/24 and 10/28/24. During an interview on 10/31/24 at 2:52 P.M., LPN A said: -Nurses were to complete the pre-dialysis assessment and that form goes to the dialysis provider to complete their portion. -Nurses assessed post dialysis per physician's order at 4:00 P.M. -Vitals are not obtained unless the resident is not feeling well. -Resident #75 was not always compliant in returning form. -He/She would only call dialysis if there was a concern. During an interview on 11/01/24 at 11:31 A.M., the Director of Nursing (DON) said: -He/She expected a resident that returned from dialysis to be assessed. -He/She expected the charge nurse to obtain the dialysis communication form. -He/She expected the charge nurse to follow up with entering weights, address labs and file in chart, and enter any new orders for be addressed. -He/She expected the charge nurse would follow up with the dialysis center if the communication form was not returned.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on interview, and record review, the facility failed to maintain documentation and ensure that Certified Nursing Assistants (CNAs), and licensed nursing staff had the appropriate competencies and skills check off completed annually and as needed. This had the potential to effect any resident care provided by care staff. The facility census was 80 residents. Review of the Facility assessment dated [DATE] showed: -The facility has staff skills and competencies to address the current and future needs of the facility's resident. -The facility had reviewed staff training and inservices program and determined that it is appropriate to provide the level and types of care needed for the resident population outlined in this assessment. The facility also reviewed staff competencies and skills sets and determined that competencies and skills sets for both staff and contractors were appropriate. 1. During the entrance conference on 10/28/24 at 9:07 A.M., the Administrator said: -The facility does not currently have an Assistant Director of Nursing (ADON). -The facility had residents with tracheostomy (surgical opening into the wind pipe into which a tube is inserted to allow passage of air and removal of secretions), wounds, colostomy (an alternative exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen), Foley catheter (a tube with retaining balloon passed through the urethra into the bladder to drain urine), tube feeding (a medical device used to provide nutrition to patients who cannot obtain nutrition by swallowing), and dialysis (process of cleansing the blood by passing it through a special machine - necessary when the kidneys are not able to filter the blood). Review of employees annual inservices and training records from 10/1/23 to 10/31/24 showed the facility did not have documentation of the staff completed skill and competency check off records. On 10/31/24 at 1:56 P.M. request the facilities staff competency skills check off for sampled employees. During an interview on 11/1/24 at 8:16 A.M., Certified Medication Technician (CMT) A said: -He/She had completed a competency skills check off about 4-5 months ago. -He/She did not keep a copy for his/her record. During an interview 11/1/24 at 11:11 A.M., Director of Nursing (DON) and Licensed Practical Nurse (LPN) B said: -The facility did not have staffing coordinator at that time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pleasant Hill Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Broadway Pleasant Hill, MO 64080	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The staffing coordinator would have been responsible for coordination of competency and skills check off, and maintaining staff competence and skill check off documentation. -The DON and LPN B were assisting with staff scheduling and training as needed until new staff were hired. -Staffing coordinator would normally coordinate a skills lab to be completed annually and as needed. -DON said: he/she was not able to locate the staff competency and skills documentation at that time for all nursing, CMT, CNA competency and skill completed. -DON would expect the facility staff coordinator to ensure to maintain and secure staff competency and skills check off documentation that had been completed for that year. On 11/1/24 at 2:06 P.M., at the time of exit, the facility administration were not able to find documentation of facility staff competency and skill check off that had been completed.

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	265565	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 19916 Based on observation and interview, the facility failed to have a regular system of checking food temperatures to ensure that hot foods (scrambled eggs) were maintained at or close to a temperature of 120 F (degrees Fahrenheit) on five trays for residents on the 500 Hall. This practice potentially affected five residents who were yet to receive breakfast room trays on 11/1/24. The facility census was 80 residents. 1. Observation on 11/1/24 showed: -At 7:31 A.M., the cart with trays for the residents in the 500 Hall left the kitchen. -From 7:34 A.M. through 7:38 A.M., trays were passed to residents who were in the 500 Hall dining room. -From 7:40 A.M. through 7:45 A.M. trays were delivered to residents who wanted trays in their rooms. -At 7:44 A.M., with Certified Nursing Assistant (CNA) A watching, the temperature of the eggs on one of the trays was measured at 113 F . During an interview on 11/1/24 at 7:46 A.M., CNA A said he/she had not seen anyone from the dietary department at the 500 Unit to check food temperatures. During an interview on 11/1/24 at 7:49 A.M., Registered Nurse (RN) A said he/she had worked for two weeks on the unit and had not seen anyone from the dietary department check food temperatures. During an interview on 11/1/24 at 8:21 A.M., Dietary [NAME] (DC) A said it had been about a month since he/she had checked food temperatures on the 500 Unit. During an interview on 11/1/24 at 8:27 A.M., the Dietary Supervisor said he/she was not sure how long the trays sat before they were passed out.

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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. 19916 Based on observation and interview, the facility failed to maintain the floors in the dry goods storage room; maintain under and behind the ice machine free from food debris and grime; failed to maintain the ceiling vents and the fan free from a dust buildup; failed to maintain the milk that was served to residents in the 500 Hall at or close to 41 F (degrees Fahrenheit); and failed to maintain the toaster free from a buildup of crumbs at the bottom of the toaster. This practice potentially affected 77 residents who ate food from the kitchen. The facility census was 80 residents. 1. Observations on 11/1/24 from 6:04 A.M. through 8:29 A.M., showed: -The presence of food crumbs, including an old orange behind the canned goods storage -The presence of food crumbs in the corner close to the chest freezer in the dry goods storage room. -A buildup of dust on the ceiling vent over the food preparation table. -A buildup of grime and food debris behind the ice making machine. -A heavy buildup of bread crumbs at the bottom of the two-slice toaster. -The presence of dust on the fan in the kitchen. During an interview on 11/1/24 at 7:29 A.M., the Dietary Supervisor said: -The dietary staff should clean the dry goods store room on a regular basis. -He/She was surprised to see the shelves were not moved. -The shelves with the canned goods should have been moved so that dietary staff could get behind that area more thoroughly. During an interview on 11/1/24 at 7:33 A.M., the Dietary Supervisor said the housekeeping department was supposed to clean the floors in the area where the ice machine was located. During an interview on 11/1/24 at 8:27 A.M., the Dietary Supervisor said: -He/She has not developed a cleaning schedule for the toaster. -They have a cleaning list for the dietary staff, but he/she needed to outline the duties with all dietary staff. (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 11/1/24 at 9:32 A.M., the Housekeeping Supervisor said it was the responsibility of both departments (dietary and housekeeping) to clean the floor, but it was very difficult to get behind the ice machine to clean the floor properly. During an interview on 11/1/24 at 11:35 A.M., the Administrator said he/she has seen housekeeping staff scrub the floors where the ice machine was located, but he/she should discuss a plan for cleaning that floor with the Housekeeping Supervisor and the Dietary Supervisor. 2. Observation on 11/1/24 at 7:42 A.M., showed the whole milk had a temperature of 50.1 F, when the temperature was measured after the Social Service Director poured the milk in a glass for measuring. During an interview on 11/1/24 at 7:46 A.M., the Activities' Director said he/she had not seen anyone form the dietary department at the 500 Unit to check temperatures of the foods. During an interview on 11/1/24 at 8:27 A.M., the Dietary Supervisor said: -No one was going to the 500 Unit to check the temperatures of the milk. -The milk was not maintaining the temperature that it is supposed for the entire time because the ice bath that the milk container sits in, melts.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on observation, interview, and record review, the facility failed to follow appropriate infection control practices during wound care to prevent the potential of cross contamination for one sampled resident (Resident #9) who at risk for infection due to open wound on left buttocks area; failed to ensure enhanced barrier precautions (EBP- an approach to the use of personal protective equipment (PPE) to reduce the transmission of Multidrug-Resistant Organisms (MDROs) between residents in skilled nursing facilities) when transferring and emptying a urinary catheter (a flexible tube inserted through a narrow opening into the bladder for removing fluid) bag for one sampled resident (Resident #5), during personal care for three sampled residents (Resident #36, #68, and #59) and during a transfer for one sampled resident (Resident #19) and to ensure hand hygiene was practiced when administering medications to two sampled residents (Resident #101 and Resident #18) out of 22 sampled residents; and failed to ensure Tuberculosis (TB- a bacterial disease that mainly affects the lungs) screening was completed annually for two sampled residents (Resident #1 and Resident #68) out of five sampled residents and for 5 of 9 sampled employees. The facility census was 80 residents. Review of the facility's policy titled Enhanced Barrier Precautions dated 4/29/24 showed: -A sign indicated the enhanced barrier precautions should be placed on the resident's door and if it is a semi-private room, it should be labeled for which bed. -PPE should be readily accessible at all times, preferably near or inside/outside of resident/guest rooms, shower rooms, and Therapy Gyms. -There should be appropriate disposal containers in the resident/guest room and Therapy gyms, showers for removal of PPE. -EBP required donning of gowns and gloves during high contact resident/guest care activities that provide opportunities for transfer of MDROs to staff hands and clothing. -EBP was indicated for resident/guests with any of the flowing: --Wounds or indwelling medical devices (central lines, urinary catheters, feeding tubes, and tracheostomies). -EBP was employed while performing high contact resident/guest care activities which included: --Dressing. --Bathing/Showering. --Transferring. --Providing Hygiene. --Changing linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Changing briefs or assisting with toileting. --Device care. --Wound care. 1. Review of Resident #9's Significant Change of Condition Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 8/17/24 showed the resident: -Was severely impaired memory for long and short term. -Was at risk for pressure injury/ulcer (is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Review of the resident's Nursing note dated 10/5/24 at 3:48 A.M., showed: -Open wound on his/her left buttocks found by staff during cares. -Small open area was about the size of a dime. Review of the resident's Wound Care Plan updated 10/15/24 showed: -Had actual skin breakdown left inner buttock. -The resident was on Enhanced Barrier Precaution (Gown and glove are used during high contact resident care activities). Review of the resident's Physician Order Sheet (POS) dated 10/15/24 showed a Wound Order for a Stage III (a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) of sacral area (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity) pressure injury, to the resident's left inner buttock. Review of the resident's Weekly Wound Assessment Report dated 10/22/24 at 4:21 P.M., showed the resident had a wound on left inner buttocks was open and pink. Observation on 10/29/24 at 9:37 A.M., of the resident's wound care showed: -The resident had signage on door for Enhanced Barrier Precaution, due to his/her wounds. -Regional Corporate Nurse with gloved hands, had unfasten and lowered the resident incontinent brief, then removed gloves washed his/her hands. -Resident incontinent brief was dry at that time. -The resident had a pea size open area on his/her left inner buttock. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The Wound Nurse cleansed the wound then applied cream to the resident's clean wound area. -Wound nurse removed the barrier and then placed the same used incontinent brief to covering the recently clean wound. During an interview on 10/29/24 at 10:13 A.M., Wound Nurse said: -He/She was not aware of the potential of cross contamination when reapplied the same used incontinent brief after completed wound care treatment. -He/She should had placed a clean unused brief on the resident help protect from potential of cross contamination of the clean wound area, since no dressing applied to cover the clean wound area. During interview 11/1/24 at 11:36 A.M., Director of Nursing (DON) and Regional Corporate Nurse said: -He/She would expect wound nurse to ensure have a new clean brief applied after the resident wound care was completed. -The clean brief applied would help protect the resident open wound from cross contamination from dirty to clean process. 51303 2. Review of Resident #59's quarterly MDS dated [DATE] showed: -The resident had some cognitive impairment that needed support from staff. -He/She had an indwelling catheter. -He/She required moderate assistance for toileting hygiene, shower/bathing, upper body dressing, lower body dressing and the putting on and taking off of footwear. Review of the resident's October 2024 POS showed enhanced barrier precautions during direct care related to foley catheter dated 12/14/23. Review of the resident's care plan start date 12/29/23 showed the problem of Foley catheter with an intervention to perform enhanced barrier precautions for foley catheter care. Observation on 10/28/24 at 8:28 A.M. a sign on the resident's door for Enhanced Barrier Precautions showed: -Everyone must clean their hands, including before entering and when leaving the room. -Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: --Providing hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Changing briefs or assisting with toileting. --Device care or use with central line urinary catheter, feeding tube, and tracheostomy. During an interview on 10/31/24 at 2:41 P.M., Licensed Practical Nurse (LPN) A said the process for foley catheter care included: -Wash hands, don gloves, complete catheter care, then perform hand hygiene prior to leaving the room. -He/She was not aware of EBP and was not aware staff were required to wear a gown while completing cares for residents on EBP. -He/She thought the sign was related to what to do if a resident had COVID (a new disease caused by a novel (new) coronavirus). -He/She did not wear a gown when completing the resident's catheter cares. During an interview on 11/01/24 at 11:31 A.M., the DON said: -He/She expected staff to perform Enhanced Barrier Precautions. -EBP would involve gown and glove use during high-contact resident care. -He/She was not aware staff had not used EBP for Resident #59 during catheter care. 21003 3. Review of Resident #19's quarterly MDS dated [DATE], showed: -The resident was alert and oriented with minimal confusion. -Had had no functional impairment in range of motion and used a walker for mobility. -Was dependent for toileting and required moderate assistance for upper and lower body dressing. Observation and interview on 10/30/24 at 1:15 P.M., showed: -There was a sign on the resident's door showing the resident was on EBP. The sign instructed the staff to stop and prior to entering the room the staff should wash or sanitize their hands, don gloves and a gown. -There was a personal protective equipment (PPE) cart containing gowns in the hallway. -The resident was laying down on his/her bed in his/her room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Certified Nursing Assistant (CNA) B entered the resident's room and without washing or sanitizing his/her hands, gowning or gloving, he/she assisted the resident to sit up on the side of his/her bed. -CNA B then assisted the resident to the bathroom and back to his/her recliner. At 1:43 P.M., CNA B was sitting down beside the resident and was feeding him/her. -Once he/she finished feeding the resident, he/she took his/her room tray out of his/her room without washing or sanitizing his/her hands. During an interview on 10/30/24 at 1:24 P.M., LPN B said: -The resident was on EBP due to an abrasion on his/her elbow. -CNA B was supposed to wash or sanitize his/her hands prior to or upon entering the resident's room and prior to providing the resident with any assistance. -Because the resident is on EBP, CNA B should have sanitized his/her hands, put on a gown and gloves before entering the resident's room. -CNA B did not follow handwashing or EBP precautions. During an interview on 10/30/24 at 1:58 P.M., CNA B said: -Normally, upon entering a resident's room and prior to performing any cares, they are supposed to wash or sanitize their hands. -If the resident is on EBP, they are also supposed to put on gowns and gloves if they are going to have any physical contact with the resident. -Before exiting the resident's room they should discard their PPE and wash or sanitize their hands. -He/She was aware that the resident was on EBP and saw the sign on his/her door. -He/She did not use PPE or wash or sanitize his/her hands because he/she forgot to. 4. Review of Resident #68's Face Sheet showed the resident was admitted on [DATE], with diagnoses including kidney disease with dialysis (a procedure that removes waste products and excess fluid from the blood when the kidneys are unable to function properly) use. Review of the resident's quarterly MDS dated [DATE], showed the resident: -Was alert and oriented without confusion. -Was independent with mobility, dressing eating and toileting and needed supervision and touch assistance with bathing. Observation on 10/29/24 at 9:54 A.M., showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There was an enhanced barrier precaution sign on the resident's room door which instructed staff to stop, clean their hands before entering and upon leaving the room and wear gown and gloves for the following: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with device care. -There was a PPE cart in the hallway two doors down from the resident's room. -Upon entering the resident's room, CNA A was in the resident's room standing beside the resident who was uncovered and laying in his/her bed. -CNA A was not wearing a gown or gloves and said he/she was providing resident care. During an interview on 10/29/24 at 10:16 A.M., CNA A said: -He/She had been trained on EBP but it had been a while since he/she reviewed it. -He/She saw the EBP sign on the resident's door, but he/she really was just trying to get his/her bath completed. -He/She thought he/she was supposed to wear a gown and gloves when a resident is on EBP, but he/she would have to read up on it again to see what the protocol was. -He/She did not see a PPE cart outside of the resident's door but he/she did see there was one in the hallway. -The resident was probably on EBP because of his/her wounds. -He/She did not wear a gown or gloves prior to entering the resident's room and providing care but he/she would review the EBP protocol. Observation and interview on 10/30/24 at 11:05 A.M., showed LPN A said he/she was going to check the resident's dialysis site. LPN A obtained his/her stethoscope and gloves went to the resident's door and knocked. Without washing or sanitizing his/her hands and donning a gown or gloves prior to entering, LPN A entered the resident's room. The resident was laying on his/her back in bed and there was a bandage over his/her dialysis access site on his/her left arm. Once LPN A finished assessing the resident he/she removed his/her gloves and washed his/her hands. LPN A said: -Regarding EBP, the resident was on EBP due to his/her wounds. -If anyone is in contact with his/her wound during cares, they were to wear a gown. -Usually when someone is on EBP, anyone who is going to complete any resident care would need to wear a gown and gloves prior to contact with the resident. -He/She said she would need to clarify if he/she was supposed to put on a gown with any direct contact with this resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The nursing staff should wash or sanitize their hands upon entry into the resident's room and prior to exiting. -He/She should have washed or sanitized her hands upon entering, but he/she put on gloves without doing so. 5. Review of Resident #36's Face Sheet showed the resident was admitted on [DATE], with diagnoses including stroke with paralysis, muscle weakness and lack of coordination. Review of the resident's Care Plan updated 6/12/24, showed the resident needed assistance to complete daily activities of care safely. Interventions showed staff was to: -Provide extensive assistance with bed mobility. -Required total assistance with bathing dressing toileting and used a full body mechanical lift (a mechanical device that helps caregivers safely transfer people who have limited mobility) for transfers. Review of the resident's quarterly MDS dated [DATE] showed the resident: -Was alert and oriented without confusion. -Needed moderate to total assistance with mobility, transfers, bathing, dressing and toileting. Observation on 10/28/24 at 11:36 A.M., showed the resident was in his/her wheelchair in his/her room. CNA F was already in the resident's room and Nurse Assistant (NA) A brought the mechanical lift into the room. Both CNA F and NA A put on gloves without washing their hands and attached the lift sling to the lift (the resident was laying on the sling) then NA A lifted the resident while CNA F assisted with moving the resident and positioning him/her in bed. CNA F and NA A removed the sling from the lift. NA A moved lift out of the room. CNA F and NA A then pulled the resident's pants down to perform incontinence care. CNA F pulled out a trash bag and placed it on the resident's bed while NA A pulled several cleansing wipes from a container, removed the resident's brief and cleaned the resident using front to back one wipe one swipe method. Both CNA F and NA A rolled the resident to the side and NA A cleaned the resident's bottom using a one wipe one swipe front to back method. NA A then, without de-gloving, washing or sanitizing his/her hands, took a clean brief and placed it under one side of the resident. CNA F and NA A rolled the resident to the left and CNA F pulled the brief under the other side of the resident. They then fastened the brief and pulled the residents pants up. CNA F and NA A both discarded their gloves and washed their hands, turning off the water with a paper towel. During an interview on 10/30/24 at 1:58 P.M., CNA A said: -Normally, upon entering a resident's room and prior to performing any cares, they are supposed to wash or sanitize their hands. -They wash or sanitize their hands during care when they change gloves. -Before exiting the resident's room they should wash or sanitize their hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/01/24 at 11:36 A.M., with the DON, the Regional Nurse Consultant, and the Regional Quality Assurance (QA) Nurse, the DON said: -He/She would expect nursing staff to wash or sanitize their hands before or upon entering the resident's room. -Staff should perform handwashing or sanitizing upon entering the resident's room, during resident cares, between performing dirty to clean tasks and prior to leaving the resident's room. 46519 6. Review of Resident #5's face sheet showed he/she admitted to the facility with the following diagnoses: -Colostomy (when a piece if colon is diverted to an artificial opening in the abdominal wall) Status. -Presence of Urogenital (relating to both the urinary and genital organs) Implants. -Pressure Ulcer Stage III. Review of the resident's annual MDS dated [DATE] showed: -The resident had a catheter. -The resident had an ostomy. -The resident had a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer. Observation on 10/29/24 at 9:03 A.M. of a wheelchair to bed transfer of the resident and emptied the resident's catheter bag completed by CNA C and CNA D showed both CNAs did not wear a gown the entire time they were completing the care of the resident. During an interview on 10/30/24 at 10:56 A.M. CNA C said: -He/She and CNA D had not worn gowns when performing the transfer and emptying the catheter bag during the resident's care. -He/She hadn't thought about putting on a gown and just entered the room due to being nervous. -EBP included wearing a gown and gloves during high contact resident care. -EBP were used to protect the resident. -Residents who have catheters, wounds, and colostomies should all be under EBP during high contact care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER: Pleasant Hill Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1300 Broadway Pleasant Hill, MO 64080	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/30/24 at 11:04 A.M. CNA D said: -After he/she and CNA C completed the resident's care, he/she realized that they forgot to put on gowns. -EBP were used for general infection control purposes and was unsure of any specifics to why a resident was on EBP. -Staff knew which residents were on EBP from a sign that was posted on the residents' door. -The facility had bins that held the necessary PPE, and they were stationed at the end of each resident hallway. During an interview on 10/31/24 at 1:30 P.M. the Infection Preventionist said: -He/She had been educated on EBP and so was the rest of the staff during an in-service. -He/She was unsure when the staff were last educated on EBP. -EBP was used for residents with portals for infections which included wounds, catheters, gastronomy tubes (a tube that is inserted through the wall of the abdomen directly into the stomach), and any other lines in general. -There were signs posted on each resident door that indicated the EBP and what the staff needed to wear in the room. -The sign also indicated the type of care that would indicate the use of the gown and gloves. -There was a cart that held the PPE on each resident hall. -The CNAs should have used EBP while performing the residents transfer and emptying the resident's catheter bag, which included the use of gloves and gowns. During an interview on 11/1/24 at 8:12 A.M. CNA A said EBP, which included the use of gowns and gloves, should be worn for any direct contact resident care. During an interview on 11/1/24 at 8:24 A.M. Registered Nurse (RN) A said he/she had not been trained on EBP and was not sure what exactly EBP indicated. During an interview on 11/1/24 at 11:36 A.M. the DON said: -EBP included wearing a gown and gloves during direct resident care. -There were signs posted on each residents' door that needed EBP and the sign would guide the staff on what to do. -Residents with wounds, catheters, indicated the need for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There was a PPE cart on each hall for the staff to utilize when EBP were needed. -The CNAs should have worn gowns and gloves during Resident #5's transfer and when they emptied Resident #5's catheter bag. 7. Review of the facility's policy titled Tuberculosis Screening dated 11/14/16 showed: -Upon admission, residents/guests should receive the purified protein derivative (PPD) two-step screening. -Residents/guests may receive an annual PPD test within one week of admission anniversary test. 8. Review of the following employee records showed there was no documentation showing these employees were given a two-step TB test upon hire or that the TB testing was not completed timely upon hire or that there was a previous TB test or X-ray to rule out TB had been completed prior to employment: -Employee A was hired 11/13/23 and his/her TB testing was started 2/5/24. He/She is still currently an employee. -Employee B was hired 7/9/24 and there was no TB test documented. He/She is currently an employee. -Employee C was hired 7/9/24 and there was no TB testing documented. He/She is currently and employee. -Employee D was hired 1/12/24 and his/her TB testing was started on 3/12/24. He/She is currently an employee. -Employee E was hired 5/20/24 and there was no TB testing documented. He/She is currently an employee. During an interview on 11/01/24 at 8:35 A.M., Financial Assistant/Human Resources said: -They completed an audit of the employee files in mid June 2024, and noticed there were some that were not completed and they tried to correct them. -Upon orientation, he/she had everyone complete the TB test step 1. -Nursing staff then complete the TB step 2 tests and they fill in the documentation. -If there were staff who had the first TB step completed and then there was no reading, and they had to start the testing over again because the nursing staff did not get it completed (this was why some were documented late). -They have not had a designated nurse that completed the TB testing for the past few months so whatever nurse that is available had to complete the TB testing and they were also supposed to track it to ensure both tests were completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-They were not able to find the TB tests on three staff sampled and he/she did not know if anyone completed their TB tests or if they just cannot be located. During an interview on 11/01/24 at 11:36 A.M., with the DON, the Regional Nurse Consultant, and the Regional QA Nurse, the DON said: -The nurse was to complete TB at orientation and read it 72 hours afterward then they complete second step within 10 days of the first test. -There should not be a reason why TB was completed late. -The staffing coordinator was responsible for ensuring the TB is completed timely, but they have not had a Staffing Coordinator and so he/she and the Infection Control Preventionist had been trying to get the TB's completed and monitor to ensure both steps were completed. -They had recently hired a Staffing Coordinator. -They do keep the TB records in one binder and they complete them by month so they know who needs to have their follow up 8. Review of Resident #1's face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's Physician Order Sheet dated October 2024 showed: -An order for Aplisol Solution (tuberculin PPD- used to test people for TB); five tuberculin (tub) unit/0.1 milliliter (ml); intradermal (situated, occurring, or done within or between the layers of the skin); Special Instructions: Yearly October PPD Test on October Third. -An order for Aplisol Solution five tub. unit/0.1 ml; read only; intradermal; Special Instructions: Yearly October PPD test results Annual on October Sixth. Review of the resident's Medication Administration Record (MAR) dated October 2024 showed: -The test was not administered because the resident had refused. -The results could not be read because the test was not administered. 9. Review of Resident #68's face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's TB Test results on 10/31/24 showed the resident last received the test in May 2023. During an interview on 10/31/24 at 1:30 P.M. the Infection Preventionist said: -He/She had not kept a book or log of all resident TB test results. -He/She used to do TB test audits, but it had been a while since the last audit was completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She was unaware that Resident #1's TB test had not been completed. -He/She was unaware that Resident #68's TB test had not been completed in over a year. -Nursing Management was responsible for completing TB tests. -Residents were to be given a two-step test upon admission, then annually thereafter. -The nurse who was responsible for completing Resident #1's TB test should have re-offered the test or to have received an order from the facility's physician for a chest x-ray. During an interview on 11/1/24 at 8:24 A.M. RN A said: -Nurses were responsible for completing resident TB tests. -He/She was unsure of who ensured the resident TB tests were completed. -Resident TB tests needed to be done upon admission and then annually. -If a resident were to refuse the TB test, then he/she would call the doctor to get an order for a chest x-ray to be done. -If a resident was lasted tested for TB in May 2023, then the resident should have had the annual test completed by that point in time. During an interview on 11/1/24 at 11:36 A.M. the DON said: -Nurses were responsible for completing resident TB tests. -The interdisciplinary team ensured completion of resident TB tests. -Residents were to receive a two-step TB test upon admission and then annually thereafter. -He/She was unaware that Resident #1 had refused his/her TB test and that the TB screening had not been completed. -He/She was unaware that Resident #68's last TB test was completed in May 2023. -The nurse responsible for Resident #1's TB test should have gotten an order form the facility's physician for a chest x-ray. -Resident #68's TB test should have been done by that point in time. 50579 10. Review of a policy titled General Dose Preparation and Medication Administration, dated 12/1/07, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff were to perform hand hygiene prior to beginning a medication administration/preparation. -Staff were not to touch medications during preparation or administration. -Medications that were dropped should be discarded. During an observation on 10/30/24 at 11:11 A.M., Certified Medication Technician (CMT) B administered a medication by mouth to Resident #101 in his/her room. After administration, CMT B returned to the medication cart, prepared two tablets of Acetaminophen (a pain reliever) 325 milligrams (mg) for Resident #9, and administered the medication in his/her room. No hand hygiene was performed from the beginning of the observation at 11:11 A.M. to the end of the observation at 11:25 A.M. During an interview on 10/30/24 at 11:25 A.M., CMT B said: -He/She forgot to sanitize his/her hands in between the administration of the medications. -He/She should have performed hand hygiene in between the medication administrations. 11. During an observation and interview on 10/31/24 at 8:59 A.M., CMT A began administering medications to Resident # 18. Hand hygiene was performed prior to preparing by mouth medications for the resident. CMT A prepared Aspirin (a pain reliever/anti-platelet aggregator) into the medication cup, then attempted to push a 5 mg Buspirone (a drug used to treat anxiety) tablet into the medication cup. The tablet missed the cup, landed on the medication cart and was picked up by CMT A with ungloved hands and placed into the medication cup. CMT A proceeded with the medication preparation and administered all ordered medications to the resident. -CMT A said he/she should not have touched the medication with his/her ungloved hand after it landed on the medication cart and placed it in the medication cup for infection control reasons. During an interview on 11/1/24 at 11:26 A.M., the DON said: -He/She would expect hand hygiene to be performed by all staff in between medication administrations. -He/She would expect staff to discard a medication that fell on to a medication cart and would not expect staff to pick up the medication with their hands and continue the administration.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to maintain the covers of cleanouts (an access point which provides access to the sewer or other plumbing line so that blockages can be removed) in a tight-fitting manner so the covers would not be a hazard to facility residents or staff located on the 100 Hall and on the 400 Hall. This practice potentially affected 31 residents who resided on those halls. 1. Observations on 10/29/24 at 1:23 P.M. and on 10/31/24 at 10:29 A.M., showed the cleanout cover outside of resident room [ROOM NUMBER] was loose when it was stepped on. During an interview on 10/31/24 at 10:30 A.M., the Maintenance Director said there has not been any work completed around that cleanout since he/she started his/her tenure at the facility in April 2024. 2. Observations on 10/31/24 at 11:31 A.M., showed the cleanout cover between 107 and 108 was loose when it was stepped on. During a phone interview on 11/6/24 at 3:08 P.M., the Maintenance Director said he/she expected the housekeeping staff who cleaned the floors in the hallways to notify him/her if one of those cleanout covers was loose.