STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Health and Rehabilitation Center	1609 Sunchase Drive Warsaw, MO 65355

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 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 40424

Based on interview and record review, facility staff failed to obtain a timely advanced directive for resident #238 who recieved CPR when he/she elected to be a DNR and failed to document residents' code status consistently as a Do Not Resuscitate (DNR) or Full Code (Resuscitate refers to cardiopulmonary resuscitation-CPR) for four residents (Resident #16, #42, #47 and #238) out of fifteen sampled residents. The facility census was 77.

1. Review of the facility's Advance Directives and Refusal of Treatment policy, dated [DATE], showed the resident has a right to formulate an advance directive for the management of his/her care. The resident shall have a copy of his/her advanced directive(s), if any, made a part of his/her medical record. Except in an emergency, prior to the start of any procedure or treatment, the resident shall receive the information necessary from his/her physician to give an informed consent. The information provided to the resident to obtain an informed consent shall include, but not necessarily be limited to, the intended procedure or treatment, the reason for the procedure or treatment, the potential risks, and the probable length of the disability.

2. Review of Resident # 238's medical record showed:

-admitted to facility on [DATE];

-Expired in facility on [DATE];

-The record did not contain a signed DNR or Full Code directive.

Review of the resident's Physician Order Sheet (POS), dated [DATE], showed the record did not contain an order for his/her code status or advanced directive.

Review of the resident's Baseline Care plan, dated [DATE], showed the care plan did not contain the resident's code status or advanced directives.

During an interview on [DATE] at 02:54 P.M., the resident's physician said he/she had not had a chance to examine the resident yet and did not have expectations regarding when the code status should or should not be performed or when the code status should be obtained.

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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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265566	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Health and Rehabilitation Center	1609 Sunchase Drive Warsaw, MO 65355

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:52 A.M., the Social Service Designee (SSD) said the resident came to the facility on a Thursday and signed a DNR form which was faxed to the physician. The physician was off Friday and on Monday, when the resident was without a pulse or breath, CPR was initiated. He/She said that during the CPR, the physician faxed the signed DNR to the facility and CPR was stopped. During an interview on [DATE] at 11:01 A.M., the admissions coordinator said he/she was in the hospital during the time the resident was admitted to the facility. 3. Review of Resident #16's medical record showed: -admitted to facility [DATE]; -The record did not contain a signed DNR or Full Code directive. Review of the resident's POS, dated [DATE], showed the record did not contain an order for his/her code status or advanced directive; Review of the resident's baseline care plan, dated [DATE], showed the care plan did not contain the resident's code status or advanced directives. 4. Review of Resident #42's medical record showed: -admitted to facility on [DATE]; -The record did not contain a signed DNR or Full Code directive. Review of the resident's POS, dated [DATE], showed the order did not contain an order for his/her code status or advanced directive. Review of the Care Plan, dated [DATE] showed the baseline care plan did not contain the resident's code status or advanced directives. 5. Review of Resident # 47's medical record showed: -admitted to facility on [DATE]; -The record did not contain a signed DNR or Full Code directive. Review of the resident's Care Plan, dated [DATE], showed the care plan did not contain the resident's code status or advanced directives. 6. During an interview on [DATE] at 10:52 A.M., The SSD said it is the responsibility of the Admissions coordinator to obtain advanced directive information upon or prior to admission, if possible. The directives are signed and given to the nurse to get an order from the physician. He/She said he/she is the backup if the admissions personnel is out of the building and was on duty when the resident came in on Thursday. (continued on next page)

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	265566	A. Building B. Wing	06/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:01 A.M., the admissions coordinator said he/she is responsible to obtain and review advanced directives on admission as part of the admission process. He/She then passes the information to the charge nurse who will obtain an order and ensure it gets put into the medical record. During an interview on [DATE] at 1:44: A.M., Licensed Practical Nurse (LPN) A said upon admission the nurse will review the hospital discharge or admitting paperwork to determine the residents code status. The nurse confirms it with the admissions coordinator, updates the care plan and obtains an order. During an interview on [DATE] at 03:07 P.M., the Administrator said advanced directives are reviewed and obtained during the admission process. He/she said once obtained, it is sent to the physician for review and order and would expect the process to be completed within 24 hours unless a weekend and would expect the process to be completed the next business day. 42484 43327

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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 40424

Based on observation, interview and record review, facility staff failed to provided a safe, clean, comfortable, and homelike environment when facility staff did not repair damage in resident rooms and bathrooms. The facility census was 77.

1. Review of the facility's Federal Rights of Residents, dated 11/01/01, showed facility will provided a safe, clean, comfortable, and homelike environment. Review showed staff are directed to:

-Clean beds and bath lines that are in good condition;

-Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

2. Observation on 06/11/24 at 10:15 A.M., showed occupied room [ROOM NUMBER]'s bathroom door with a large plastic scratch guard hung loose on one side with sharp edges and a heavily stained bathroom floor.

Observation on 06/11/24 at 11:02 A.M., showed occupied room [ROOM NUMBER] doorframe with chipped paint, shower floor with brown stained tile, stained caulk around the toilet and privacy curtain partially torn.

Observation on 06/11/24 at 11:07 A.M., showed occupied room [ROOM NUMBER] shower floor with stained tile and call light tapped to the wall with bandage tape.

Observation on 06/11/24 at 11:22 A.M., showed occupied room [ROOM NUMBER] wall behind the residents bed with a gouge, the baseboard by the shower wall loose, the shower floor stained and a rust-colored ring in the sink bowl.

Observation on 06/11/24 at 12:21 P.M., showed occupied room [ROOM NUMBER] wall behind the resident's beds with multiple areas of gouges and chipped paint.

Observation on 06/12/24 at 8:16 A.M., showed occupied room [ROOM NUMBER] bathroom floors with areas of lifted and cracked floor tiles. Observation showed the bathroon floor tiles with heavy black stains in the grout lines.

Observation on 06/14/24 10:23 at A.M., showed resident occupied room [ROOM NUMBER]'s door did not close and latch with ease. Certified Nursing Assistant (CNA) N attempted to shut the door and shoved the door closed with force.

Observation on 06/14/24 at 11:03 A.M., showed resident occupied room [ROOM NUMBER]'s bedroom floor tiles chipped around the perimeter of the bed with gray stains between the beds, black residue between the tiles under the heating/cooling unit. Observation of the resident bathroom showed the base of the toilet discolorwd and the bathroom door scratched.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/14/24 at 11:05 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom sink pipes wrapped in black tape and a tub under the pipe filled with gray water. The bathroom door contained gouges, and the baseboard missing with crumbled drywall. The bathroom tiles in the bathroom had yellow stains and the caulk with black residue. Observation on 06/14/24 at 11:08 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom with yellow stains on the tiles, and black residue in the caulking. Observation on 06/14/24 at 11:10 A.M., showed resident occupied room [ROOM NUMBER]'s wall by both beds with areas drywall and paint peeled. Observation of the bathroom showed the tiles behind the toilet with black residue. Observation on 06/14/24 at 11:08 A.M., showed the 400-hallway floor tiles cracked, chipped tiles, and with multiple stains. 3. During an interview on 06/14/24 at 9:50 A.M., Certified Nurse Aid (CNA) M said he/she tells the maintenance supervisor verbally if they find damaged items in a residents room. He/She said they were aware of the damage to the resident rooms. During and interview on 06/14/24 at 10:02 A.M., CNA N said if damage is noticed to a resident room he/she tells the Maintenance supervisor directly. He/She said they have told the maintenance supervisor about the damage in the rooms. During an interview on 06/14/24 at 10:17 A.M., Housekeeper C said many of the floors need to be replace because they can not be cleaned correctly due to the damage on them. He/She said they report damage to the housekeeping supervisor and to the maintenance department. During an interview on 06/14/24 at 11:09 A.M., the maintenance supervisor said staff should use the maintenance tracking computer software (TELS) to report repairs needed so it can be tracked, but chose to report it verbally instead. He/She was aware of the rooms that needed to be fixed. During an interview on 06/14/24 at 2:37 P.M., the Director of Nursing said staff should tell the maintenance supervisor through the electronic maintenance system, not verbally so it can be tracked. Maintenance is responsible for the repairs to resident rooms. During an interview on 06/14/24 at 3:17 P.M., the administrator said the maintenance supervisor is responsible for repairs to the building and that they were aware of the damage. Staff should report damage in the electronic system not verbally alone. Any immediately dangerous damage should be fixed right away. 43327

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48982 Based on interview and record review, facility staff failed to report an allegation of abuse for one resident (Resident #1) to the Department of Health and Senior Services (DHSS) within the required two-hour timeframe after being told the resident said a staff member tired to kill them. The facility census was 84. 1. Review of the facility's policy titled, Abuse, Neglect, Misappropriate of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, revised 10/24/22, showed certain incidents and accidents must also be reported to the appropriate state agencies. faclity staff are required to report all instances of abuse, neglect, exploitation, and misappropriation of resident/guest property, and suspicious injuries of unknown origin as required by state and federal law. Each employee has an obligation to immediately report any incident or allegation that constitute and instance of abuse, neglect, an injury of unknown origin, exploitation or misappropriation to the administrator, Director of Nurisng (DON), or department supervisor. If the report is made to the DON or department supervisor, that individual will notify the Administrator. The facility will report all alleged instances of abuse. The administrator or designee will report to the State Agency and all other required agencies, per regulation. All allegations of abuse and instances that result in serious bodily injury must be reported within 2 hours. 2. Review of Resident #1's medical record showes the resident admitted to the facility on [DATE]. Review of the resident's nurse's notes, dated 06/01/24 at 9:23 A.M., showed Licensed Practical Nurse (LPN) C documented staff alerted him/her the resident had requested pain medication. LPN C entered resident's room and noted resident to be visibly upset. Review showed staff documented the resident said his/her spouse called an ambulance and he/she was leaving. Review showed the resident said LPN C was trying to kill him/her and threaten him/her with his/her medications. Review showed staff alerted LPN C resident's spouse was in the room and the resident told his/her spouse he/she was threatened with his/her medications. Review of the facilities investigation, dated 06/26/24, showed staff documented LPN C reported on 06/01/24 at 8:29 A.M. the resident said LPN C tried to threaten the resident with his/her medications and tried to kill the resident on or around 06/01/24 at 8:23 A.M. Review of the investigation showed staff documented they notified DHSS on 06/26/24 at 1:17 P.M. During an interview on 06/26/24 at 1:25 P.M., the Regional Nurse said the DON and him/her were completing random chart audits and discovered a nurse's note written on 06/01/24 by LPN C. The Regional Nurse said the note exaplained a resident told him/her that he/she was threatening him/her with his/her medications and trying to kill him/her. The Regional Nurse said this was not report to DHSS until 06/26/24 when he/she found the note. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 1:25 P.M., the DON said he/she and the Regional Nurse were doing random chart audits and discovered a nurse's note written on 06/01/24 by LPN C which showed a resident told him/her that he/she was threatening him/her with his/her medications and trying to kill him/her. The DON said this incident was reported to the administrator the date of the incident but not to DHSS. The DON said the information was reported to DHSS on 06/26/24. During an interview on 06/27/24 at 8:42 A.M., the administrator said he/she does not remember the conversation with LPN C on 06/01/24. The administrator said he/she would have referred LPN C to the DON since he/she was on vacation. The administrator said he/she has not had any previous concerns or reports regarding LPN C. The administrator said if allegations of threats or abuse are reported to him/her then he/she is responsible to complete an investigation and report it to DHSS withing two hours. During an interview on 06/27/24 at 8:51 A.M., LPN C said he/she was the charge nurse on 06/01/24 the day. LPN C said he/she was alerted by staff that the resident requested pain medication. LPN said he/she entered the resident's room with the pain medication and noticed the resident was visibly upset. LPN said he/she asked the resident what was wrong, and the resident replied he/she couldn't get staff's help all night and was leaving the facility. LPN C said the resident told him/her, he/she had contacted his/her spouse and they called an ambulance to assist the resident to leave the facility. LPN C said he/she explained to the resident if he/she left AMA that LPN C could not send his/her medications with him/her. LPN C said the resident responded by saying LPN C was threatening him/her with his/her medications and trying to kill him/her. LPN C said the administrator was on vacation and asked LPN C to contact the DON. LPN C said he/she called the DON and just told her the resident left AMA. LPN C said he/she did not tell the DON the whole story. LPN C said he/she received abuse/neglect training upon hire, monthly in the staff meetings, and as needed. LPN C said any abuse/neglect must be reported to DHSS within two hours. LPN C said anyone can make a report to DHSS but generally the Administrator or DON make those reports. MO00238182

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48982 Based on interview and record review, facility staff failed to complete a thorough investigation when Licensed Practical Nurse (LPN) C reported he/she was accused by one resident (Resident #1) of making threats. The facility census was 84. 1. Review of the facility's policy titled, Abuse, Neglect, Misappropriate of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, revised 10/24/22, showed staff were directed to: -The facility will investigate and document all incidents and accidents involving residents/guests, certain incidents and accidents must also be reported to the appropriate state agencies; -The facility will report all alleged instances of abuse -Notify the Administrator of an unusual situation in the facility, whether reportable or not, immediately; -The Administrator or designee will report to the State Agency and all other required agencies, per regulation; -All allegations of abuse and instances that result in serious bodily injury must be reported within 2 hours; -The Administrator is responsible for conducting a thorough investigation and obtaining witness statements. 2. Review of the resident's face sheet showed: -admitted [DATE] at 9:32 P.M.; -discharged [DATE] at 9:00 A.M. Review of the resident's nurses notes showed: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/01/24 at 9:23 A.M., LPN C documented staff alerted him/her the resident had requested pain medication. LPN C entered resident's room and noted resident to be visible upset. LPN C asked the resident what was wrong, and the resident responded that staff did not answer his/her call light, did not come assist her, and his/her roommate cried all night. LPN C offered the resident a room change but the resident responded that he/she had called his/her spouse. The resident said his/her spouse called an ambulance and he/she was leaving. LPN C explained to the resident if he/she left against medical advice (AMA) that he/she would be responsible for his/her room charge and LPN C could not send the resident's medications with him/her. The resident responded she didn't care then proceeded to say that LPN C was trying to kill her and threaten her with his/her medications. LPN C administered requested pain medications and left the room. Staff came and alerted LPN C about 10 minutes later that the resident's spouse was in the room and the resident told his/her spouse he/she was threatened with his/her medications. LPN C spoke to the spouse and attempted to explain what happened, but spouse interrupted LPN C and said he/she was taking the resident out of the facility. LPN C called the residents physician and left a message. LPN C asked resident's spouse to sign an AMA form which he/she did and LPN C made the spouse a copy. LPN C assisted ambulance staff to move the resident from the bed to the gurney. LPN C called the Administrator and DON after. 3. Review of the facility's investigation, dated 06/26/24, showed the investigation did not contain documentation staff started the investigation until 06/26/24 at 11:50 A.M. 4. During an interview on 06/26/24 at 1:25 P.M., the Regional Nurse said the Director of Nursing (DON) and him/her were completing random chart audits and discovered a nurse's note written on 06/01/24 by LPN C. LPN C and the Administrator were suspended immediately when the note was discovered today until the investigation is completed. He/She got a statement from LPN C about the incident. During an interview on 06/26/24 at 1:25 P.M., the DON said he/she and the Regional Nurse were doing random chart audits and discovered a nurse's note written on 06/01/24 by LPN C. The DON said this incident was reported to the Administrator but not to Department of Health and Senior Services (DHSS). The DON said he/she remembered LPN C called him/her about the resident leaving AMA but did not tell him/her about the resident's comment. The DON said he/she found out about the comment with the chart audit. During an interview on 06/27/24 at 8:42 A.M., the Administrator said the day the resident was admitted he/she left at 5:00 P.M. for vacation. The Administrator said he/she did not meet the resident as the resident was admitted after he/she left. The Administrator said he/she does not remember the conversation with LPN C on 06/01/24. The Administrator said he/she would have referred LPN C to the DON since he/she was on vacation. The Administrator said he/she has not had any previous concerns or reports regarding LPN C. The Administrator said if allegations of threats or abuse are reported to him/her then he/she is responsible to complete an investigation and report it to the DHSS within two hours. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/27/24 at 8:51 A.M., LPN C said he/she was the charge nurse on 06/01/24 the day the resident left AMA. After the resident left he/she called the Administrator and reported the whole story to him/her. LPN C said the Administrator was on vacation and asked LPN C to contact the DON. He/She called the DON and just told her the resident left AMA. He/She did not tell the DON the whole story. LPN C said he/she received abuse/neglect training upon hire, monthly in the staff meetings, and as needed. LPN C said the Regional Nurse did abuse/neglect and medication training at discharge with him/her on 06/26/24 too. If he/she knows of abuse/neglect happening he/she would report it to the Administrator or DON. LPN C said any abuse/neglect must be reported to DHSS within two hours. LPN C said anyone can make a report to DHSS but generally the Administrator or DON make those reports. MO00238182

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered care plan for each resident to meet the resident's medical and nursing needs for five (Resident #17, #20, #21, #82 and #244) of sixteen sampled residents. The facility census was 77. 1. Review of the facility's Nursing Assessment's policy, dated August 2018, showed: -The facility conducts, a comprehensive, standardized assessment of each resident's functional capacity necessary to develop a person centered care plan and to modify the care plan and care services based the resident's status and resident goals and preferences, future discharge; -Comprehensive assessments should be completed on admission, quarterly and with a significant change in the resident's condition; -The comprehensive person-centered care plan is established with input from the resident/resident representative and upon completion of a comprehensive Minimum Data Set (MDS) assessment, a federally mandated assessment tool completed by facility staff, by the interdisciplinary team (IDT); -The initial nursing assessment on admission should include a baseline plan of care to be completed within 48 hours of admission; -The comprehensive assessment should include an IDT plan of care developed within 21 days of admission; -The quarterly nursing assessment should include a quarterly update of the IDT care plan; -A significant change of condition assessments should include an update to the plan of care to reflect the change of condition; -Information in the medical record, as documented by nursing personnel aids in the development of accurate plans. 1. Review of Resident #17's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/06/24, showed staff assessed the resident as: -Inattentive and disorganized thinking that fluctuates; -Use of a walker or a wheelchair; -Required parital/moderate staff assistance for sitting to lying; -Required partial/moderate staff assistance for lying to sitting; -Required partial/moderate assistance for chair to bed-to chair transfers; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Warsaw Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 Sunchase Drive Warsaw, MO 65355	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required partial/moderate assistance for sit to stand transfers; -Did not use bed rails. Review of the resident's care plan, dated 06/10/24, showed the care plan did not contain direction for the following: -Use of bed rails; -Cognitive loss/demenia; -Activities of daily living (ADL) function; -Urinary incontenence; -Psychosocial well-being; -Behaviors; -Activities; -Dehydration; -Surgical wounds; -Enhanced Barrier Precautions. Observation on 06/11/24 at 11:03 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/12/24 at 9:50 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/13/24 at 7:58 A.M. and 1:31 P.M., showed the resident in bed with bilateral quarter size side rails in the raised position. 2. Review of Resident #20's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -No behaviors or rejection of care; -Dependent on staff for all mobility and hygiene; -Had an indwelling catheter; -Diagnosis of Multiple Sclerosis (MS), anxiety, and depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Warsaw Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1609 Sunchase Drive Warsaw, MO 65355	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/11/24 at 11:33 A.M., showed the resident in bed with raised bed rails. Observation on 06/14/24 at 09:01 A.M., showed the resident in bed with raised bed rails. Review of the resident's care plan, dated 3/1824, showed the care plan did not contain direction for the following: -Activities of daily living (ADL) function; -Catheter care; -Use of bed rails. 3. Review of Resident #21's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Inattentive and disorganized thinking that fluctuates; -Required supervision/touching for sitting to lying; -Required partial/moderate staff assist for lying to sitting; -Required substantial/moderate assistance for chair to bed-to chair transfers; -Dependent on staff for sit to stand transfers; -No restraints; -Diagnosis of hip fracture, Alzheimer's disease, anxiety and depression. Review of the resident's care plan, dated 05/09/24, showed the care plan did not contain use or direction for use of bed rails. Observation on 06/12/24 at 8:28 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. Observation on 06/13/24 at 4:46 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. During an interview on 06/13/24 at 6:06 A.M., Certified Nurse Aide (CNA) G said he/she did not know what it said regarding the side rails for the resident. During an interview on 06/14/24 at 9:03 A.M., CNA F said he/she did not know what it said regarding the side rails for the resident, but knows they are on the bed. 4. Review of Resident #82's Admission MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mild cognitive impairment; -Inattentive and disorganized thinking that fluctuates; -Use of a wheelchair; -Required supervision/touching for sitting to lying; -Required partial/moderate staff assistance for lying to sitting; -Required parital/moderate assistance for chair to bed-to chair transfers; -Dependent on staff for sit to stand transfers; -Has pressure ulcers; -No restraints. Review of the resident's care plan, dated 05/29/24, showed the care plan did not contain direction or intervention for the following: -Use of bed rails; -Cognitive loss/demenia; -Activities of daily living (ADL) function; -Urinary incontenence; -Psychosocial well-being; -Behaviors; -Nutrition; -Enhanced Barrier Precautions. Observation on 06/11/24 at 10:59 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/12/24 at 8:22 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/13/24 at 7:51 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. 5. Review of Resident #244s Admission MDS, dated [DATE], showed staff did assessed the resident as follows: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitive; -Bilateral upper and lower extrimity impairment; -Surgical wounds; -Used wheelchair. During an interview on 06/12/24 at 10:06 A.M., the resident said the bed rail assists with mobility while in the bed and getting into his wheelchair. Observation on 06/13/24 at 1:23 P.M., showed the resident in bed with bilateral quarter size side rail in the raised position. Observation on 06/14/24 at 11:05 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Review of the resident's care plan, 06/07/24, showed the care plan did not contain direction for the use of bed rails. 6. During an interview on 06/13/24 at 06:06 A.M., CNA G said the care plans are in the computer and in a book off the secured unit. He/she has access to them but does not always have time to read them. During an interview on 06/14/24 at 09:03 A.M., CNA F said the care plans are in the computer and in a book off the secured unit. He/she has access to them and include specialized care needs such as call lights, assistance level, behavioral interventions, skin breakdown and falls. During an interview on 06/14/24 at 01:44 P.M., Licensed Practical Nurse (LPN) A said CNA's on the secured unit would have to ask the charge nurse and therapy how to care for a resident if its not in a care plan. He/She said the care plans are kept in a book at the nurse station and CNA's that work on the secured unit would have to come out to review them and someone would have to cover for them while they are off the unit. During an interview on 06/14/24 at 2:30 P.M., the Director of Nursing (DON) said residents should have a baseline care plan completed within 48 hours then a comprehensive after the admission MDS is completed. He/She said it is the responsibility of the MDS nurse to complete/accurate and update the care plans to include: activities of daily living, risk for elopement, potential for weight variations, potential for skin breakdown, falls, code status, incontinence and anything that would trigger on the MDS assessment. He/She said it is the DON's responsibility to ensure staff are following the care plans. During an interview on 06/14/24 at 3:07 P.M., the Administrator said care plans should be initiated by the MDS nurse and should include falls, infection, anything that changes with the resident, wounds, interventions for prevention of skin breakdown, special diets and infection prevention such as Enhanced Barrier Precautions (EBP). He/She said the IDT staff review the daily nurse notes and can update the care plans at that time with any changes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43327 50753

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interviews, and record review facility staff failed to provide appropriate personal hygiene, bathing, and incontinence care for seven (Resident #3, #20, #21, #47, #52, #54, and #81) out of 18 dependent sampled residents. The facility census was 77. 1. Review of the facility;s Hygiene and Grooming policy, dated 11/01/01, showed good hygiene and grooming help prevent the spread of infection and promote the resident's feelings of self-worth and dignity Review showed staff care to include: A.M. Care to include: a) Offer bedpan, urinal or assistance to the bathroom; b) If the resident is incontinent of urine or stool, provide perineal care; c) Wash hands after returning utensils to proper place; d) Get a basin of warm water, and take to bedside for the resident to wash face and hands . Assist the resident as needed; e) Gather oral hygiene supplies, and take to bedside for the resident to brush teeth. Assist the resident as needed; f) Wash hand after returning utensils to proper place; g) Assist the resident to dress in desired clothing for breakfast; h) Assist the resident to comb an brush hair, as needed; i) Assist the resident to the dinning room, when appropriate. Position the resident in comfortable sitting position, when eating in the room. Be sure call light is within reach, when the resident remains in the room. P. M. Care to include: a) Offer bedpan, urinal assistance to the bathroom; b) If the resident is incontinent of urine or stool, provide perineal care; c) Wash hands after returning utensils to proper place; d) Get a basin of warm water, and take to beside for the resident to wash face and hands. Assist the resident as needed; e) Apply lotion as needed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f) Gather oral supplies, and take to the beside for the resident to brush teeth. Assist the resident as needed; g) Wash hands after returning utensils to proper place. Review of the facility's Shaving the Resident policy, dated November 2001, showed male and female residents are shaved daily or as needed. Review of the facility's Nail Care policy, dated November 2001, showed nail care is a routine part of grooming each day. 2. Review of Resident #3's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated 05/14/24, showed staff assessed the resident as follows: -Cognitively intact; -Bathing substantial assistance. Review of the resident's care plan, dated 03/20/24, showed staff were directed to provide assistance with toileting, ambulation, and other personal needs; Review of the resident's care summary, dated 04/01/24 through 06/11/24, showed staff documented the resident received a shower on 04/12/24, 05/03/24, 05/24/24, and 06/04/24. Observation on 06/12/24 at 10:33 A.M., showed the resident in his/her room with his/her hair loosely pulled back in a ponytail greasy and disheveled. Observation on 06/14/24 at 9:00 A.M., showed the resident had greasy disheveled hair pulled back loosely in a ponytail. During an interview on 06/12/24 at 10:38 A.M., the resident said he/she had not received a shower in over two weeks and that it was frustrating for him/her to have to wait so long. 3. Review of Resident #20's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Dependent on staff for toilet hygiene and personal hygiene. Review of the resident's care plan, dated 03/18/24, showed the care plan did not address the resident's need for assistance to complete daily activities of care. Observation on 06/11/24 at 11:33 A.M., showed the resident with body odor, long fingernails with dark residue underneath, greasy uncombed hair, and facial hair. Observation on 06/12/24 at 11:11 A.M., showed the resident with body odor, long fingernails with dark residue underneath, greasy uncombed hair, and facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/13/24 at 10:00 A.M., showed the resident with body odor, long fingernails with dark residue underneath, greasy uncombed hair, and facial hair. Observation on 06/14/24 at 09:01 A.M., showed the resident with body odor, long fingernails with dark residue underneath, greasy uncombed hair, and facial hair. During an interview on 06/12/24 at 11:11 A.M., the resident said he/she was not offered a bed bath frequently enough. The resident said he/she liked to be clean and without facial hair. The resident said he/she felt unpleasant to him/herself and others. 4. Review of Resident #21's Quarterly MDS dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -No behaviors or rejection of care; -Dependent on staff for toilet hygiene and personal hygiene; -Diagnosis of Alzheimer disease. Review of the resident's care plan, dated 05/9/24, showed staff assessed the resident required assistance to complete daily activities of care safely. Review of the Resident Care summary, dated 04/14/24 through 05/14/24, showed staff documented the resident received three showers. Review of the Resident Care summary, dated 6/14/24, showed staff documented the resident received five showers during the 30-day look back peroid. Observation on 06/11/24 at 12:21 P.M., showed the resident with long fingernails, long facial hair and uncombed hair. Observation on 06/12/24 at 08:28 A.M., showed the resident with long facial hair with a red stain around the mouth, long fingernails and uncombed hair. Observation on 06/13/24 at 4:45 A.M. through 6:25 A.M., showed the resident in bed with a visibly saturated brief and smelled of urine. Observation on 06/13/24 at 1:53 P.M., showed the resident with long facial hair and long fingernails. Observation on 06/14/24 at 8:25 A.M., showed the resident with long facial hair and long fingernails. His/her hair was uncombed. During an interview on 06/13/24 at 1:52 P.M., the family said the resident did not have facial hair in the past and would not let his/her nails get so long. He/She said that his/her nails could scratch his/her skin and maybe get a tear. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 6:30 A.M., Certified Nurse Aid (CNA) G said the resident can be resistive during care at times but is not an excuse. He/She said he/she is on the hall by him/herself a lot and do the best they can. 5. Review of Resident #47's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Required set-up for showers; -Diagnosis of Parkinson's Disease and depression. Review of the resident's care plan, dated 04/08/24, showed the care plan did not address the resident's need for assistance to complete daily activities of care. Review of the Resident Care summary, dated 03/14/23 through 04/11/24, showed staff documented the resident received one bed bath. Review of the Resident Care summary, dated 04/15/23 through 05/15/24, showed staff documented the resident received one shower. Review of the Resident Care summary, dated 05/16/24 to 06/22/24, showed staff documented the resident received three showers. Observation on 06/11/24 at 3:11 P.M., showed the resident's hair was greasy and with facial hair. Observation on 06/11/24 at 10:20 A.M., showed the resident's hair was greasy and with facial hair. During an interview on 06/11/24 at 10:20 A.M., the resident said he/she was upset because showers were not regularly available. The resident said he/she wants to appear clean and does not want facial hair. 6. Review of Resident #52's Annual MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Dependent for personal hygiene; -Total dependence bathing; -Diagnosis of alzheimers, and dementia. Review of the resident's care plan, dated 05/23/24, showed staff were directed as follows; -Assess skin daily with routine care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Full skin assessment with bath/shower: -Hair done during activities. Review of the resident's care summary, dated 04/01/24 through 06/1/24, showed staff documented the resident received a shower on 05/06/24, 05/23/34, and 06/08/24. Observation on 06/11/24 at 2:50 P.M., showed the resident's hair was very disheveled and dry in appearance. Observation on 06/14/24 at 10:20 A.M., showed the resident's hair was uncombed and disheveled. 7. Review of Resident #54's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -No behaviors or rejection of care; -Dependent on staff for personal hygiene; -Required substantial/maximum assistance for dressing; -Diagnosis of Alzheimer disease. Review of the Resident Care summary,dated 03/16/24 through 06/13/24, showed staff documented the resident received eight showers. Review of the resident's care plan, dated 07/12/23, showed: -The resident required assistance to complete daily activities of care safely; -Bath per schedule; -Assist with shaving; -Assist with hair; -The care plan did not contain direction or guidance for dressing. Observation on 06/11/24 at 11:02 A.M., showed the resident wore a blue shirt with pale blue sweatpants. The shirt and paints contained stains and debris and hair was disheveled. Observation on 06/11/24 at 12:44 P.M., showed the resident in the dining room for lunch with stains and debris on his clothing and hair was uncombed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 6:30 A.M., CNA G said that the resident can do a lot of things by himself but should not be wearing soiled clothing or have uncombed hair. Staff should help the resident if he/she cannot do the task. He/She said he/she is often on the hall by him/herself and does the best they can. 8. Review of Resident #81's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Independent with personal hygiene and toileting; -Required supervision with dressing; -Diagnosis of dementia. Review of the residnet's care plan, dated 04/08/24, showed: -Provide pericare after each incontinent episode; -Dressing with one person assist; -Bathing per schedule with one person assist; -Toilet with one person assistance. Review of the Resident Care summary, dated 03/16/24 through 06/13/24, showed staff documented the resident received ten showers. Observation on 06/12/24 at 8:35 A.M., showed the resident wore green pants with a black shirt with a white logo across the front. Observation on 06/13/24 at 6:06 A.M., showed the resident up ambulating the hallway wearing green pants with a black shirt with a white logo across the front. He/She smelled of urine and his/her pants were visibly wet. The resident's sheets and mattress were wet, hair was uncombed. During an interview on 06/13/24 at 06:30 A.M., CNA G said that the resident normally takes themself to the bathroom and does not know why they were so wet. He/She said the resident was last checked on around 4:15 or 4:30 A.M. 9. During an interview on 06/14/24 at 9:52 A.M., CNA M said we do not have enough staff to get the showers done and we often stay over time to try and finish them. During an interview on 06/14/24 at 9:58 A.M., CNA N said we do showers at least every three days but he/she did not think they were all getting done due to low staff numbers. During an interview on 06/14/24 at 10:07 A.M., Licensed Practical Nurse (LPN) P said showers should be done at least twice a week. He/She said we are not currently able to always do that and it is inappropriate. The residents are not receiving showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24 at 10:34 A.M., the Director of Nursing said showers should be done twice a week, nails and hair are done in the morning. Incontinence care should be done as soon as possible and all grooming finished before a resident leaves their room. The memory care unit may not be getting this task done because we do not currently have two staff in the unit. During an interview on 06/14/24 at 3:07 P.M., the Administrator said staff should shower/bathe residents twice a week at least. All morning care like brushing teeth, washing faces, and changing clothes should be be done. Typically it is done but not always in the morning because staff are to busy. All facility staff can help get hygiene finished. We schedule showers by room numbers. 42484 43327

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 43327 Based on observation, interview, and record review, facility staff failed to provide daily activities for all residents who reside on the secured unit. The facility census was 77. 1. Review of the facility's Delegation of Activity Program Duties policy, dated March 2008, showed: -The activities program should provide stimulation or solace; promote physical, cognitive and/or emotional health; enhance to the extent practicable, each resident's physicial and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice; -Activities should be designed to provide meaningful activity to each resident, consistent with their background and interests, every day. Review of the facility's Resident Daily Routines and Activities on the dementia unit policy, dated May 2002, showed: -Time not involved with activites of daily living care or formal activites can be meaningful for the resident by providing space that is safe, with objects for free exploration, such as scrapbooks, magazines, seed catalogs, memory boxes, etc.; -Activities should be age appropriate; -When helpful, use background music to create a mood conducive to activities; -Daily routines should be established for each resident, based on their level of functioning and preferences for activity; -Activities should provide an appropriate stimulation level to avoid hyperactivity or overly passive activities; -Passive activities are more appropriate in the early evening hours, to cue rest and sleep and active-participatory activites are more appropriate in early day, when it is time to be busy; -The activity department may assist in the dementia unit, but the primary caregivers should be responsible to conduct daily recreational activites. Review of the Activity Calendar, dated June 2024 posted on the secured unit showed: -On 6/11/24, at 11:30 A.M., fold laundry and at 2:00 P.M., counting numbers; -On 06/12/24, at 11:30 A.M., church service and at 2:00 P.M., fresh fruit; -On 06/13/24 at 11:30 A.M, craft/make a flag and at 2:00 P.M., ring toss; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/14/24 at 11:30 A.M, Father's day social and at 2:00 P.M., iced tea time. Observation on 06/11/24 at 11:45 A.M., showed residents sat at the dining room table, wandered the halls, or were in their rooms. Staff did not provide the fold laundry activity. Observation on 06/11/24 at 2:17 P.M., showed residents sat at the dining room table, wandered the halls, or were in their rooms. Staff did not provide the counting numbers activity. Observation on 06/13/24 at 2:13 P.M., showed residents sat at the dining room table, wandered the halls, or were in their rooms. Staff did not provide the ring toss an activity. During an interview on 06/14/24 at 9:03 A.M., Certified Nurse Aide (CNA) F said activities is responsible to organize and assist with the first activity of the day and nursing is responsible for the second in the afternoon. He/She said activities don't always happen because there is usually only one staff member on the secured unit that are responsible for toileting, bathing/showers, naps, snacks, feeding and watch and deal with resident behaviors. He/She said he/she does the best they can. During an interview on 06/14/24 at 12:53 P.M., the activity director said activities assist with providing spelling bees, memory games, name that price, painting and always try new things. He/She said he/she puts a calendar on the wall for staff to use as a guide to complete activities on the secured unit. He/She said he/she reminds the staff to document the resident's participation, but knows it is not always done. He/She said the secured unit residents do not go to facility group activities very often because it is a lot for him/her to watch them. During an interview on 06/14/24 at 2:30 P.M., the Director of Nursing (DON) said activites are performed on the secured unit once or twice a day by the activity director and knows the regular staff will sometimes color with the resident or do things they like. He/She said ideally, there would be two staff on the unit, so activities could get done but right now, most of it is done by the activity director. During an interview on 06/14/24 at 3:07 P.M., the administrator said there is an activity calendar on the secured unit that are performed one time a day by the activity director. He/She said sometimes there are volunteers and churches that come in as well as TV time. The administrator said the residents are often tired by 7:00 P.M. or 8:00 P.M., and go to bed, but rise early in the morning.

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NAME OF PROVIDER OR SUPPLIER: Warsaw Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1609 Sunchase Drive Warsaw, MO 65355	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview, and record review, facility staff failed to safely propel two residents (Resident #25, and #52) out of two residents in wheelchairs. Facility staff failed to ensure the residents' environment remained free of accident hazards when staff did not ensure access to a key for the employee bathroom on the secured unit was available and the door locked at all times to keep residents from entry. The facility census was 77. 1. Review of the facility's policies showed staff did not provide a policy for the use of wheelchairs. 2. Review of Resident #25's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/15/24, showed staff assessed resident as: -Severely cognitively impaired; -Required no assistance for locomotion short distances and partial assistance for long distances; -Wheelchair used as a mobility device. Observation on 06/12/24 at 07:14 A.M., showed Licensed Pratical Nurse (LPN) O propelled the resident in his/her wheelchair from the hallway to the dining room without foot pedals. 3. Review of Resident #52's Annual MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Total dependence transfer; -Total dependence wheelchair; -Diagnosis of Alzheimer disease, and dementia. Observation on 06/11/24 at 12:25 P.M., showed LPN K propelled the resident in his/her wheelchair from the dinning area to a common area and one foot dragged on the floor. During an interview on 06/11/24 at 12:30 P.M., LPN K said he/she should have put the residents foot on the footrest before moving the resident in the wheelchair because it is not safe to do otherwise. 4. During an interview on 06/14/24 at 2:33 P.M., The Director of Nursing (DON) said staff should not propel residents in wheelchairs without footrests because they could be injured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/14/24 at 3:14 P.M., the administrator said staff should have the footrests on wheelchairs when propelling residents to prevent injury to the resident. 5. Review of the facility's Dementia Unit Characteristics policy, dated October 2003, showed the same safety features as if a house was child proofed should be used. Review showed doors to hazardous areas closed and locked and hazardous objects or substances kept in locked closets. Observation on 06/11/24 at 12:32 P.M., showed a room labeled employee break room on the secured unit. Observation showed the room employee break room unlocked and contained a linen barrel, a mop bucked with the mop and water, and a toilet. The call light did not have a string to alert staff if a resident wandered into the room and the door locked from the inside. Observation on 06/13/24 at 4:48 A.M. and 1:55 P.M., showed a room labeled employee break room on the secured unit. Observation showed the room employee break room unlocked and contained a linen barrel, a mop bucked with the mop and water, and a toilet. The call light did not have a string to alert staff if a resident wandered into the room and the door locked from the inside. Observation on 06/14/24 at 08:35 A.M., showed a room labeled employee break room on the secured unit. Observation showed the room employee break room unlocked and contained a linen barrel, a mop bucked with the mop and water, and a toilet. The call light did not have a string to alert staff if a resident wandered into the room and the door locked from the inside. During an interview on 06/12/24 at 4:58 A.M., Certified Nurse Aide (CNA) G said residents often go to the employee bathroom and open it up and try to go in it. He/She said there had not been a key for it since the locks were changed a while ago. CNA G said if a resident would go in the room and lock the door, staff would have to call maintenance to get them out. During an interview on 06/14/24 at 03:07 P.M., the administrator said he/she was not aware the door did not lock to the employee bathroom on the secured unit. He/She said if the door does not lock, a resident could wander in there and get hurt. 42484

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50753 Based on observation, interview and record review, facility staff failed to obtain informed consent, complete entrapment assessments, and/or complete a side rail assessment the use of side rails and/or grab bars for nine (Resident #17, #20, #21 #32, #39, #41, #54, #82, and #244) of nine sampled residents . The facility census was 77. 1. Review of the facility's Proper Use of Side Rails Policy, dated 10/26/22, showed side rails should be addressed in the care plan and the resident and the resident representative should give informed consent to the use of the device, prior to its use. The facility did not provide entrapment or side rail assessments upon request. 2. Review of Resident #17's Admission Minimum Data Set (MDS), a federally mandated assessment, dated 05/06/24, showed staff assessed the resident as: -Required partial/moderate assist in bed mobility; -Required partial/moderate assist in sit to stand; -Required partial/moderate assist in chair/bed to chair transfer; -Did not use side rails/restraints. Review of the resident's medical record, showed the record did not contain a signed consent, an entrapment assessment or side rail assessment for the use of side rails. Observation on 06/11/24 at 11:03 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/12/24 at 9:50 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/13/24 at 7:58 A.M. and 1:31 P.M., showed the resident in bed with bilateral quarter size side rails in the raised position. 3. Review of Resident #20's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -No behaviors; -Not Applicable to assess bed mobility; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent for chair to bed-to chair transfers; -Not Applicable to assess sit to stand transfers; -No restraints; -Diagnoses of Multiple Sclerosis. Review of the resident's medical record showed the record did not contain a signed consent, an entrapment assessment or side rail assessment for the use of side rails. During an interview on 06/11/24 at 11:23 A.M., the resident said he/she used the grab bars to hold him/herself in position for personal care. Observation on 06/11/24 at 11:33 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. Observation on 06/12/24 at 8:58 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. Observation on 06/13/24 at 10:00 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. Observation on 06/14/24 at 9:01 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. 4. Review of Resident #21's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Impaired cognition; -Required supervision for sitting to lying; -Required partial/moderate staff assist for lying to sitting; -Required substantial/moderate assistance for chair to bed-to chair transfers; -Dependent on staff for sit to stand transfers; -No restraints; -Diagnosis of hip fracture. Review of the residents medical record showed the record did not contain an entrapment assessment. Observation on 06/12/24 at 8:28 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/13/24 at 4:46 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. 5. Review of Resident #32's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Partial/moderate assist is bed mobility, sit to stand, and chair/bed to chair transfer; -Did not use side rails/restraints. Review of the resident's medical record, showed the record did not contain a signed consent, an entrapment assessment or side rail assessment for the use of side rails. Observation on 06/12/24 at 08:19 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. 6. Review of Resident #39's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Independent for bed mobility, sit to stand, and transfers between the bed and chair; -Did not use restraints. Review of the resident's medical record showed the record did not contain a signed consent, an entrapment assessment, or an assessment for the use of side rails. Observation on 06/11/24 at 11:47 A.M., showed the resident sat on the edge of the bed with the bed rail in the raised position. Observation on 06/12/24 at 8:54 A.M., showed the resident sat on the edge of the bed with the bed rail in the raised position. Observation on 06/14/24 at 8:30 A.M., showed the resident sat on the edge of the bed with the bed rail in the raised position. 7. Review of Resident #41's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -No behaviors; -Independent with all mobility; -No restraints. Review of the resident's medical record showed the record did not contain a signed consent, an entrapment assessment or side rail assessment for the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/11/24 at 11:47 A.M., showed the resident in bed with the grab bar in the raised position. Observation on 06/12/24 at 10:21 A.M., showed the resident in bed with the grab bar in the raised position. Observation on 06/14/24 at 09:34 A.M., showed the resident in bed with the grab bar in the raised position. During an interview on 06/12/24 at 9:40 A.M., the resident said he/she did not use the bed rails. 8. Review of Resident #54's Quarterly MDS, dated [DATE] showed staff assessed the resident as: -Cognitively impaired; -Required supervision for roll left to right and sitting to lying; -Required partial to moderate staff assistance for lying to sitting; -Required substantial/maximum assistance for sit to stand and chair/bed-to-chair transfers; -No restraints; -Diagnosis of Alzheimer's dementia. Review of the resident's medical record, showed the record did not contain a signed consent, an entrapment assessment or side rail assessment for the use of side rails. Observation on 06/11/24 at 11:02 A.M. and 2:51 P.M., showed the resident in bed with grab bars on both sides of the bed in the up position. Observation on 06/12/24 at 08:36 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. Observation on 06/14/24 at 08:39 A.M., showed the resident in bed with grab bars on both sides of the bed in the up position. 9. Review of Resident #82's Admission MDS, dated [DATE], showed staff assessed the resident as: -Partial/moderate assist is bed mobility; -Partial/moderate assist in sit to stand; -Partial/moderate assist in chair/bed to chair transfer; -Did not use side rails/restraints; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record, showed the record did not contain a signed consent, an entrapment assessement or side rail assessment for the use of side rails. Observation on 06/11/24 at 10:59 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/12/24 at 8:22 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. Observation on 06/13/24 at 7:51 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. 10. Review of Resident #244's Entry Tracking Record dated 05/31/24, showed staff assessed the resident as follows: -Cognitive; -Bilateral upper and lower extremity impairment: -Partial to maximum assistance needed for bed mobility. Review of the resident's medical record showed the record did not contain a signed consent, an entrapment assessement or side rail assessment for the use of side rails. Observation on 06/13/24 at 1:23 P.M., showed the resident in bed with bilateral quarter size side rail in the raised position. Observation on 06/14/24 at 11:05 A.M., showed the resident in bed with bilateral quarter size side rails in the raised position. During an interview on 06/12/24 at 10:06 A.M., the resident said the bed rail assists with mobility while in the bed and getting into his wheelchair. 11. During an interview on 06/14/24 at 2:42 P.M., the Director of Nursing (DON) said side rail assessments should be done and in the electronic chart. He/She said maintenance completes the entrapment assessments, and then staff gets consents. Who monitors it is being completed and why not done? During an interview on 06/14/24 at 03:07 P.M., the administrator said it is the responsibility of maintenance and Physical Therapy to obtain the consents. He/she said the consent forms are kept in the office of the DON. She said she could not find the consent forms. 42484 43327

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45564 Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 77. 1. Review of the facility's Dietary Manager / Food Services Director job description, reviewed 06/30/03, showed the individual must be a Certified Dietary Manager (CDM) in good standing or in training to satisfactorily complete the requirements to become a CDM. During an interview on 06/11/24 at 10:21 A.M., the Dietary Supervisor (DS) said he/she worked in the facility for 8 months and started as DS about two months ago. The DS said he/she had not started CDM classes yet and had never taken other food safety manager courses. The DS said he/she had food safety handling classes four or five years ago. The DS said he/she was not given a training completion timeline and had not received CDM course enrollment paperwork. During an interview on 06/12/24 at 2:00 P.M., the Registered Dietician (RD) said the facility had not been able to find a Certified Dietary Manager to work at the facility. The RD said the facility was working toward the dietary supervisor's CDM credential. The RD said the DS was not scheduled to attend any food service manager training other than the CDM course. During an interview on 06/13/24 at 1:45 P.M., the administrator said the facility was having a hard time finding a CDM. The administrator said he/she thought the DS was allowed one year from hire date to obtain CDM credential so he/she did not look at alternatives.

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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. 45564 Based on observation, interview and record review, the facility staff to allow sanitized dishes to air dry prior to stacking in storage and use to prevent the growth of food-borne pathogens. Facility staff failed to maintain the kitchen ceiling in good repair to prevent the potential contamination of food. These failures have the potential to affect all residents. The facility census was 77. 1. Review of the facility's Handling Serviceware / Silverware policy, dated February 1, 2002, showed serviceware should be air dried and stored turned upside down, or covered. 2. Observation on 06/11/24 at 10:54 A.M., showed Dishwasher Q removed clean plate covers, plates, and cups from a rack on the drain board and placed the items on a service cart and a shelf above the drain board. Observation showed the items were stacked while still wet. Observation on 06/11/24 at 11:18 A.M., showed eight sheet pans stacked under the prep table while wet. Observation on 06/11/24 at 11:20 A.M., showed Dishwasher Q stacked service trays and plate warmers on a service cart. Observation showed the trays and warmers were stacked while wet. Observation on 06/12/24 at 1:45 P.M., showed Dishwasher Q removed plates from a dish machine rack and stacked the plates in a plate warmer. Observation showed the plates were stacked while wet. Observation on 06/12/24 at 1:45 P.M., showed a shelf on the clean side of the dish machine contained two service trays which contained stacks of small plastic serving bowls. Observation showed the bowls were wet. During an interview on 06/12/24 at 2:00 P.M., the Registered Dietician (RD) said the biggest problem in the kitchen was stacking items when wet and not allowing them to air dry. The RD said the facility purchased new shelving three or four weeks ago, but the shelving had not been installed. 3. Review of the facility's building maintenance policies showed the policies did not contain a policy related to the kitchen ceiling. Observation on 06/11/24 at 11:31 A.M., showed an open crack along the sheetrock seam on the ceiling above the steam table and food prep counter. During an interview on 06/11/24 at 11:32 A.M., Cooks R said they told maintenance about the crack but did not complete a paper work order to have the crack repaired. During an interview on 06/13/24 at 9:30 A.M., the maintenance director said he/she was aware of the ceiling crack in the kitchen. The maintenance director said the crack in the ceiling was there since he/she started one year ago but he/she had not fixed it because it was hard to work in the kitchen since staff were cooking all the time. The maintenance director said he/she was not aware of new shelving for the kitchen. (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 6/13/24 at 1:45 P.M., the administrator said kitchen wares should not be stacked wet. The administrator said the dishwasher is responsible, but other kitchen staff tried to help when they could. The administrator said maintenance staff were responsible for maintain the facility ceilings and he/she was not aware of the ceiling crack above the food prep area.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50753 Based on record review, the facility administration failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes when facility staff failed to have an unlimited year history on the Criminal Background Checks (CBC) through the Missouri Highway Patrol for all new employees. The facility census was 77. 1. Review of the facility's Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation Policy, dated 10/24/22 showed the facility will search the appropriate registries and will conduct a background investigation to determine whether a finding of abuse, neglect, mistreatmnet, exploitation or misappropriation [NAME] been entered against a potential employe. This search will include all registries that the facility believes may have information. 2. Review of the contracted company for CBC checks letter, dated 6/12/24, showed the contracted company is to provide background screening services for pre-employment purposes. Review showed the company will search within a seven year timeframe for misdemeanor records. Felony convictions are reported out as far back as the state allows. In the state of Missouri, our statewide criminal search uses the online court search website to find criminal records. During an interview on 06/13/24 at 2:53 P.M., Financial Specialist Assistant said he/she is responsible for completing the CBC. He/She enters the potential employees name in the to the contracted company to complete the checks. This system has been used for about a year and started after the last survey. He/She was not aware the CBC checks only goes back seven years and did not know it had to be unlimited. He/She said he/she uses what corporate tells him/her to use.

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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** 42484 Based on observation, interview, and record review, facility staff failed to prevent the spread of bacteria for three residents (Resident #21, #62, and #81) of four sampled residents when staff did not wash hands and change gloves during the provision of care, failed to prevent the spread of bacteria when staff did not wear the appropriate Personal Protective Equuipment (PPE) for one resident (Resident #21) of one sampled resident who had a wound and failed to post precaution signs on the doors of resident rooms to alert staff and visitors of the needed precautions for three residents (Resident #17, #82, and #244) of four sampled residents who required Enhanced Barrier Precautions (EBP). The facility census was 77. 1. Review of the facilty's Hand Hygiene policy, dated June 2020 directed staff to perform hand hygiene: -When hands are visibly soiled; -Before and after entering isoation precautions settings; -Before and after assisting a resident with personal care; -Upon and after coming in contact with a resident intact skin; -Before and after assisting a resident with toileting; -After contact with a resident body fluids or excretions; -After handling soiled or used linens or catheters/urinals; -After removing gloves. Review of the facility's perineal care policy, dated November 2001, directed staff to: -Remove any fecal matter or urine wiping with tissue from front to back; -When wash clothes and soap are used, the water should be changed before rinsing the resident; -Wash perineal area first, using a different corner or a new wipe area with each wipe; -If the resident has an indwelling catheter, gently wipe the catheter from the insertion site, down the catheter approximately three inches being careful not to pull the catheter and rinse well; -Turn the resident on to his/her side and wipe from front to back wiping from inner buttocks extending over buttocks, changing wipes or corners as needed. Review of the facility's EBP policy, dated April 2024, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Warsaw Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1609 Sunchase Drive Warsaw, MO 65355	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A sign indicating the enhanced barrier precautions should be placed on the resident's door and if it is a semiprivate room, it should be labeled for which bed; -EBP requires donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDRO) to staff hands and clothing; -EBP is indicated for residents with wounds or indwelling medical devices even if resident is not known to be infected or colonized with MDRO; -EBP is employed while performing high-contact resident care activities such as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, devices care or use (central line, urinary catheter, feeding tube, tracheostomy (artificial opening to the throat), and wound care (any skin opening requiring a dressing); -EBP is intended for the length of the resident' stay or until resolution of the wound or discontinuance of the indwelling device that placed them at a higher risk. 2. Review of Resident #21's Quarterly Minimum Date Sheet (MDS), a federally mandated assessment, dated 05/08/24, showed staff assessed the resident as: -Cognitively impaired; -Dependent on staff for toilet hygiene; -Always incontinent; -Diagnosis of hip fracture and Alzheimer disease. Review of the resident's wound healing progress report, showed on 06/06/24 staff documented the presence of an unstageable (cannot see the base of the wound) suspected deep tissue injury to the resident's right hip. Observation on 06/12/24 at 09:15 A.M., showed a sign on the residents door explained everyone must clean hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, devices care or use central line, urinary catheter, feeding tube, tracheostomy (artificial opening to the throat), and wound care. Observation on 06/12/24 at 9:15 A.M., showed Certified Nurse Aide (CNA) F entered the residents room to provide care and did not apply a gown. With gloved hands the CNA pushed a soiled brief down between the resident's legs, provided pericare, rolled resident to his/her side, removed the soiled brief from under the resident and did not change his/her gloves or wash hands. With same soiled gloves, the CNA applied a clean brief, lowered the bed with the bed control, applied a sheet over the resident, gathered soiled linens and trash and removed his/her gloves. Observation showed the CNA did not wash his/her 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 06/12/24 at 9:30 A.M., CNA F said staff should perform hand hygiene when going in a room, when leaving a room and when removing his/her gloves. He/She said he/she was nervous being watched and the resident was being resistive during care and did not know the resident was on the EBP until the other day. He/She said he/she should have worn the gown because the resident has a wound, but didn't think about it. 3. Review of Resident #62's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Used catheter: -Occasionally incontinent of bowel; -Required substantial/maximum assist of staff for toilet hygiene. Observation 06/14/24 at 10:23 A.M., showed CNA N entered the resident room and applied gloves. Observation showed teh CNA wiped bowel movement off the resident's buttocks. The CNA removed his/her gloves and did not perform hand hygeine before he/she put on clean gloves to wipe the catheter tubing from insertion area toward the bag. During an interview on 06/14/24 at 3:05 P.M., CNA N said hand hygiene should be performed between glove changes. CNA N said he/she did not do it because he/she was in a hurry to complete the task. 4. Review of Resident #81's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Independent with toilet hygiene; -Occasionally incontinent; -Diagnosis of dementia. Observation on 06/13/24 at 6:06 A.M., showed CNA F and CNA G entered the room to provide care. CNA F applied gloves and assisted the resident to the restroom. Observation showed CNA F continued to wear the same soiled gloves and removed the brief, applied a clean brief and clean pants. CNA F removed his/her gloves, did not perform hand The mattress under the sheets was visibly wet. CNA F did not clean the wet bed mattress and applied a bed pad turned upside down over the wet area of the mattress. CNA G put clean linens over the pad on the mattress and CNA F assisted the resident to bed. CNA F and CNA G left the room and did not perform hand hygiene. During an interview on 06/13/24 at 6:15 A.M., CNA F said staff should perform hand hygiene when going in a room, when leaving a room and when removing his/her gloves. He/She said the resident was not feeling well so was trying to hurry to get him/her to bed. (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 06/13/24 at 6:22 A.M., CNA G said staff are supposed to wash their hands when entering a room and before leaving a room and between glove changes. He/She was getting ready to leave for the day and trying to help where he/she could and didn't think about washing, but did sanitize when entering the room with the linen barrels. He/She said there is so much to do in twelve hours that staff need to do the best they can. 5. Review of Resident #17's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitive loss/Dementia; -Did not have surgical wounds; -Received an antibiotic. Review of the resident's Physician Order Sheet (POS), dated June 2024, showed an order, on 06/08/24, to change peripherally inserted central catheter ((PICC) a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart) line dressing change every 72 hours. Review showed an order, on 06/12/24, for wound vac (uses negative pressure to help heal wounds) dressing change every three days. Observation on 06/11/24 at 11:03 A.M., showed the resident in bed with a PICC to right upper arm. A wound vac machine on the floor by the bed. Observation showed the resident door did not have a EBP sign. Observation on 06/13/24 at 1:17 P.M., showed the resident in bed with a PICC to right upper arm. A wound vac machine on the floor by the bed. Observation showed the resident door did not have a EBP sign. Observation on 06/13/24 at 2:04 P.M., showed CNA M placed resident on the bedpan and did not wear EBP. Observation on 06/14/24 at 9:04 A.M., showed CNA M transfered the resident from the wheelchair to the bed, placed the resident on the bed pan and did not wear EBP. 6. Review of Resident #82's Admission MDS, dated [DATE], showed staff assessed the resident as: -Mild cognitive impairment; -The resident had a pressure ulcer. Review of the resident's POS, dated June 2024, showed an order for dressing changes to the resident's left heel pressure ulcers in two different areas and two areas of the resident's sacrum. Observation on 06/11//24 at 10:59 A.M., showed the resident's door did not contain a EBP sign. Observation on 06/13/24 at 8:44 A.M., showed the resident's door did not contain a EBP sign. 7. Review of Resident #244s Admission MDS, dated [DATE], showed assessed the resident as follows: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Cognitive; -Bilateraly upper extremity impairment; -Surgical wounds. Review of the resident's Physician Order Sheet, dated June 2024, showed an order on 06/01/24 for EBP related to wounds. Review of the resident's care plan, dated 06/07/24 showed direction to initiate and follow isolation precautions as ordered. Observation on 6/11/24 at 11:19 A.M., showed the resident with a dressing to his/her right leg, left foot, and a dressing to his/her left and right arm. Observation showed the resident's door did not have a Enhanced Barrier Precaution sign. Observation on 06/12/24 at 10:21 A.M., showed the resident had a dressing to his/her left foot, right below the knee amputation, left arm, right arm and right ear. Observation showed the resident's door did not contain a EBP sign. Observation on 06/14//24 at 01:15 P.M., showed the resident's door did not contain a EBP sign. 8. During an interview on 06/14/24 at 2:30 P.M., the Director of Nursing (DON) said staff are expected to perform hand hygiene when entering a room, before leaving a room and between glove changes to decrease the risk of infection spread. He/She said staff are expected to post signs on the resident doors indicating they are on EBP for wounds, catheters and ostomies and is the responsibility of the wound nurse, but he/she is new so it would fall on the DON to make sure they are there. Staff are expected to follow the guidance on the signs including wearing of gowns during provisions of care and wound care. He/she did not know why the signs were not posted. During an interview on 06/14/24 at 3:07 P.M., the administrator said residents with EBP precautions should have a sign on the door indicating the precautions needed. He/She said if staff do not follow the guidance there is a potential for the spread of infection. The administrator said any resident with a wound should have an EPB sign on their door. The staff should then be aware that proper PPE should be used during resident care. 43327 50753