STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265590	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	200 South St Paris, MO 65275

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 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** 32530 Based on interview and record review, the facility failed to notify the physician when two residents (Residents #1 and #2), in a review of four sampled residents, had a change in condition. The facility's census was 68. 1. Review of an email received from the facility's Director of Nursing (DON) on 11/13/24 showed the facility did not have a policy for when to notify physician. 2. Review of the Resident #1's face sheet showed the following: -He/She admitted to the facility on [DATE]; -Diagnoses included an ileus. Review of the resident's Nursing Progress Note, dated 08/01/24 at 7:04 A.M., showed the resident's physician examined the resident and reviewed medications with no new orders. Review of the resident's Physician's Progress Note, dated 08/01/24, showed the following: -The resident was admitted for rehabilitation on 07/26/24; -The resident had a history of dementia and congestive heart failure (the heart cannot pump blood well enough to give the body a normal supply) with recent hospitalization ; -The resident's abdomen was soft and nontender; -The resident had no edema; -The resident's respiratory effort was normal; -Continue to monitor and assess for health status changes and contact physician with any changes. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Progress Notes, dated 08/01/24 at 4:01 P.M., showed staff had increased concerns with the resident's confusion and abdominal distension. (Review showed no documentation staff notified the resident's physician of the resident's increased confusion and/or abdominal distention.) Review of the resident's Progress Note, dated 08/01/24 at 4:38 P.M., showed staff notified the resident's family of the resident's decline in condition from previous note with increased labored breathing, abdominal distension, and edema. (Review showed no documentation staff notified the resident's physician of the resident's change in condition.) Review of the resident's Skilled Nursing Assessment, dated 08/02/24 at 1:45 A.M., showed the following: -The resident had difficulty concentrating and was anxious; -His/Her abdomen was swollen and distended. Review of the resident's Progress Note, dated 08/02/24 at 1:52 A.M., showed the resident continued to have confusion. Review of the resident's medical record showed no documentation staff notified the resident's physician of the resident's increased confusion and abdominal distention on 08/02/24. Review of the resident's Skilled Nursing Assessment, dated 08/03/24 at 3:43 P.M., showed the resident had edema in his/her abdomen. Review of the resident's Progress Note, dated 08/03/24 at 3:43 P.M., showed the resident had edema in his/her abdomen. (Review showed no documentation staff notified the resident's physician of the resident's abdominal edema on 08/03/24.) Review of the resident's Skilled Nursing Assessment, dated 08/04/24 at 6:36 A.M., showed the resident had edema in his/her abdomen. Review of the resident's Progress Note, dated 08/04/24 at 5:07 P.M., showed the following: -Lab (Potassium level 3.0 milliequivalents per liter (mEq/L)) (the normal range for potassium is between 3.5 and 5.2 mEq/L) reported to the resident's physician and orders obtained for potassium chloride 40 mEq by mouth three times a day and repeat BMP on 08/08/24; -The resident's family was not pleased with the orders and came to transport the resident to the hospital for further treatment. During an interview on 10/28/24 at 1:35 P.M., the Director of Nursing (DON) said she expected staff to notify the resident's physician with any changes in the resident's condition and document the notification in the resident's medical record. During an interview on 10/31/24, Registered Nurse (RN) A said the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She thought the physician was aware of the resident's change in condition; -If he/she notified the physician, he/she should document the physician notification in the resident's electronic medical record. During an interview on 11/06/24 at 10:00 A.M., the resident's physician said the following: -He saw the resident on 08/01/24 and didn't note any significant changes that warranted further evaluation; -He did not recall staff notifying him/her of the resident's change in condition; -He expected staff to notify him of any changes in the resident's condition. 3. Review of Resident' #2's care plan, last revised on 05/13/24, showed the resident exhibited behavioral symptoms (tells everyone that someone stole his/her stuff) regarding misplaced wallet, personal items, and family pictures. Review of the resident's Progress Note, dated 08/01/24 at 7:06 A.M., showed the resident's physician assessed the resident and ordered a repeat UA specimen to be obtained. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 08/02/24, showed the following: -His/Her cognition was severely impaired; -He/She had delusional behaviors; -He/She was physically and verbally aggressive towards others daily; -He/She had other behaviors that were not directed towards others four to six days of the previous seven-day look back period. Review of the resident's Progress Note for Behavioral Monitoring, dated 08/02/24 at 4:37 P.M., showed the resident exhibited verbal outbursts, wandering, agitation, and restlessness. Review of the resident's medical record showed no documentation staff notified the resident's physician of the resident's behaviors on 08/02/24. Review of the resident's progress note, dated 08/03/24 at 3:37 P.M., showed the resident's behaviors included restlessness, pacing, rummaging, and wandering. Review of the resident's Progress Note, dated 08/04/24 at 11:57 A.M., showed the resident displayed verbal outbursts, exit seeking, and increased paranoia. Review of the resident's Progress Note, dated 08/04/24 at 12:47 P.M., showed the resident experienced hallucinations, increased agitation, and paranoia due to previous diagnosis of UTI and was sent to the hospital for evaluation. (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 medical record showed no documentation staff obtained the UA as ordered on 08/01/24, and no documentation to show staff notified the resident's physician that the UA was not obtained. Review of the resident's progress note, dated 08/04/24 at 4:12 P.M., showed the resident was admitted to the hospital for confusion and urine issues. During an interview on 10/30/24 at 9:50 A.M., Licensed Practical Nurse (LPN) B said the following: -The resident's cognition declined, and the resident showed increased confusion, anxiety, agitation, and hallucinations; -The resident refused cares which should have been documented in the resident's electronic medical record; -Staff should have notified the resident's physician of the resident's increased behaviors and refusal of care/treatment; -He/She thought the resident's physician was aware, but was not 100% sure; -Staff should document when they notify the physician in the resident's electronic medical record. During an interview on 10/31/24 at 8:49 A.M., RN A said the following: -Staff should notify the resident's physician when a resident refused care and treatments; -Staff should document the physician notification in the resident's electronic medical record. During an interview on 11/12/24 at 11:10 A.M., the DON said the following: -Staff notified the resident's physician of increased behaviors on 8/1/24 and obtained an order for a UA; -Staff were unable to obtain the urine specimen for the UA due to resident's incontinence, and staff were not able to straight cath the resident because the resident was delusional and thought staff were trying to harm him/her. (Review of the resident's medical record showed no documentation staff attempted to obtain a urine sample.) -She expected staff to notify the physician of the resident's refusal and inability to obtain the urine specimen, and document in the resident's electronic medical record. During an interview on 11/06/24 at 10:00 A.M., the resident's physician said the following: -He expected staff to notify him/her when the resident refused care/treatment; -He did not recall staff notifying him/her about the inability to obtain the repeat UA. MO240027 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO240225 MO 241299

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530 Based on observation, interview, and record review, the facility failed to ensure three residents (Residents #2, #1, and #3), in a review of four sampled residents, received care and/or services per physician's orders and professional standards of care. Staff failed to ensure Resident #2, who had a significant wound/skin history, had weekly skin assessments completed and/or documented as ordered, and failed to obtain a follow up urinalysis (urine test used to detect an infection) ordered on 08/01/24. The facility failed to obtain labs as ordered and failed to follow up timely on lab results to monitor Resident #1's potassium level, who had a diagnoses of hypokalemia (low blood potassium level) and an ileus (a temporary condition where your intestine can't push food and waste out of your body which can be caused by chemical, electrolyte, or mineral imbalances such as decreased blood potassium level). The facility failed to follow discharge orders for Resident #3 by failing to complete dressing changes as ordered. The facility census was 68. 1. Review of an email received from the Director of Nursing (DON) on 11/13/24 showed the facility did not have a policy for following physician orders. 2. Review of Resident #2's Care Plan, last reviewed/revised on 05/16/24, showed the following: -He/She had pressure ulcers related to incontinence/decreased mobility; -Assess and record the condition of the skin surrounding the pressure ulcer weekly; -Assess the pressure ulcer for location, stage, size (length, width, and depth), presence/absence of granulation tissue, and epithelization weekly; -Conduct a systematic skin inspection weekly and report any signs of further skin breakdown; -He/She had history of cellulitis (bacterial infection of your skin and the tissues beneath your skin); -Monitor bilateral lower extremities (BLE) for signs/symptoms of cellulitis i.e. redness, swelling, etc. -He/She had history of ulcers to bilateral lower extremities. Review of the resident's Physician's Orders, dated June 2024, showed an order to complete a skin assessment observation weekly on Friday day shift (6:30 A.M. to 6:30 P.M.). Review of the resident's weekly skin assessment documentation, dated June 2024, showed no documentation staff completed a skin assessment from 6/21/24-6/30/24. Review of the resident's Physician's Orders, dated July 2024, showed an order to complete skin assessment observation weekly on Friday day shift (6:30 A.M. to 6:30 P.M.). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's wound management detail report, dated 07/08/24, showed the facility's wound care nurse, Registered Nurse (RN) A, documented the following: -A declining 4.5 centimeter (cm) by 1 cm by 0.1 cm (length x width x depth) venous ulcer (a wound on the leg or ankle caused by abnormal or damaged veins) located on the right shin (lower leg); -A stable 2.4 cm by 2.4 cm by 0.1 cm venous ulcer located on the right ankle; -A declining 5 cm by 4.6 cm venous ulcer located on the left proximal (situated near the center of the body or center of attachment) shin; -A declining 0.6 cm by 0.5 cm venous ulcer located on the left distal (situated away from the center of the body or point of attachment) shin. Review of the resident's weekly skin assessment documentation, dated 07/13/24, showed the resident had abnormal skin with no new areas. (The assessment did not include any additional information regarding the resident's venous ulcers.) Review of the resident's weekly skin assessment documentation, dated July 2024, showed no documentation facility staff completed a skin assessment from 07/13/24 through 7/31/24. Review of the resident's July 2024 Physician's Orders, showed an order dated 7/24/24 for Rocephin (antibiotic) 1 gram intramuscularly (IM) with lidocaine (anesthetic) 2.1 milliliters (ml) every day for five days to treat UTI (discontinue date 7/28/24). Review of the resident's wound care clinic orders, dated 07/26/24, showed to complete the following dressing changes to bilateral lower extremities every third day and as needed: -Cleanse the legs/feet and dry well; -Paint all wounds and skin with Betadine (antiseptic solution) and allow to dry; -Once Betadine is dry, apply Cavilon Advance Wand (barrier to protect skin) around all wound beds and between toes, and allow to dry to protect from drainage; -Cover all wound beds with Mepilex (absorbent foam dressing to treat chronic and acute wounds); -Follow with double layer of Medigrip size E from toes to knees and keep legs elevated; -Cut a one inch strip of Interdry(used to prevent moisture) and weave in/out toes to help wick moisture every A.M./P.M. Review of the resident's Progress Note, dated 08/01/24 at 7:06 A.M., showed the resident's physician assessed the resident and ordered for a repeat UA specimen to be obtained. Review of resident's Progress Notes, dated 08/01/24 to 08/03/24, showed no documentation staff attempted to obtain the UA, no documentation the resident refused for staff to collect urine, and no documentation staff notified the physician when unable to collect a urine specimen for the UA. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's weekly skin assessment documentation, dated August 2024, showed no documentation facility staff completed a skin assessment on 8/1/24 (the facility's last documented skin assessment was completed on 7/13/24). During an interview on 10/30/24 at 9:50 A.M., Licensed Practical Nurse (LPN) B said the following: -A licensed nurse was to complete weekly skin assessments on shower days and to document the assessment in the resident's electronic medical record; -He/She was not sure why the UA was not obtained for the resident; -The resident often refused care. Staff were to document in the resident's electronic record when a resident refused care and multiple attempts to provide care; -The physician should have been made aware when the resident refused, and staff should have documented this in the electronic medical record. During an interview on 10/31/24 at 8:49 A.M., Registered Nurse (RN) A, the facility's wound care nurse, said the following: -He/She or the charge nurses completed the weekly skin assessments. -He/She was responsible for completing the wound assessments, but the charge nurses could complete them in his/her absence. -Staff should document when a resident refused care, including dressing changes, tests, and assessments, in the resident's electronic medical record; -If a resident refused care, staff should make multiple attempts to provide the care and should document the attempts and interventions in the resident's electronic medical record. During an interview on 11/12/24 at 11:10 A.M., the DON said the following: -She expected staff to complete skin assessments weekly as ordered and to document the assessment in the resident's electronic health record ; -The charge nurses were responsible to complete weekly skin assessments and to document the assessments in electronic medical record when they were due; -The Care Plan Coordinator looked at residents' skin after each shower; -Staff notified the resident's physician of the resident's increased behaviors on 8/1/24 and obtained an order for a UA but staff could not straight cath (insert tube into the bladder to drain/collect urine specimen) the resident who thought staff were trying to hurt him/her. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/12/24 at 11:10 A.M., the Care Plan Coordinator said the shower aides completed the shower sheets. She monitored the shower sheets to see if there were any skin issues that needed to be addressed. The shower aides came to her if they saw anything concerning and she assessed the resident, but she did not physically assess every resident's skin after each shower. If she assessed the skin, she would have documented it in the resident's medical record. During an interview on 11/06/24 at 10:00 A.M., the resident's physician said the following: -He expected staff to complete weekly skin assessments as ordered and to document the assessments in the medical record; -He expected staff to complete all orders as written; -He expected staff to make multiple attempts to fulfill the orders and to document the attempts in resident's medical record; -He expected staff to notify him/her when a resident refused the care; -He did not recall staff notifying him/her that they were unable to obtain the repeat UA (ordered on 8/1/24). 3. Review of Resident #1's hospital records, dated 07/23/24, showed the resident had a blood potassium (mineral the body needs to work properly) value of 3.0 (normal potassium level is 3.5 to 5.2) and was started on intravenous (IV) potassium as the resident had been reported to have an ileus. Review of the resident's hospital discharge instructions, dated 07/26/24, showed the following: -Basic Metabolic Panel (BMP; bloodwork to measure electrolyte levels including potassium) for hypokalemia to be completed on 07/28/24; -Potassium chloride (potassium supplement) 20 milliequivalents (mEq) tablet, extended release; three tablets twice a day (BID) until 07/28/24, then draw BMP and magnesium level and notify physician to adjust medication; -Potassium chloride 20 mEq, extended release; one tablet once a day at bedtime until 07/28/24, then draw BMP and magnesium level and notify physician to adjust medication. Review of the resident's undated Face Sheet showed the following: -He/She was admitted to the facility on [DATE]; -Diagnoses included an ileus. Review of the resident's Physician's Orders, dated 07/26/24, showed the following: -Potassium chloride 20 mEq tablet, extended release; three tablets BID for hypokalemia (end date 07/28/24); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Potassium chloride 20 mEq, extended release; one tablet once a day at bedtime for hypokalemia (end date 07/28/24). (Review showed no documentation of an order to obtain a BMP on 7/28/24.) Review of the resident's Medication Administration Record (MAR), dated July 2024, showed staff did not administer the potassium chloride 20 mEq, extended release at bedtime on 07/28/24 due to the medication was unavailable. Review of the resident's medical record showed no documentation staff obtained the ordered labs for potassium and magnesium on 7/28/24 through 7/31/24. Review of the resident's Family Nurse Practitioner's progress note, dated 07/30/24, showed an order for a comprehensive metabolic panel. (The progress note did not identify the resident had a diagnosis of hypokalemia and history of an ileus, and did not provide instructions to discontinue or continue the potassium supplement.) Review of the resident's progress note, dated 08/01/24 at 4:01 P.M., showed staff had increased concerns with the resident's confusion and abdominal distension. Labs were drawn with results pending. (The lab for potassium level was originally ordered for 7/28/24 and was not drawn until 08/01/24). Review of the resident's lab report, obtained 08/01/24, showed the following: -The resident's potassium level was obtained on 08/01/24; -No documentation when the facility received report of the results. Review of the resident's medical record for 08/01/24 through 08/03/24 showed no documentation the facility received the results of the resident's ordered lab for potassium level that was obtained on 8/1/24. Review of the resident's Progress Note, dated 08/04/24 at 5:07 P.M., showed lab reported (potassium was 3.0) to the resident's physician and orders obtained for potassium chloride 40 mEq by mouth three times a day (TID) and repeat BMP on 08/08/24. (The facility received the results of the ordered lab on 08/04/24. The original order directed staff to obtain the lab for potassium level on 7/28/24. The resident did not receive potassium supplement from 7/30/24-8/4/24. Once lab results were received on 08/04/24 (seven days after the labs were originally ordered), the physician ordered to restart the potassium.) During an interview on 10/28/24 at 1:35 P.M., the DON said the following: -The resident was admitted to the facility from the hospital on 07/26/24 with a history of an ileus; -The resident's hospital discharge orders included potassium chloride twice a day (BID) and at bedtime, and to recheck potassium level on 07/28/24; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility had issues with the lab company not coming to the facility to obtain labs; this was the reason for the delay in obtaining the resident's ordered labs. The facility also had issues with the lab company not sending the results of ordered labs; -The lab company collected the resident's blood specimen on 08/01/24; -She contacted the lab on 08/02/24 for the results. There were no results and she was unsure why; -She did not work on 08/03/24, and no one contacted the lab for results; -She contacted the lab on 08/04/24 and obtained the results; -Charge nurses have the capability to call the lab company for lab results and should follow up if the labs were not received. During an interview on 10/31/24 at 8:49 A.M., RN A said the following: -The facility had problems with the lab company not completing the ordered labs and with turn around times for results; -Generally, there was a 24-hour turn around time for lab results; -If the facility did not receive the lab results within a 24-hour timeframe, staff should call and inquire about the results; -He/She recalled the facility having to contact the lab for the results of the resident's lab work, but did not recall the date. During an interview on 11/06/24 at 10:00 A.M., the resident's physician said he/she expected staff to follow orders as written. 4. Review of Resident #3's Face Sheet showed he/she admitted to the facility on [DATE] with diagnoses of biliary acute pancreatitis (gallstones get stuck in the ducts that lead from your gallbladder to your small intestines through your pancreas), cholecystitis (inflammation of gallbladder), cholangitis (inflammation in your bile ducts). Review of the resident's hospital discharge orders, dated 10/10/24, showed the following: -Cleanse around biliary drain tube (catheter through the skin and into the bile ducts) with normal saline, pat dry, and apply dry sponge dressing daily and as needed (PRN); -Cleanse around the gastrostomy tube (g-tube; a tube inserted through the belly that brings nutrition directly to the stomach) with normal saline, pat dry, and apply drain sponge daily and PRN. Review of the resident's Physician Orders, dated 10/10/24 to 10/28/24, showed the following: -No documentation of an order to cleanse around biliary drain tube with normal saline, pat dry, and apply dry sponge dressing daily and PRN; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No orders to cleanse around the g-tube with normal saline, pat dry, and apply drain sponge daily and PRN. Review of the resident's Treatment Administration Record (TAR), dated 10/10/24 to 10/27/24, showed the following: -No documentation of an order to cleanse around biliary drain tube with normal saline, pat dry, and apply dry sponge dressing daily and PRN; -No orders to cleanse around the g-tube with normal saline, pat dry, and apply drain sponge daily and PRN. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/17/24, showed the resident's cognition was intact. Review of the resident's Care Plan, dated 10/28/24, showed the following: -He/She required a feeding tube (g-tube); -There was no documentation to show the resident had a biliary drain tube. Observation on 10/28/24 at 11:30 A.M. showed the resident had a g-tube and biliary drain tube. During an interview on 10/28/24 at 11:30 A.M., the resident said he/she had two drains (a biliary drain tube and a g-tube). Earlier that morning, staff told him/her the dressings should have been changed daily. He/She was not sure when the last time they were changed and/or how often they were supposed to be changed. When staff removed the dressings on 10/28/24, the old dressings looked like there was some drainage on them and the g-tube dressing had an odor. During an interview on 10/28/24 at 4:55 P.M., Licensed Practical Nurse (LPN) D said the following: -The resident had a g-tube and biliary drain tube; -Staff should change the dressings daily; -He/She was not sure why staff had not changed the dressings prior to today. -The DON and/or management staff enter all of the orders for all new residents. During an interview on 10/28/24 at 5:00 P.M., the DON said the resident did not have orders for dressing changes to the g-tube and biliary drain tube. After she reviewed the discharge orders, she noted the order was overlooked when transcribed and the resident should have daily dressing changes to both the g-tube and biliary drain tube. She and/or nursing management staff review and transcribe all new admission orders. She was unsure why the order was missed. MO240027 MO240225 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265590	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	200 South St Paris, MO 65275

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO241299