STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265605	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forsyth Care Center	477 Coy Blvd Forsyth, MO 65653

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, record review, and interview, the facility failed to support each resident's right to self-administer medication when the facility did not explore one resident's (Resident #1) ability to self-administer medications and creams the resident had in his/her room. The facility's census was 71. Review of the facility's policy titled, Medication Storage in the Facility, dated April 2017, showed the following: -Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate per facility policy; -A written order for the bedside storage of medications to be present in the resident's medical record; -Bedside storage of medications is indicated on the resident mediation administration record (MAR) and in the care plan for the appropriate medications; -For residents who self-administer medications, the following conditions are met for bedside storage to occur: the manner of storage prevents access by other residents. lockable drawers or cabinets are required only if unlocked storage is deemed inappropriate; facility management should have a copy of the key in addition to the resident; the medications provided to the resident for beside storage are kept in the original containers; and the bedside medication record is reviewed per facility policy; -All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for beside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of the procedure and related policy when necessary; -Bedside medication storage is routinely monitored by facility nursing personnel. 1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and diabetes mellitus (commonly known as diabetes, is a chronic condition characterized by high blood sugar levels). Review of the resident's Admission Agreement, dated and signed by the resident on 04/21/23, showed all prescribed medications and medications such as antacids, cough syrups, laxatives, and ointments brought into the facility, must be left at the nurses' station. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/01/24, and showed the following information: -Moderate cognitive impairment; -Staff did not mark application of ointments/medications other than to feet. Review of the resident's care plan, updated on 11/12/24, showed the following information: -The resident was at risk for skin breakdown related to history of burns, diabetes melilites, and oxygen use; -The resident's skin would remain intact; -The staff would observe the resident for presence of risk factors; -The resident's skin would be kept clean and dry as possible. Review of the resident's December 2024 Physician Order Summary Report (POS) showed the following: -An order, dated 05/31/23, for abilify (used to treat bipolar disorder) 20 milligram (mg), 1 tab, once daily at 8:00 A.M.; -An order, dated 11/05/24, for lexapro (used to treat anxiety) 20 mg, 1 tab once a day at 12:00 P.M. (Staff did not document any orders related to medicated shampoo or medicated cream.) Review of the resident's physician progress note, dated 12/06/24, showed the following: -The resident was getting meds from a telehealth mental health doctor and had someone take him/her to a local pharmacy to get them; -A box was found in the resident's room that contained abilify and lexapro, both of which he/she received at the facility, but with different dosages; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was educated about it being a dangerous practice and that doubling doses could have serious and dangerous effects. Review of the resident's current care plan showed staff did not update the care plan to reflect the medication storage of the duplicate medications in the resident's room. Review of the resident's medical record showed staff did not document regarding if the resident would be a able to store his/her medications at bedside. Observation on 12/16/24, at 10:05 A.M., of the resident's face and ears showed the following: -The resident had scaly patches of skin, yellowish in color, on his/her forehead, in the temple area on both sides of his/her face, and on the resident's head; -A partially used tube, labeled ketoconazole (antifungal) cream 2%, was observed on the resident's bedside table; -The resident had a prescribed bottle of medicated shampoo, ketoconazole shampoo 2%, in his/her cabinet; -The shampoo was prescribed by a physician and was filled on 12/01/24; -The directions on the prescription read, shampoo scalp and beard 1 time daily for two weeks, let soak five minutes and rinse. During an interview on 12/16/24, at 10:05 A.M., the resident said the following: -The resident washed his/her face in his/her bathroom; -The resident applied the ketoconazole cream to his/her face one to two times a day; -The resident said he/she had a fungus on his/her skin that caused his/her skin to build up and get crusty; -The resident said his/her dermatologist prescribed the cream and shampoo; -The resident did not know if staff were aware that he/she had the prescribed shampoo and cream at his/her bedside. During an interview on 12/16/24, at 1:10 P.M., Certified Nursing Assistant (CNA) A said the following: -All prescription medication was to be kept in the medication cart or medication room; -Residents were not allowed to keep any medication at bedside without an order from the physician; -A prescription was required for a resident using a medicated shampoo or cream; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A was not aware of the resident had a medicated shampoo or a medicated cream. During an interview on 12/16/24, at 3:37 P.M., CNA F said the following: -CNA F was not aware of the resident having any prescribed medication at his/her bedside; -CNA F was not aware of the resident having prescribed shampoo and cream to treat a fungus; -CNA F would report to the certified medication technician (CMT) or registered nurse (RN) any found prescribed or over the counter medication found at a resident's bedside. During an interview on 12/16/24, at 1:21 P.M., CMT B said the following: -No prescribed medications or creams were to be kept bedside without a physician order; -The nurse was responsible for providing treatments, including creams, to the residents; -CMT B looked at the resident's physician orders and did not see orders for a cream or shampoo. During an interview on 12/16/24, at 1:50 P.M., RN C said the following: -Residents should not have prescribed medication or treatments at bedside without an order from the physician; -The resident sees other physicians when he/she is out of the building and will set up procedures, obtain new prescriptions, and not inform the facility; -The resident had brought other creams and medication into the facility previously; -The resident was not compliant with following physician orders or facility policy. During an interview on 12/16/24, at 1:33 P.M., the resident's physician said the following: -The resident had no orders for a medicated shampoo or cream; -All prescribed treatments should be on the resident's Medication Administration Record (MAR); -The physician felt the resident would be a candidate to have medications, including the cream and shampoo at his/her bedside; -The physician is fine with residents keeping treatments at bedside as long as there is an order for the treatment. During an interview on 12/16/24, at 2:40 P.M., the Director of Nursing (DON) said the following: -Last month the resident had brought into the facility two prescriptions, abilify and lexapro; -The resident set up telehealth psych services on his/her own and did not inform the facility; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was already prescribed ability and lexapro from the facility physician; -The DON spoke with the resident regarding the facility policy on bringing in outside medications; -The resident said he/she understood the safety concern. During an interview on 12/16/24, at 3:54 P.M., the Administrator said over the counter medications and prescription medications should not be kept at a resident's bedside without a physician order. MO00246507

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, interview, and record review, the facility staff failed ensure each resident's right to self-determination was supported when facility staff failed to offer and provide showers as preferred for one resident (Resident #1). The facility census was 71. Review of the facility's policy titled, Activities of Daily Living (ADLs), undated, showed the following: -This facility provides each resident with care, treatment, and services according to the resident's individualized care plan. -Based on the individual resident's comprehensive assessment, facility staff will ensure that each resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that the decline was unavoidable, including: bathing, dressing, grooming, transferring, locomotion, ambulation, toileting, eating and communication. 1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and diabetes mellitus (commonly known as diabetes, is a chronic condition characterized by high blood sugar levels). Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 11/01/24, and showed the following information: -Moderate cognitive impairment; -Required setup or clean-up assistance when shower/bathing. Review of the resident's monthly summary, dated 11/07/24, showed the following: -The resident required assistance with grooming and hygiene; -The resident required set-up assess with showering/bathing. Review of the resident's care plan, updated on 11/12/24, showed the following: -The resident had self-care deficits with ADLs such as bathing, hygiene, dressing, and toileting related to weakness and shortness of breath; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident will shampoo and shower two times a week with fingernails and toenails cleaned and checked; -The resident required one staff assistance with help getting dressed, toileting, and bathing. Review of the resident's shower sheets, dated 10/01/24 through 12/16/24, showed the following: -One shower sheet, dated 11/22/24, showed the resident showered by him/herself after supper; -There were no other shower sheets for the resident during that timeframe. Observation on 12/16/24, at 10:05 A.M., showed the following: -The resident had scaly patches of skin, yellowish in color, on his/her forehead, in the temple area on both sides of his/her face, and on the resident's head; -A partially used tube, labeled ketoconazole (an antifungal medication) cream 2%, was observed on the resident's bed side table; -The resident had a prescribed bottle of medicated shampoo, Ketoconazole shampoo 2%, in his/her cabinet; -The directions on the prescription read, shampoo scalp and beard one time daily for two weeks, let soak five minutes and rinse; -The tamper/safety seal was secured to the bottle showing that the shampoo had not been opened. During an interview on 12/16/24, at 10:05 A.M., the resident said the following: -The resident washes his/her face in his/her bathroom; -The resident has not had a shower in three weeks; -The resident has asked staff for a shower and staff blow him/her off; -The resident got tired of asking staff for a shower; -The resident had not refused any showers; -The resident wanted a shower at least once a week. During an interview on 12/16/24, at 1:10 P.M., Certified Nursing Assistant (CNA) A said the following: -Residents received a shower at least once a week; -A shower aide was available every day during the week; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Showers were documented on shower sheets and kept in the shower book at each nursing station; -CNA A was not sure when the resident last received a shower or how often the resident showered. During an interview on 12/16/24, at 1:21 P.M., Certified Medical Technician (CMT) B said the following: -Residents received showers twice a week; -CMT B was not aware of the resident's shower schedule. During an interview on 12/16/24, at 1:33 P.M., the resident's physician said the resident should receive a shower at least twice a week and/or as needed. During an interview on 12/16/24, at 1:50 P.M., Registered Nurse (RN) C said the following: -Residents received showers at least twice a week; -Resident showers were documented on shower sheets and kept in the shower books at each nursing station; -The resident was advised to wash his/her face and apply lotion; -The resident wants to do what the resident wants to do when he/she wants to do it; -The resident was not compliant with following physician orders or facility policy. During an interview on 12/16/2,4 at 2:04 P.M., CNA D said the following: -CNA D was a shower aide; -Residents' showers were documented on shower sheets and kept in the shower book at the nurses' station; -The last shower sheet for the resident was from 11/22/24 and showed the resident does self after supper. During an interview on 12/16/24, at 3:35 P.M., CNA E said the resident's shower day was Friday. The resident often refuses showers. During an interview on 12/16/24, at 3:37 P.M., CNA F said the following: -The resident showers him/herself and did not ask for help; -The resident was very independent; -The resident was offered a shower every Friday; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was allowed to shower anytime he/she asked; -The resident had not showered on Fridays during the day for several weeks; -Resident showers are documented on shower sheets and kept in the shower book; -Residents refusing showers are documented on the shower sheet and kept in the shower book. During an interview on 12/16/24, at 2:40 P.M., the Director of Nursing (DON) said the following: -The resident typically showers on his/her own; -The resident has a history of refusing showers; -Residents should receive a shower at least twice a week. During an interview on 12/16/24, at 3:54 P.M., the Administrator said the following: -Resident showers are done a minimum of once a week, preferably twice a week; -Shower refusals by residents should be documented on a shower sheet and kept in the shower book. MO00246507

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, interview, and record review, the facility failed provide care per standards of practice to all residents when staff failed to to assess, identify, and provide appropriate treatment for a skin condition and failed to notify the physician of the change in condition for one resident (Resident #1) who developed a skin condition on the resident's face and head that required prescription shampoo and cream to treat. The facility census was 71 residents. Review of the facility's policy titled Wound Prevention, revised 8/2023, showed the following: -Conduct a comprehensive assessment upon move in to identify any existing wounds, skin conditions, or risk factors for wound development; -Perform routine skin assessments on all residents during regular monthly assessments; -Document and review the assessed information to establish appropriate wound prevention measures for each resident; -Promote good hygiene practices, including regular showering, and regular changing of soiled garments or incontinence products; -Ensure the use of mild, pH-balanced, fragrance-free soaps, moisturizers, and protective creams suitable for the individual resident's skin condition; -Document all wound prevention measures, assessments, and interventions in resident's service plan and medical records; -Promptly report an new wounds, changes in skin condition, or concerns related to wound preventions to the appropriate healthcare personnel. 1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and diabetes mellitus (commonly known as diabetes, is a chronic condition characterized by high blood sugar levels). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/01/24, and showed the following information: -Moderate cognitive impairment; -The resident had no ulcers, wounds, or skin problems; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident received no applications of ointment/medications. Review of the resident's monthly summary, dated 11/07/24, showed the condition of the resident's skin was fair, warm, and dry. Review of the resident's care plan, updated on 11/12/24, showed the following information: -The resident was at risk for skin breakdown related to history of burns, diabetes melilites, and oxygen use; -The resident's skin would remain intact; -The staff would observe the resident for presence of risk factors; -Staff would conduct a systematic skin inspection weekly and with showers. Review of the resident's weekly skin assessment, dated 12/04/24, completed by Registered Nurse (RN) C showed the resident's skin intact with no skin issues and no interventions or treatments in place. Review of the resident's weekly skin assessment, dated 12/11/24, completed by Licensed Practical Nurse (LPN) G showed the resident's skin intact with no skin issues and no interventions or treatments in place. Observation on 12/16/24, at 10:05 A.M., showed the following: -The resident had scaly patches of skin, yellowish in color, on his/her forehead, in the temple area on both sides of his/her face, and on the resident's head; -A partially used tube, labeled ketoconazole (antifungal) cream 2%, was observed on the resident's bed side table; -The resident had a prescribed bottle of medicated shampoo, ketoconazole shampoo 2%, in his/her cabinet; -The directions on the prescription read, shampoo scalp and beard one time daily for two weeks, let soak five minutes and rinse; -The fill date on the bottle showed 12/01/24; -The tamper/safety seal was secured to the bottle showing that the shampoo had not been opened. During an interview on 12/16/24, at 10:05 A.M., the resident said the following: -The resident washed his/her face in his/her bathroom; -The resident applied the ketoconazole cream to his/her face one to two times a day; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said he/she had a fungus on his/her skin that caused his/her skin to build up and get crusty; -The resident said his/her dermatologist prescribed the cream and shampoo. Review of the resident's medical record showed staff did not document notifying the resident's physician the skin condition on the resident's face. During an interview on 12/16/24, at 1:33 P.M., the resident's physician said he was not aware of the resident having a fungus or skin condition affecting the resident's face or head. During an interview on 12/16/24, at 1:21 P.M., Certified Medical Technician (CMT) B said the following: -The nurse was responsible for completing weekly skin assessments on the resident; -The nurse is responsible for providing treatments, including creams, to the residents; -The resident appeared to have psoriasis (a chronic skin condition that causes inflamed, raised plaques of skin that are often covered in silvery scales) on his/her face. During an interview on 12/16/24, at 1:50 P.M., RN C said the following: -The resident had dry skin around his/her face and was referred to the physician; -The resident was advised to wash his/her face and apply lotion; -RN C had offered several times to assist the resident with washing his/her face; -The resident did have a rash; -RN C completes skin assessments; -RN C had notified the physician of the resident's skin condition before and the resident was on the physician's list to be seen; -RN C did not remember when he/she had notified the physician about the resident's skin condition. During an interview on 12/16/24, at 3:35 P.M., Certified Nurse Aide (CNA) E said the following: -He/she had not noticed any changes in the resident's skin condition; -When CNA E notices anything new regarding a resident's skin condition he/she reports it to the RN; -RN's are responsible for completing skin assessments with the residents. During an interview on 12/16/24 at 3:37 P.M., CNA F said the resident regularly had dry skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/24, at 3:45 P.M., the Assistant Director of Nursing (ADON) said the following: -Staff should report a change in the resident's skin condition to the charge nurse, who would then report it to the physician; -The ADON saw the resident this morning, but did not notice the dry skin on the resident's face; -The ADON was not aware that the resident had any orders for shampoo or cream to treat the dry skin or fungus. During an interview on 12/16/24 at 3:54 P.M., the Administrator said the following: -Residents should be receiving thorough skin assessments by the nurse; -Any changes in the residents' skin should be documented on the skin assessment; -Any change in a resident's skin should also be reported to the physician. MO00246507