STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265643	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center Inc	810 East Edwards Street Maryville, MO 64468

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 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** 44395 Based on observation, record review and interviews, the facility failed to ensure they maintained a safe, clean, comfortable environment for the residents when staff did not keep all areas of the facility clean and safe and when they did not maintain the only drinking fountain. The facility census was 28. The facility did not provide an environmental policy. 1. Observations beginning on 4/23/24 at 9:24 A.M. showed: -room [ROOM NUMBER] door had scuff marks, the frame had chipped paint with exposed wood; -The exit door's frame was chipped, exposing wooden frame underneath; -The fan heater below the handrail, had a bent metal frame, causing a sharp protrusion of metal at knee/calf height; -Sliding bathroom door of room [ROOM NUMBER] had molding loose on one side, with a 2 inch screw exposed; -Sliding bathroom door of room [ROOM NUMBER] had molding loose on one side, with 2 screws, measuring 1.5 inches and 1 inches, exposed; -room [ROOM NUMBER] door frame had chipped paint with exposed wood; -room [ROOM NUMBER] door frame had chipped paint with exposed wood; -room [ROOM NUMBER] had large gouges and chips in the sheet rock behind the resident's bed. The door frame was chipped with exposed wood; -200 hall fire door laminate was chipped with exposed wood; -The mattress in room [ROOM NUMBER] plastic, protective coating was peeling with foam exposed; -room [ROOM NUMBER] had large gouges and scrapes into the sheetrock behind the resident's chair. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/24 at 12:15 P.M. the Maintenance Supervisor said: -He started working at the facility about eight months ago; -He was aware there are areas that need to be fixed; -He was working on a schedule of repairs and audits. During an interview on 4/25/24 at 9:36 A.M. the Administrator said: -She was aware that there are door frames that need repaired; -She had a list by room for needed repairs; -There is a performance improvement plan (PIP) for building repairs; -The new maintenance man had made major strides in completing tasks; -Once a week housekeeping should wash resident's beds and notify her if there are any rips, tears or reason to replace the mattress. 27584 2. Observation on 4/23/24 at 1:07 P.M., showed the only water fountain in the facility, by the nurse's station near room [ROOM NUMBER], did not dispense water when pushed. Observation on 4/23/24 at 1:10 P.M. showed a hydration station by the activity room. Observation on 4/24/24 at 9:38 A.M., showed no exception posted for the hydration station in lieu of a water fountain. During an interview on 4/24/24 at 11:30 A.M., the Administrator said the Director of Nursing had worked at the facility for five years and the water fountain had not worked since she worked at the facility. They thought it may have been disconnected due to COVID-19. They set up a hydration center near the activity room and thought they did not need the water fountain. They did not realize a State tag existed that said the water fountain needed to be maintained and in good repair. They had not received or submitted approval for an exception to the regulation.

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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** 46987 Based on observation, interview and record review, the facility failed to ensure residents had a complete, accurate and individualized care plan, to address the specific needs for three of the 12 sampled residents (Residents #1, #13 and #22). The facility census was 28. Review of the facility's 2018 policy on Resident's Plan of Care., showed: -Every resident will have a formal plan of care within 48 hours of admission. The care plan team is responsible for periodic review and updating of care plans. -Care plans should be updated when there is a significant change in the resident's condition, with a readmission from the hospital, and at least quarterly. Review of Resident #22's Admission MDS (Minimum Data Set) A federally mandated comprehensive assessment completed by facility staff. Completed on 3/26/24., showed: - Not Cognitively Intact - History of behaviors and wondering in the last 7 day look back period. - Limited supervision with activities of daily living. - Independent with mobility and meals. - Diagnoses: Right femur fracture, dementia with mood disturbances, anxiety, heart failure. - Admission 3/20/24 - Not Cognitively Intact Review of Physicians Orders for the month of March 2024., showed: -Lorazepam 0.5 mg by mouth three times a day as needed for anxiety. -Antibiotics for Urinary Tract Infection- Cephalexin 500 mg by mouth four times a day from 4-11-24 through 4-18-24 -Hydrocodone 5-325 mg by mouth every 8 hours as needed for pain. -Lorazepam 0.5 mg by mouth four times a day at 8 A.M. 12 Noon, 4 P.M. and 8 P.M. routinely. -Zoloft 50 mg by mouth daily. - Up ad lib (Up when the resident wants to be and independently) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No orders for any positioning alarms in the physician orders. Review of March 2023 medication administration records., showed: - 4/17/24 at 6:00 A.M. Lorazepam 0.5 mg given- Resident fell on [DATE] at 10:30 A.M. - 4/17/24 at 8: 00 A.M. Hydrocodone 5-325 mg given for pain- Resident fell at 4/17/24 at 10:30 A.M. - 4/20/24 at 6 :00 A.M. Lorazepam 0.5 mg given- Resident fell on [DATE] at 8:20 A.M. - 4/20/24 at 8:00 A.M. Zoloft 50 mg given- Resident fell on [DATE] at 8:20 A.M. - 4/20/24 at 6:30 A.M. Hydrocodone 5-325 mg given for pain- Resident fell at 8:20 A.M. - 4/24/24 at 6:00 A.M. Lorazepam 0.5 mg given- Resident fell on [DATE] at 7:15 A.M. - 4/24/24 at 6:21 A.M. Hydrocodone 5-325 mg given for pain- Resident fell on [DATE] at 7:15 A.M. Review of progress notes in the medical record for the month of March, 2023., showed: - 4/17/24 at 10:30 A.M., witnessed fall that resident fell while ambulating with only one shoe on and without walker in resident's room. Resident expressed pain to the back of his/her head. Daughter notified and neurological checks started. Pupils documented as sluggish. No other interventions. - 4/20/24 at 8:20 A.M., unwitnessed fall in the resident's room. Resident expressed moderate pain in the back with abrasion and bruising to arm. Found by staff lying on side between the bed and wall. Note does not indicate who found the resident, which side resident was lying on the floor, or where the area of bruising was located. Linens on the floor indicated resident fell due to linens around feet. Resident was placed in bedside chair with an alarm. -4/24/24 at 7:15 A.M., unwitnessed fall in the resident's room. Resident expressed pain at tailbone area. No injury noted in the progress notes. Resident was found sitting on the floor with pajama bottoms and brief at the resident's knees. Assisted to toilet with max assist of two certified nursing assistants. Physician and daughter notified. Request to the physician for body alarm was the first intervention. - There was no documentation in the clinical record to support any changes to the care plans or interventions related to medication usage. Review of the resident's care plan prior to 4/24/24., showed: - Supervision needed with ambulation and that resident used a four wheeled walker with a seat. - Resident is at risk for falls. Interventions are to monitor the resident's activity. and provide non-slip footwear. - Pain associated with previous hip fracture, to monitor for pain and medicate as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No care plan related to Urinary Tract Infection and increase fall risk. - No care plan related to personal alarms. - No care plan related to moving the resident closer to the nurses station. During an interview on 4/24/24 at 4:00 P.M. the Director Of Nursing (DON) said; - She and the Administrator had spoken with the family of the resident regarding the possibility of moving the resident into a room closer to the nurses station that morning. - The DON is currently completing the MDS and Care Plans for the facility and the nurses can also update the care plans. - The resident's physician will order and provide whatever the family's wishes are. - Care plans should be updated with a change in the residents routine or needs. During an interview on 4/24/24 at 4:10 P.M., the Administrator said: - A fall risk assessment was not re-assessed for the resident, since the resident was already a high risk for falls. - Changes in residents conditions should be care planned. - She would consider a hematoma an injury and neurological assessments have been every 15 minutes. - They were working on other interventions and met with family this morning. - The goal would be to have the resident moved closer to the nurses station. - She would expect personal alarms and positioning devices to have a physician order. 44395 2. Review of Resident #1 Quarterly MDS dated [DATE] showed: -Brief Interview of Mental Status (BIMS) of 14, indicated no cognitive loss; -Able to understand and make self understood; -Independent for Activities of Daily Living (ADL's: fundamental skills required to care for oneself, such as eating, bathing, and mobility); -No limits in range of motion; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included: Atrial Fibrilliation (irregular and often very rapid heart rhythm), diabetes (a condition that affects how your body turns food into energy), dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and macular degeneration (disease that affects a person's central vision and can result in a severe loss of vision). Review of the resident's April 2024 physician order sheet showed: -Azelastine aerosol spray; 137 micrograms (mcg), one spray each nostril twice a day as needed for seasonal allergic rhinitis. (May keep at bedside and self administer) -Flonase allergy relief 50 mcg, two sprays once a day as needed for seasonal allergic rhinitis (may keep at bedside) Review of the resident's comprehensive Care Plan dated 2/2/24 showed: -No care plan for keeping medications at bedside. Review of Resident #1's Self Administration Assessment completed 1/31/24 showed: -The resident was alert and oriented; -He/she was able to make needs and decisions; -He/She was capable and able to administer own medications of Flonase, and Azelastine. Observation on 4/22/24 at 3:25 P.M. showed the resident had Azelastine nasal spray and Flonase nasal spray sitting out on his/her over the bed table. During an interview on 4/22/24 at 3:25 P.M. the resident said: -He/She takes the sprays once a day when he/she needed them for allergies. 3. Review of Resident #13 Annual MDS dated [DATE] showed: -BIMS of 11, indicated some cognitive loss; -Rejection of care 1-3 days; -Substantial to maximum assistance with ADL's; -Therapeutic Diet; -Diagnoses of : Dementia, Congestive Heart Failure (a weakened heart that causes fluid buildup in the feet, arms, lungs, and other organs), cardiac pacemaker (a small device, implanted in the chest, to treat irregular heartbeats) and respiratory failure (a condition where the blood does not have enough oxygen) Review of the resident's April physician order sheets showed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diet: Regular/No Added Salt (NAS: a diet that limits the amount of salt intake); -2500 milliliter (ml) fluid restriction in 24 hours. Review of Resident #13's Comprehensive Care Plan showed: -No care plan for fluid restriction and NAS diet. Observation on 4/22/24 at 12:16 P.M. showed: -He/She requested salt for his/her meal; -Certified Nurse Aide (CNA) A gave the salt shaker to the resident; -He/She liberally salted his/her food. During an interview on 4/25/24 at 8:45 A.M. CNA A said: -He/she did not know if any resident was on a no added salt diet; -Resident #13 was on a fluid restriction; the resident does not follow it. 4. During an interview on 4/25/24 at 8:38 A.M. CNA B said: -He/She was not aware of residents with medications at bedside; -Resident #13 is on a fluid restriction, but is non complaint and gets his/her own water and soda; -He/She tries to limit the resident's fluid but is not always able, since the resident can get it him/herself; -The care plan is used to tell what care a resident needs; -There is a communication book to notify staff of any changes to the care plan. 5. During an interview on 4/25/24 at 9:08 A.M. RN A said: -He/She started work at the facility about a week ago; -He/She was not sure if anyone was on a fluid restriction or no added salt diet; -He/She was not sure about medication at bedside; -He/She can update care plans as needed, then would notify the Director of Nursing of updates. 6. During an interview on 4/25/24 at 9:36 AM the DON said: -There was a care plan book at the desk with a working copy of the care plan; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The computer care plan is updated quarterly; -Residents who have keep at bedside orders should have a care plan. 7. During an interview on /25/24 at 9:56 AM the Administrator said: -She was not aware there was a resident with medication at bedside; -Care plans are updated as needed, then computer updates are completed quarterly; -Any changes in a care plan are passed on in report from the nurse to the CNA's; -New staff are educated about care plans in New Employee Orientation; -A CNA communication/report book was at the nurse's station for any changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46987 Based on observation, interview, and record review, the facility failed to ensure systems and interventions were put in place for one resident to ensure the resident's safety, (Resident #22), This resident had a urinary infection, severely impaired cognition, medication use daily for anxiety as well as narcotic use and had sustained three falls with in a week's time resulting in a hematoma (a collection for blood outside of the broken blood vessel, causing swelling and bruising) to the back of the head, without additional interventions put into place. This effected one resident (Resident #22), of 12 sampled residents. The facility census was 28. Review of the facility policy on Fall Clinical Protocol, dated March of 2018., showed: - The nursing staff will help identify individuals with a history of falls and risk factors for falling. - Those individuals with repeated falls often have an underlying cause. - Staff will identify medical conditions affecting fall risk, complications of falls, and risks for bleeding associated with a fall. - Appropriate interventions will be put into place to prevent further falls. 1. Review of Resident #22's Admission MDS (Minimum Data Set) A federally mandated comprehensive assessment completed by facility staff. Completed on 3/26/24., showed: - Not Cognitively Intact; - History of behaviors and wondering in the last 7 day look back period; - Limited supervision with activities of daily living; - Independent with mobility and meals; - Diagnoses: Right femur fracture, dementia with mood disturbances, anxiety, heart failure; - Admission 3/20/24. Observation on 4/22/24 at 12:30 P.M., showed: - Resident sitting in the dining room with elbow on table, resting his/her head in the palm of his/her hand and eye closed with lunch tray uneaten; - Resident had purple, raised bump the size of a golf ball to the back of his/her head and small bruises to bilateral hands and forearms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/22/24 at 1:45 P.M., showed: -Resident's room is the last room at the end of the hallway, and farthest from the nurses station; - The resident is alone in this room and is without a roommate; - Resident is unable to utilize a call light related to severe cognitive impairment, even though the call light is in close proximity to the resident's reach. Observation on 4/23/24 at 8:30 A.M., showed: - Resident sitting at the dining room table rest his/her head on right arm, sleeping, with breakfast meal sitting in front of him/her, and untouched. Observation on 4/23/24 at 12:15 P.M., showed; -Resident sitting in the front living room, holding head, and appears sleepy. Observation on 4/24/24 at 10:11 A.M., showed: - Resident walking alone with walker after morning fall, outside of the resident's room. - Once staff saw the resident walking alone, a gait belt was then applied to the resident's waist. - There was no alarm sounding to indicate the resident was up and walking alone. Review of Physicians Orders for the month of March 2024., showed: -Lorazepam 0.5 mg by mouth three times a day as needed for anxiety. -Antibiotics for Urinary Tract Infection- Cephalexin 500 mg by mouth four times a day from 4-11-24 through 4-18-24 -Hydrocodone 5-325 mg by mouth every 8 hours as needed for pain. -Lorazepam 0.5 mg by mouth four times a day at 8 A.M. 12 Noon, 4 P.M. and 8 P.M. routinely. -Zoloft 50 mg by mouth daily. - Up ad lib (Up when the resident wants to be and independently) -No orders for any positioning alarms in the physician orders. Review of March 2023 medication administration records., showed: - 4/17/24 at 6:00 A.M. Lorazepam 0.5 mg given- Resident fell on [DATE] at 10:30 A.M. - 4/17/24 at 8: 00 A.M. Hydrocodone 5-325 mg given for pain- Resident fell at 4/17/24 at 10:30 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/20/24 at 6 :00 A.M. Lorazepam 0.5 mg given- Resident fell on [DATE] at 8:20 A.M. - 4/20/24 at 8:00 A.M. Zoloft 50 mg given- Resident fell on [DATE] at 8:20 A.M. - 4/20/24 at 6:30 A.M. Hydrocodone 5-325 mg given for pain- Resident fell at 8:20 A.M. - 4/24/24 at 6:00 A.M. Lorazepam 0.5 mg given- Resident fell on [DATE] at 7:15 A.M. - 4/24/24 at 6:21 A.M. Hydrocodone 5-325 mg given for pain- Resident fell on [DATE] at 7:15 A.M. Review of progress notes in the medical record for the month of March, 2023., showed: - 4/17/24 at 10:30 A.M., witnessed fall that resident fell while ambulating with only one shoe on and without walker in resident's room. Resident expressed pain to the back of his/her head. Daughter notified-Neurological checks started. Pupils documented as sluggish. No other interventions. - 4/20/24 at 8:20 A.M., unwitnessed fall in the resident's room. Resident expressed moderate pain in the back with abrasion and bruising to arm. Found by staff lying on side between the bed and wall. Note does not indicate who found the resident, which side resident was lying on the floor, or where the area of bruising was located. Linens on the floor indicated resident fell due to linens around feet. Resident was placed in bedside chair with an alarm. -4/24/24 at 7:15 A.M., unwitnessed fall in the resident's room. Resident expressed pain at tailbone area. No injury noted in the progress notes. Resident was found sitting on the floor with pajama bottoms and brief at the resident's knees. Assisted to toilet with max assist of two certified nursing assistants. Physician and daughter notified. Request to the physician for body alarm was the first intervention. Review of the resident's care plan prior to 4/24/24., showed: - Supervision needed with ambulation and that resident used a four wheeled walker with a seat. - Resident is at risk for falls. Interventions are to monitor the resident's activity. and provide non-slip footwear. - Pain associated with previous hip fracture, to monitor for pain and medicate as needed. - No care plan related to Urinary Tract Infection and increase fall risk. - No care plan related to personal alarms. - No care plan related to moving the resident closer to the nurses station. During an interview on 4/23/24 at 10:45 A.M. Certified Medication Tech (CMT) A said the resident had shown a decline in the last week with more falls, more sleepiness, and less of a desire to participate in meals with feeding his/her self. CMT said the resident get Lorazepam four times a day and narcotics for pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/24 at 11:30 A.M. Restorative Aid (RA) A said the he/she had noticed in the last week that the resident is much slower, needing more assistance with daily care, and had another fall that morning. RA said he/she had not considered the possibility of moving resident closer to the nurses station. During an interview on 4/24/24 at 3:45 P.M. the resident's family member said he/she was aware that recent infection, use of anxiety medications and narcotics, placed the resident at risk for more falls. He/She spoke with facility administrator regarding the possibility of moving the resident to a room closer to the nurses station. Family member said that the resident had a hip fracture at home resulting from a fall which is why he/she was now at the nursing home. The family member said keeping the resident sedated is better than having resident upset with behaviors. During an interview on 4/24/24 at 4:00 P.M. the Director Of Nursing (DON) said; - She and the Administrator had spoken with the family of the resident regarding the possibility of moving the resident into a room closer to the nurses station that morning. - The DON is currently completing the MDS and Care Plans for the facility and the nurses can also update the care plans. - The resident's physician will order and provide whatever the family's wishes are. During an interview on 4/24/24 at 4:10 P.M., the Administrator said: - A fall risk assessment was not re-assessed for the resident, since the resident was already a high risk for falls. - Changes in residents conditions should be care planned. - She would consider a hematoma an injury and neurological assessments have been every 15 minutes. - They were working on other interventions and met with family this morning. - The goal would be to have the resident moved closer to the nurses station. - She would expect personal alarms and positioning devices to have a physician order.