STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265655	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Living Center	404 E Third Street Stover, MO 65078

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37131 Based on interview and record review, facility staff failed to consistently document the code status as Do Not Resuscitate (DNR) or Full Code (Cardiopulmonary resuscitation (CPR)) in the comprehensive care plan for nine residents (Resident #10, #18, #19, #21, #40, #41, #42, #8, and #32), and failed to transcribe or correct code status orders for two residents (Resident #8, and #32) out of 14 sampled residents. The facility census was 45. 1. Review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR/DNR) Policy, dated [DATE], showed when a resident chooses to be a Full Code or a DNR, the order should be approved by the physician and entered into the electronic medical record as such. A DNR paper or Transportable Physician Order for Patient Preferences (TPOPP) must be signed by a physician. Review of the facility's policy titled, Physician Orders per e-Charting, dated [DATE], showed: -Any new order is to be transcribed to the paper physician order form by the physician or the nurse taking the verbal order; -The order is to immediately be entered into the electric chart by the nurse taking off the order; -24 hour chart audits are to be completed daily to ensure that all new orders have been addressed. Review of the facility's policy titled, Care Plan Completion Policy, dated [DATE], showed: -The facility shall use a care plan to provide daily care and treatment to the resident; -The care plan shall be completed and updated according to regulatory requirements; -Care plans shall be reviewed and updated at least upon admission, and quarterly and/or significant change; -For items that need addressed or revised prior to the next care plan meeting, a Care Plan Addendum shall be completed, and copy given to all departments; (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident has a right to refuse any or all portions of the plan of care; the refusal shall be noted in a progress note by the Minimum Data Set (MDS), a federally mandated assessment tool completed by staff, Coordinator or Social Service Designee (SSD) at the completion of the care plan meeting and/or as needed; -The MDS Coordinator shall initiate care plan addendums at any time an individual presents a need that requires a change or addition to the care plan; -The Director of Nursing (DON) shall ensure that the care plan is completed according to the resident's individual and unique needs and that measurable goals with timeframes are continued throughout the resident's stay. 2. Review of Resident #10's Quarterly MDS, dated [DATE], showed staff documented the resident cognitively intact. Review of the resident's face sheet, undated, showed staff documented the resident's code status as DNR. Review of the Physician Order Sheet (POS), dated [DATE], showed an order for a code statusas DNR. Review of the medical record showed a TPOPP and Out of Hospital DNR (OHDNR) dated [DATE]. Review of the care plan, dated [DATE], showed staff did not document the resident's code status. During an interview on [DATE] at 2:53 P.M., the MDS coordinator said he/she did not know the code status is not listed in the resident's care plan, but saidit should be. 3. Review of Resident #18's Significant Change MDS, dated [DATE], showed staff assessed the resident as significantly cognitively impaired. Review of the resident's Face Sheet, undated, showed staff documented the resident's code status as DNR. Review of the POS, dated [DATE], showed an order for DNR code status dated [DATE]. Review of the care plan, dated [DATE], showed staff did not document the resident's code status. 4. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident with moderate cognitive impairment. Review of the resident's Face Sheet, undated, showed staff documented the resident's code status as DNR. Review of the POS, dated [DATE], showed an order for DNR code status dated [DATE]. Review of the care plan, dated [DATE], showed staff did not document the resident's code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:59 P.M., the MDS Coordinator said he/she does not know the resident's code status and the code status should be on the resident's care plan. He/She said he/she does not know why it is not in the care plan. During an interview on [DATE] at 3:38 P.M., the SSD said the resident should have his/her code status on his/her care plan. The SSD said he/she can't remember if he/she told the MDS Coordinator the resident's code status. During an interview on [DATE] at 11:17 A.M., the DON said the resident should have a code status on his/her care plan. 5. Review of Resident #21's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's Face Sheet, undated, showed staff documented the resident's code status as DNR. Review of the POS, dated [DATE], showed an order for DNR code status dated [DATE]. Review of the care plan, dated [DATE], showed staff documented the resident's code status as full code. During an interview on [DATE] at 2:54 P.M., the MDS Coordinator said he/she thinks the resident's code status should be on the care plan. The MDS Coordinator said he/she should update the resident's care plan immediately if the resident's code status changes. The MDS Coordinator said he/she knows the resident had a code status change and to be honest he/she forgot to update the resident's care plan, it should have been updated. During an interview on [DATE] at 3:38 P.M., the SSD said during the resident's care plan meeting, the resident said he/she wanted to be a DNR and signed the forms. The SSD said he/she did not check the resident's care plan. The SSD said the resident's care plan should have been updated. During an interview on [DATE] at 11:17 A.M., the DON said he/she knows the resident switched to a DNR code status. The DON said he/she did not know the resident's care plan had him/her listed as a Full code. The DON said the resident's care plan should be updated immediately with code status change. 6. Review of resident #40's Quarterly MDS, dated [DATE], showed staff assessed the resident with mild cognitive impairment. Review of the resident's face sheet, undated, showed staff documented the resident's code status as full code. Review of the POS, dated [DATE], showed an order for full code status. Review of the TPOPP, undated, showed staff documented the resident's code status as full code. Review of the care plan, dated [DATE], showed staff did not document the resident's code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #41's Quarterly MDS, dated [DATE], showed staff assessed the resident as rarely/never understood, and with short and long term memory problems. Review of the resident's face sheet, undated, showed staff documented the resident's code status as DNR. Review of the POS, dated [DATE], showed an order for DNR code status dated [DATE]. Review of the resident's care plan, dated [DATE], showed staff did not document the resident's code status. 8. Review of Resident #42's Quarterly MDS, dated [DATE], showed staff assessed the resident as rarely/never understood, and with short and long term memory problems. Review of the resident's face sheet, undated, showed staff documented the resident's code status as DNR. Review of the resident's POS, dated [DATE], showed an order for DNR code status dated [DATE]. Review of the resident's care plan, dated [DATE], showed staff did not document the resident's code status. 9. Review of Resident #8's Significant Change MDS, dated [DATE], showed staff documented the resident had short and long term memory problems. Review of the resident's face sheet, undated, showed staff documented the resident's code status as DNR. Review of the POS, dated [DATE], showed an order for Full Code status dated [DATE]. Review of the resident's TPOPP, dated [DATE] showed to attempt CPR, full code, uploaded to the electronic health record (EHR) on [DATE]. Review of the resident's TPOPP, undated, showed resident to be DNR, uploaded to the EHR on [DATE]. Review of the resident's care plan, dated [DATE], showed staff did not document the resident's code status. During an interview on [DATE] at 9:15 A.M., LPN A said he/she did not know the resident did not have a code status on the care plan, he/she said I guess I didn't pay attention and did not know the code status did not match on the face sheet and POS. During an interview on [DATE] at 11:52 A.M., the administrator said the resident had changed back and forth regarding his/her code status and it should have been changed on the POS to DNR. The administrator said he/she did not know why it had not been updated. 10. Review of Resident #32's Admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's face sheet, undated, showed staff documented the resident's code status as DNR. Review of the POS, dated [DATE], showed it did not contain an order for code status. Review of the resident's care plan, dated [DATE], showed staff did not document the resident's code status. 11. During an interview on [DATE] at 9:00 A.M., LPN K said he/she reviewed the two full code sheets that were posted on the hallway. The LPN said he/she is unable to determine which full code list is accurate. The LPN said if there are two lists there is a possibility to grab the wrong one and potentially not carry out a resident's code status wishes. During an interview on [DATE] at 2:54 P.M., the MDS Coordinator said he/she thinks code status should go on care plan. The MDS Coordinator said the SSD gives him/her the residents code status, and there should be an order for it. During an interview on [DATE] at 3:38 P.M., the SSD said if the facility does not get anything from the hospital, he/she starts the resident as a full code, until the resident gets to the facility and signs sign the document for the code status wishes. The SSD said nursing will notify him/her, or hospitals will notify him/her, if a resident's code status changes and he/she notifies the MDS Coordinator. The SSD said when he/she gets the code status, he/she takes the TPOPP to the nurses at the nurse's station. If the nurse is not at the nurse's station, he/she will lay it on the nurse's computer keyboard. The SSD said he/she does not follow up after that. The SSD said the resident's care plan should be changed as soon as staff can do it. The SSD said if the code status is wrong on the care plan, there is a risk staff would provide CPR to a resident that is a DNR. There is also a risk staff would not resuscitate a resident that is a full code. During an interview on [DATE] at 8:48 A.M., Licensed Practical Nurse (LPN) K said residents code status should be on the care plan. The LPN said the MDS coordinator is responsible for reviewing code status information and updating the care plan. During an interview on [DATE] at 9:11 A.M., CNA G said he/she would look in the care plan to see the resident's code status. CNA G said it absolutely should be in the care plan, and he/she did not know it was not in the care plan for Residents #8, #18, #32, #41, and #42. CNA G said he/she thinks the office takes care of the code status when they are admitted . During an interview on [DATE] at 9:15 A.M., LPN A said the code status is on the computer on the face sheet. LPN A said usually the nurses put the orders in on admission on the POS and it is based on the baseline care plan and TPOPP or OHDNR sheets. LPN A said the SSD will change the code status on the face sheet, and he/she is supposed to notify the nurses and then the nurses change the order in the computer. LPN A said code status is usually on the care plan, and when he/she has care plan meetings the resident is asked if they want to continue with the same code status. He/she did not know residents #18, #41, and #42 did not have their code status on the care plan. LPN A said the risk of not having an order is doing CPR on someone who is a DNR or not doing anything for someone that is a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:17 A.M., the DON said they would not necessarily expect a code status to be on the care plan. He/she said the code status orders the nurses initially receive for the residents are from the hospital. The DON said if the code status changes, the SSD lets the nursing staff know. The DON said he/she expects the POS to contain a code status order and it should match the residents wishes. The DON said the MDS Coordinator looks at orders that come from the hospital and if there is a change in code status, the SSD should verbally communicate it with the nursing staff and MDS Coordinator. The DON said the MDS coordinator is responsible for updating the care plans, and he/she gets the code status information as it is updated from the SSD. The DON said having the wrong code status could cause confusion a resident may receive care they do not want. The DON said the nurse that the SSD hands the updated code status to, is responsible for getting the updated order. The DON said she is not sure why the resident's code status is not on the care plan. During an interview on [DATE] at 11:52 A.M., the administrator said the SSD is responsible for getting the code status for residents, and once the SSD has it he/she is to take it to the nurse's station and give it to the nurse. The SSD puts the code status on the resident's face sheet. The nurse is responsible for putting the order on the POS when completing the admission paperwork. The administrator said the MDS coordinator is responsible for updating the care plan. The administrator said he/she did not think code status needed to be on the care plan. 45489 48982 50361

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 50361 Based on interview and record review, facility staff failed to perform a pre-dialysis (procedure to remove waste products from the blood when the kidneys stop functioning properly) assessment and to have a system in place for ongoing communication with the dialysis clinic for one (Resident #25) of one sampled resident. Facility census was 45. 1. Review of the facility's dialysis services policy and procedure, dated 04/05/23, showed staff are directed to obtain communication with the dialysis clinic. Review of the facility's memorandum of agreement with the dialysis clinic, undated, showed the facilities responsibilities are: -If the long term care facility is a skilled nursing facility appropriate long term care facility healthcare staff will make an assessment of each patient's physical condition and determine whether the patient is stable enough to be dialyzed; -If it is determined that a patient is sufficiently stable, this assessment will be communicated to the dialysis facility's nurse manager or designee; -This assessment and communication will occur prior to each and every transfer of a patient to the dialysis facility regardless of the number of times any particular patient may be transferred and dialyzed. 2. Review of Resident #25's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/04/25, showed staff documented the resident did not receive dialysis services, and diagnoses of renal insufficiency, renal failure, or end stage renal disease. Review of the Physician Order Sheet (POS), dated January 2025, showed an order for dialysis on Monday, Wednesday and Friday. Review of the care plan, dated 01/22/25, showed staff documented the resident attends dialysis every Monday, Wednesday, and Friday. Obtain weight, blood pressure, and pulse prior to leaving for and when returned from dialysis. Review of the medical record showed facility staff did not document they assessed the resident prior to dialysis and did not contain the pre and post dialysis vital sign communication form with required weight, blood pressure, pulse or assessment required from 11/04/24-11/11/24 and from 11/12/24-01/28/25. During an interview on 01/28/25 at 8:48 A.M., the resident said staff do not check his/her vital signs before he/she leaves for dialysis or when he/she returns from dialysis. He/She said the dialysis clinic staff send him/her back to the facility with a piece of paper that has information on it. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 9:13 A.M., Licensed Practical Nurse (LPN) K said there is no formal continuous communication between the dialysis clinic and the facility. The nurse said he/she can call the clinic if he/she needs to talk to them. The night shift staff check the residents weight before dialysis but do not communicate this with the clinic. The LPN said staff do not complete an assessment before the resident goes to dialysis. During an interview on 01/29/2025 at 9:23 A.M., the Director of Nursing (DON) said the dialysis clinic sends the facility blood work results once a week and the resident sometimes returns from dialysis with a form that lets staff know how much fluid had been removed and what the resident's vital signs were while at the dialysis clinic. Staff check the resident's vital signs after dialysis and document it in the resident treatment record. The staff check the resident's weight prior to dialysis and the resident is responsible for telling the dialysis clinic his/her weight. The facility does not have ongoing communication with the dialysis clinic. The DON said he/she did not know staff were not following the facility policy, and the staff does not have a good system in place. During an interview on 01/30/2025 at 9:36 A.M., the administrator said the resident is alert and oriented and can make decisions and communicate with the dialysis clinic. The administrator said if there are concerns at the facility or the dialysis clinic they would call or send paperwork to communicate the concern. The administrator said he/she is not aware of any regular ongoing communication between the facility and the dialysis clinic. The administrator said he/she did not know if vital signs were communicated between the facilities and did not know the form was not being used.