STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265667	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 46519 Based on interview and record review, the facility failed to invite one sampled resident (Resident #22) to his/her quarterly care plan meeting out of 15 sampled residents. The facility census was 53 residents. Review of the facility's undated policy titled Comprehensive Care Plans showed: -The comprehensive care plan would be prepared by an interdisciplinary that included the resident and the resident's representative, to the extent possible. -No policy related to the actual invitation to care plan meetings. 1. Review of Resident #22's face sheet showed he/she admitted to the facility with the following diagnoses: -Generalized Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats). -Congestive Heart Failure (CHF- a weakness of the heart that leads to the build-up of fluid in the lungs and surrounding tissues). -Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin. -Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). -Post-Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). -Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation). (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/19/2024 showed the resident was moderately cognitively impaired. Review of a Care Plan Meeting Sheet dated 6/20/24 showed: -The resident had a care plan meeting on 6/20/24. -The resident was not in attendance to this care plan meeting. -The resident had not received a copy of his/her care plan. -There was a place for the resident to initial for receiving his/her care plan and that was blank. During an interview on 7/15/24 at 12:06 P.M. the resident said: -He/She was not getting invited to his/her care plan meetings. -He/She wanted to be involved and invited to his/her care plan meetings. Review of the resident's medical records showed no documentation of a written invitation given to the resident for the care plan meeting on 6/20/24. During an interview on 7/16/24 at 2:00 P.M., the Director of Nursing (DON) said: -He/She could not provide any documentation related to the resident's invitation to his/her care plan meeting on 6/20/24. -The Social Services Designee (SSD) would have been responsible for giving the resident a written invitation to his/her care plan meeting. -He/She was aware of the regulation indicating that residents needed to be provided written invitations to their care plan meets and expected the SSD to complete the task. During an interview on 7/17/24 at 10:43 A.M., Certified Nursing Assistant (CNA) E said: -All residents needed to be invited to their care plan meetings. -He/She was unsure if the resident was getting invited to his/her care plan meetings. -He/She thought the resident would be appropriate to go to his/her care plan meeting. -He/She thought the care plan invitations should be communicated in written and verbal form. During an interview on 7/17/24 at 11:49 A.M., Licensed Practical Nurse (LPN) C said: -All residents needed to be invited to their care plan meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unsure if the resident was invited to his/her care plan meetings. -He/She felt the resident would be appropriate and able to go to his/her care plan meetings. -He/She thought the residents should receive their care plan invitations in written and verbal form. -He/She was unsure of who was responsible for giving the invitations to the residents. During an interview on 7/17/24 at 12:54 P.M., the SSD said: -He/She was responsible for inviting residents and residents' families to care plan meetings. -He/She invited all residents to their care plan meetings. -He/She thought the resident had not wanted to attend any of his/her care plan meetings. -He/She thought the resident had been verbally invited to his/her care plan meeting. -Families were the ones that received written notification to care plan meetings. -He/She only invited the residents to care plan meetings in verbal form. -He/She was not aware that residents needed a written invitation to their care plan meetings. During an interview on 7/18/24 at 8:32 A.M. the MDS Coordinator said: -The SSD was responsible for inviting residents to their care plan meetings. -He/She thought all residents were to be invited to their care plan meetings. -All residents had the right to attend their care plan meetings. -He/She was aware that residents needed to be invited to their care plan meetings in written form. During an interview on 7/18/24 at 9:12 A.M. the Assistant Director of Nursing (ADON) said: -All residents should be invited to their care plan meetings. -The SSD was responsible for inviting residents to their care plan meetings. -He/She thought the resident would be appropriate and able to attend his/her care plan meeting.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 19916 Based on interview and record review, the facility failed to prepare and deliver quarterly statements to the Public Administrator (a guardian usually appointed or elected, who is responsible for the management of each ward's life, including where they reside, needed medical attention, and other decisions pertaining to personal well-being) who was the guardian for four sampled residents (Residents #14, #12, #15 and #22) who had resident funds at the facility. The facility census was 53 residents. 1. Review of the resident trust records for Residents #14, #12, #15 and #22, showed the absence of quarterly statements which were supposed to be prepared and delivered to their Public Administrator. During an interview on 7/17/24 at 12:50 P.M. the Business Office Manager (BOM) said: -He/She was hired as the BOM in April 2023. -He/She was not trained in preparing and sending quarterly statements. During an interview on 7/17/24 at 1:49 P.M., the Administrator said: -He/She did not know that the current BOM was not trained in preparing quarterly statements. -He/She expected the BOM to prepare and send out quarterly statements to the residents and/or their responsible parties.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 21003 Based on interview and record review, the facility failed to follow facility policies and procedures for checking Nurse Aide Registry and completing criminal background checks (CBC) within a timely manner and in accordance with state requirements prior to employing four of 10 employees sampled for the criminal background screening. The facility census was 53 residents. Review of the facility's Abuse and Neglect policy and procedure dated 2023, showed: -The facility, to provide these protections (protecting the health, welfare and rights of each resident in the facility), the facility must develop written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property. -The facility must not hire an employee or engage an individual who was found guilty of abuse, neglect, exploitation, mistreatment of residents or misappropriation of a resident's property by a court of law; who has a finding in the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of a resident's property, or has had a disciplinary action in effect taken against his/her professional license. -The facility must report knowledge of actions by a court of law against an employee that indicates the employee is unfit for duty. 1. Review of four employee records on 7/17/24, showed: -Cook A was hired on 4/29/24; documentation showed staff requested the CBC on 6/13/24 and received it on 6/13/24. -Certified Medication Technician (CMT) B was hired on 12/1/23; documentation showed staff requested the CBC on 4/12/24 and received it on 4/12/24. -Dietary Aide A was hired on 12/28/23; the documentation showed the facility staff requested the CBC on 1/10/24 and received it on 1/13/24. -Certified Nursing Assistant (CNA) was hired on 9/11/23; documentation showed the facility staff checked the Nurse Aide Registry on 6/13/24. During an interview on 7/18/24 at 8:38 A.M., the Human Resource Manager said: -Some of the staff were hired under the former company and they were not completing the criminal background screenings correctly or timely. -He/She had been auditing employee files and making corrections but noticed there were several mistakes or missing information. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Regarding [NAME] A, he/she was not in the Family Safety Care Registry upon hire so they waited to run his/her CBC and eventually they had to pay for him/her to become registered and that's when they ran the CBC. -Regarding CMT B and Dietary Aide A, he/she did not know why the CBC was not completed timely. -Regarding CNA F, he/she could not find the Nurse Aide Registry report showing it was run upon hire.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to ensure the baseline care plan showed the primary health conditions and interventions implemented for two sampled residents with significant health conditions (Resident #154 and #155) out of 15 sampled residents. The facility census was 53 residents. Review of the facility's Baseline Care Plan dated 2023 showed the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet the professional standards of quality of care. The baseline care plan will: -Be developed within 48 hours of the resident's admission. -Include the minimum healthcare information necessary to properly care for the resident, including, but not limited to initial goals based on admission orders, physician orders, dietary orders, therapy services, social services. -The admitting nurse or supervising nurse on duty shall gather information from the admission assessment, hospital transfer information, physician's orders, and discussion with the resident and resident representative if applicable. -Interventions shall be initiated that address the resident's current needs including any health and safety concerns to prevent decline or injury, any identified needs for supervision, behavioral intervention or assistance with activities of daily living and any special needs. -Once established, goals and interventions shall be documented in the designated format. 1. Review of Resident #154's Face Sheet showed the resident was admitted on [DATE] with diagnoses of pain, malnutrition, gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), pelvic tumor, sepsis (a serious condition in which the body responds improperly to an infection) high blood pressure, arthritis, history of prostate cancer and depression. Review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) showed there was no admission MDS completed yet. Review of the resident's Initial Nursing Admission assessment dated [DATE], showed: -The resident was admitted from the hospital with a surgical repair to perforations in his/her stomach and cholecystostomy (a medical procedure used to drain fluid from the gallbladder into a bag). -The resident was alert and oriented. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had a history of malnutrition, respiratory failure, a wound on his/her buttock and staples on his/her abdomen from surgery and had no pain. Review of the resident's Physician's Order Sheet (POS) dated 7/2024, showed physician's orders for cholecystostomy drain to be checked and drained every two hours. Monitor for signs and symptoms of infection every two hours (7/12/24). Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated 7/2024, showed physician's orders the resident's cholecystostomy drain was being monitored and drained as ordered. Review of the resident's Baseline Care Plan dated 7/12/24, showed: -There was no documentation showing the resident had any special treatments, procedures or programs. -It did not show the resident had a cholecystostomy drain that should be drained every two hours or that he/she had pain and did not show any interventions addressing these two health concerns. Observation on 7/16/24 at 8:47 A.M., showed the resident was laying down on his/her back in bed with the head of his/her bed up. The resident's shirt was pulled up to show the resident's abdomen and there was a clean bandage over the gastronomy site and the cholecystostomy site. In the center of the resident's abdomen was a long surgical site that was covered with a clear tape. The resident's cholecystostomy tube collection bag was laying on the mattress beside the resident and there was no fluid in the bag at this time. His/her gastronomy tube feeding machine was to the left of his/her bed and was on. The resident said: -He/She wore a Fentanyl (a topical pain medication that delivers medication through the skin) patch on his/her shoulder and also received pain and other medications through his/her gastronomy tube. -He/She had two gall bladder surgeries and had the gastronomy and cholecystostomy tubes placed then. -Nursing staff were not supposed to touch the surgical site but they did come in to clean around all of the tubing and empty the cholecystostomy drainage bag when full. During an interview on 7/17/24 at 2:40 P.M., Licensed Practical Nurse (LPN) A said: -The resident had two gallbladder drainage tubes and a gastrostomy tube. -The drainage bag from his/her cholecystostomy tubes was maintained and checked every two hours. -The nurse completed and documented a full body assessment on the resident and they usually documented information related to a pertinent health condition like wounds or skin issues. The nurse should document if a resident has a specialized care need like a cholecystostomy or gastrostomy tube. -Regarding this resident, they should have documented that the resident had a drainage tube on his/her Admission Baseline Care Plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #155's Face Sheet showed the resident was admitted on [DATE], with diagnoses including osteoporosis (a disease in which the bones become very porous, break easily, and heal slowly), lower back pain, left hip pain, a left hip fracture, and a history of falling. Review of the resident's admission MDS showed the resident did not have a completed admission MDS at this time. Review of the resident's Nursing Admission assessment dated [DATE], showed the resident was admitted after he/she had a left hip fracture resulting from a fall and was receiving rehabilitation services. The skin assessment showed the resident was admitted with a dressing on his/her left hip that was dry and intact. The pain assessment showed the resident had no pain. Review of the resident's Baseline Care Plan dated 7/8/24, showed the resident: -Needed one person assistance with hygiene, toileting, dressing, bathing, transferring and mobility and used a wheelchair. -Had no special treatments or procedures, but had a fall prior to admission and had a left hip fracture. -Had no pain and had no skin integrity issues. -The document did not show the resident had a surgical site to his/her left hip and had no interventions showing how the facility staff was to monitor the surgical site. Review of the resident's Physician's Order Sheet (POS) dated 7/2024, showed physician's orders for: -Tylenol 4 grams in 24 hours give every 6 hours as needed for Pain (7/9/24). -Hydrocodone-Acetaminophen 5-325 milligrams (mg) every 4 hours as needed for severe pain for 14 days (7/8/24). -The POS did not show any treatment to the resident's surgical site. Review of the resident's Functional Ability assessment dated [DATE] showed the resident: -Was independent with eating and hygiene. -Needed moderate assist with transfers, mobility, bathing dressing and toileting. -Was continent of bowel and bladder. -Used a wheelchair and walker for mobility. -Did not show the resident had a surgical site to his/her left hip. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/15/24 at 11:44 A.M., the resident was sitting up in his/her recliner. The resident said he/she entered the facility after a surgical repair to his/her left hip and was here for rehabilitation. During an interview on 7/17/24 at 2:40 P.M., Licensed Practical Nurse (LPN) A said: -The Charge Nurse or admitting nurse completed the Admission Nursing Assessment and Baseline Care Plan documents. -The information from the Admission Nursing Assessment and any added information they know about the resident should be documented on the resident's Baseline Care Plan. -The nurse should document if a resident has a specialized care need and it should have shown the resident had a surgical site to his/her left hip due to the hip fracture repair on the resident's Baseline Care Plan. -Residents who have been admitted post-surgery should show the surgical site, any treatments or monitoring needs and pain management. This should also be on the resident's baseline care plan. During an interview on 7/18/24 at 9:51 AM the Director of Nursing (DON) said: -All of the information they obtain from the initial nursing assessment should be a part of the resident's Baseline Care Plan. -The MDS Coordinator usually developed the Baseline Care Plan, but nursing staff can update or add information to the Baseline Care Plan if there is information that has not been added to it.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on observation, interview and record review, the facility failed to ensure the low air loss mattress (LAL - an air mattress covered with tiny holes that are designed to let out air very slowly which helps keep the skin dry and [NAME] away any moisture) settings were set by weight according to physician orders for one sampled resident (Resident #20), who had pressure ulcers (pressure injuries - damage to an area of the skin caused by constant pressure on the area) out of 15 sampled residents. The facility census was 53 residents. Review of the facility policy for Use of Support Surfaces copyright 2023 showed: -Support surfaces will be used in accordance with evidence-based practices for resident with or at risk for pressure injuries. -For powered devises, or those requiring air, the licensed nurse will check each shift and as needed for proper functioning and inflation. -Support surfaces will be utilized accordance with manufacturer recommendations. 1. Review of the Resident #20's Physician Order Sheet (POS) dated 6/11/24, showed the resident had a physician order to have a LAL mattress in place for wound management. The settings for the mattress per resident's weight. Nursing staff were to monitor setting and LAL mattress every day and night shift. Review of the resident's Hospice physician order dated 6/24/24 showed he/she had a physician's order for a LAL Mattress and staff were to set air flow per resident weight. Review of the resident's weight record on 6/24/24 showed the resident's weight was at 166.8 pound. Review of the resident's Significant Change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 7/3/24, showed he/she: -Was severely cognitively impaired and had short term and long-term memory problems. -Had Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) Pressure Ulcer/wound (PU, localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). -Had Stage III (a full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcer/wound. Review of the resident's weights showed: -On 7/1/24 his/her weight was 162 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/8/24 his/her weight was 160.5 pounds. Review of the resident's Treatment Administration Record (TAR) 7/1/24 to 7/16/24 showed: -Had a physician order (PO) to have a LAL mattress in place for wound management. The settings for the mattress per resident's weight. Nursing staff were to monitor setting and LAL mattress every day and night shift. --Had nursing initial for each day and night shift the LAL mattress was monitored. -Had PO for nursing staff were to obtain weekly weight for the resident, one time a day on Mondays. --Nursing staff documented the resident last weight was on 7/8/24, and his/her weight was 160.5 pounds. Review of the resident's care plan revised on 7/9/24 showed the resident: -Was at risk for skin breakdown. -The resident had an open area on his/her buttocks and on his/her coccyx at that time. -Intervention included: --The resident was to be utilizing a low air loss mattress: nursing was to verify settings were set for appropriate weight. Review of the resident Skin/Wound Note dated 7/14/24 at 12:20 P.M. showed: -The resident was seen by Hospice Licensed Practical Nurse (LPN) for weekly wound assessment on 7/11/24. -Areas to coccyx and right buttock assessed and measured by LPN. -The resident continues to have a LAL mattress in place at that time. NOTE: did not indicate what the LAL mattress setting were at that time. Observation on 7/16/24 at 9:15 A.M., of resident care showed: -His/Her low air loss mattress was set on 450 pounds was fully inflated. -Power devices had instruction the devices should be set by the resident weight. Observation on 7/17/24 at 10:00 A.M., of the resident showed: -He/she was laid in bed on his/her LAL mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The LAL mattress was set at 450 pounds and fully inflated. During an interview on 7/17/24 at 10:08 A.M., CNA A said: -Once setting are set, he/she would observe the mattress and look for any flashing light which mean possible issue with the mattress, he/she would notify the charge nurse any concerns. -He/She was not aware of what the setting for the resident's LAL mattress should be. -Most of the LAL mattress go by the resident weights. -The resident charge nurse would be responsible monitoring LAL Mattress settings and documentation of monitoring. During an interview on 7/17/24 at 10:22 A.M., CNA C said: -He/She would check LAL mattress machine to ensure was running. -He/She thought the LAL mattress setting were set by maintenance staff when they would setup the mattress and machine. -The resident's LAL mattress should be set by his/her weight. -He/She was not aware the resident LAL mattress was set for 450 pounds. -Nursing staff would be responsible checking setting and documentation. Observation on 7/17/24 10:34 A.M. showed: -The nursing staff entered the resident room. -Did not observe the nursing staff looking at the LAL mattress settings at that time. During an interview on 7/17/24 at 10:41 A.M., LPN C said: -Nursing staff would ensure to have a physician order for the resident's LAL mattress with required setting. -The resident LAL mattress would be set by his/her weight. -The resident's weight was around 160+ pounds, so the setting should be around that weight. -LPN C had observe resident LAL mattress setting and noted was set at 450 pounds. -LPN C said that setting was too high. -LPN C changed the setting of the mattress to 180 pounds since the resident's weight was just a little over 160 pounds. (option was 160 or 180 pounds). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse assigned that day or night shift would be responsible for monitoring and adjusting the resident's LAL mattress settings as needed. -Nursing staff would document on the resident's TAR with nursing initials and check mark that the resident's LAL mattress was set at the correct settings. -Nursing staff should review the resident's physician order to verify LAL mattress setting. -If the resident LAL mattress was not set at right setting, potential to affect the resident pressure relief, wound healing processing. During an interview on 7/17/24 at 12:44 P.M., Assistant Director of Nursing (ADON) said: -The resident had a Stage III wound on his/her coccyx. -Nursing staff would be responsible to ensure to have physician's order for LAL mattress, to include what the setting should be. Normally set by the resident's weight and to be monitored every shift by nursing staff. The resident LAL mattress set on 450 pounds was not correct. -The resident LAL mattress should be set at his/her current weight. -With resident LAL mattress setting not set correctly, he/she had potential to place the resident at risk for pressure point concerns and could affect the resident wound healing process. During an interview on 7/18/24 at 9:51 A.M., Director of Nursing (DON) said: -CNA's would be responsible for notify the charge nurse any error or concern with the resident's LAL mattress. -The charge nurse would be responsible for monitoring and documentation of the monitoring of the resident LAL mattress. -The nursing staff would document monitoring on the resident TAR. This would include the staff checked to ensure the LAL mattress was set at the correct settings. -LAL mattresses assist in pressure relief for those resident at risk for skin changes or currently have skin changes. -The resident does have a LAL mattress and should be set to his/her current weight. -He/She was not aware of the resident current weight. -The resident's setting for LAL mattress should not be set at 450 pounds. -With the incorrect mattress setting, could place the resident at risk of rolling out of his/her bed, and affect the process of wound healing due to improper pressure points.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the failed to ensure respiratory nasal cannulas (a device used to deliver supplemental oxygen through a lightweight tube which on one end splits into two prongs which are placed in the nostrils and from which a mixture of air and oxygen flows), face masks and tubing was kept in a way to prevent cross contamination and failed to ensure that his/her care plan reflected that he/she used respiratory equipment and that there were interventions related to oxygen use for one sampled resident (Resident #36) out of 15 sampled residents. The facility census was 53 residents. 1. Review of Resident #36's Face Sheet showed the resident was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive disease that is characterized by shortness of breath and difficulty breathing), and heart failure. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 6/28/24, showed the resident: -Was alert and oriented with no cognitive deficiencies or behaviors. -Had shortness of breath when lying flat and with exertion. -Used intermittent oxygen therapy and other respiratory treatments. Review of the resident's Physician's Order Sheet (POS) dated 7/2024, showed physician's orders for: -Supplemental oxygen at 2 liters per minute via nasal cannula every night for COPD (6/22/24). -Pulmicort Inhalation Suspension 0.5 milligrams (mg) inhale orally two times a day for COPD (6/21/24). -Brovana Inhalation Nebulization Solution 15 micrograms (mcg) inhale orally via nebulizer (a device used to administer medication to people in the form of a mist inhaled into the lungs) two times a day for COPD (6/21/24). Review of the resident's Nursing Notes dated 7/10/24, showed: -The resident had an occasional dry cough and a humidifier was added to his/her oxygen concentrator. -He/She continued on skilled services and was able to speak in complete sentences without signs or symptoms of shortness of air. -The resident's respirations were even and unlabored on 2 liters per minute of oxygen via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/14/24 at 10:56 A.M., showed the resident was sitting in his/her recliner and was not wearing oxygen. It was noted the resident's oxygen concentrator was next to his/her bed with the nasal cannula and tubing coiled around the concentrator and was uncovered. There was no plastic bag or covering beside or around the concentrator. There was a nebulizer machine on top of the dresser beside the bed and the face mask was covered with a plastic bag. Observation on 7/15/24 at 3:30 P.M., showed the resident was in his/her recliner with his/her eyes closed resting comfortably. The resident's oxygen concentrator was still beside his bed and the tubing was still coiled around the concentrator uncovered. Observation and interview on 7/15/24 at 12:17 P.M., showed the resident was in his/her recliner. His/Her oxygen concentrator was sitting beside his/her bed and the nasal cannula and oxygen tubing was coiled around the concentrator and was not in a bag. His/Her nebulizer machine was sitting on top of the dresser beside his/her bed and the face mask was covered with a plastic bag. The resident said: -Nursing staff had to assist him/her with all of his/her cares. -He/She used the nebulizer treatments during the day and in the evening. -He/She used oxygen at night. -He/She did not have a bag for his nasal cannula and tubing but they had put the facemask in a bag. Observation on 7/16/24 at 9:18 A.M., showed the resident was reclined in his/her recliner watching TV and eating a snack. His/Her nasal cannula and oxygen tubing was coiled around his/her oxygen concentrator that was sitting beside his/her bed, uncovered. His/Her nebulizer machine was sitting on top of the dresser beside his/her bed. The face mask was uncovered and sitting beside the nebulizer machine. During an interview on 7/17/24 at 11:32 A.M., Certified Nursing Assistant (CNA) D said: -There are usually little baggies on the oxygen concentrator that the tubing and nasal cannula is to be stored in when not in use. -The nursing staff usually checked to ensure the nasal cannulas, oxygen tubing and face masks were kept covered. -The resident wore oxygen as needed. -Oxygen supplies should have been kept in a plastic bag to prevent contamination. During and interview on 7/17/24 at 2:40 P.M., Licensed Practical Nurse (LPN) A said oxygen nasal cannulas, tubing and face masks were supposed to be kept in a plastic bag when not in use. She said the bags were usually placed on the oxygen concentrator. She said the resident's oxygen tubing should have remained covered as long as it was not in use and the bag should have been labeled and dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24 at 9:51 AM the Director of Nursing (DON) said nasal cannulas, face masks and oxygen tubing should be stored in a bag marked with the date and time it was changed out when not in use. The oxygen supplies are changed out weekly, and the bags are usually placed on the oxygen concentrator. The nursing staff is responsible for monitoring to ensure the oxygen supplies are stored properly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to accurately assess resident pain risk and failed to ensure the resident's Baseline Care Plan included minimum healthcare information regarding the specific care need of the resident to include pain for one sampled resident (Resident #155) out of 15 sampled residents. The facility census was 53 residents. Review of the facility's Pain policy and procedure dated 2023, showed: -The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of the resident's pain. -Based on professional standards of practice, an assessment of pain by the appropriate members of the interdisciplinary team may necessitate gathering the following information as applicable to the resident: -History of pain and its treatment including pharmacological and non-pharmacological and alternative medicine and whether or not this treatment has been effective, history of addiction, past and ongoing treatment for opiod (narcotics) use, asking the resident to rate pain intensity, reviewing the resident's current medical condition, identifying current characteristics of pain (duration, frequency, location, timing, pattern and radiation of pain). -Obtaining descriptors of pain, identifying impact of pain on the resident's quality of life, identifying activities, resident care or treatment that precipitate or exacerbate pain and those that eliminate pain. -Current pain medications, dosage and frequency, goals for [NAME] management and satisfaction with his/her current level of pain control. -Any physical or psychological issues that may exacerbate pain. -Based on the evaluation, the facility in collaboration with the physician other health care professionals and the resident or the resident's representative will develop, implement, monitor and revise as necessary, interventions to prevent or manage each individual resident's pain beginning at admission. 1. Review of Resident #155's Face Sheet showed the resident was admitted on [DATE], with diagnoses including osteoporosis (a disease in which the bones become very porous, break easily, and heal slowly), lower back pain, left hip pain, a left hip fracture, and a history of falling. Review of the resident's Fall Risk dated 7/8/24 showed the resident's fall risk score was 8.0 showing moderate to high risk. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nursing Admission assessment dated [DATE], showed the resident was admitted after he/she had a left hip fracture resulting from a fall and was receiving rehabilitation services. The skin assessment showed the resident was admitted with a dressing on his/her left hip that was dry and intact. The pain assessment showed the resident had no pain. There was no documentation showing the resident's source of pain, signs or symptoms of pain, what reduced his/her pain, pharmacological and non-pharmacological pain interventions and management interventions. Review of the resident's electronic Record showed the resident did not have a Pain Risk Assessment completed. Review of the resident's Baseline Care Plan dated 7/8/24, showed the resident: -Had no skin issues, had no pain and did not show the resident was admitted after surgical repair of his/her him with orders for narcotic pain medication. Review of the resident's Functional Ability assessment dated [DATE] showed the resident: -Was independent with eating and hygiene. -Needed moderate assist with transfers, mobility, bathing dressing and toileting. -Was continent of bowel and bladder. -Used a wheelchair and walker for mobility. -Did not show signs or symptoms of pain. Review of the resident's Pain Level Grid showed the nursing staff was assessing the resident's pain daily, from 7/8/24 to 7/16/24. On 7/8/24 the resident's pain level was checked four times and the scores were 4, zero, 8, and zero (on a scale from zero to 9, 9 was the highest level of pain). The daily pain assessments showed varying results showing the resident's pain was from zero pain to a pain level of 9. The resident's average level of pain was around 7. Review of the resident's Physician's Order Sheet (POS) dated 7/2024, showed physician's orders for: -Tylenol 4 grams in 24 hours give every 6 hours as needed for Pain (7/9/24). -Hydrocodone-Acetaminophen 5-325 milligrams (mg) every 4 hours as needed for severe pain for 14 days (7/8/24). Review of the resident's Medication Administration Record dated 7/2024, showed the nursing staff administered the resident Tylenol and Hydrocodone daily as needed according to the resident's physician's orders and documented his/her pain level at the time of administration. During an observation and interview on 7/15/24 at 11:44 A.M., the resident was sitting up in his/her recliner. He/She said: -He/she was in the facility after a hip repair and was receiving rehabilitation. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had pain, was not on a scheduled pain pill and had to request it as needed and when he/she requested it, usually the aide came in and then he/she had to go to get the Certified Medication Technician (CMT) or nurse to give him/her the pain medication. -Sometimes he/she had to wait to receive the pain medication but when he/she received it, the medication did manage his/her pain. During an interview on 7/17/24 at 2:40 P.M., Licensed Practical Nurse (LPN) A said: -The Charge Nurse or admitting nurse completed the admission nursing assessment. -The nurse documented a full body assessment on the resident and they usually documented information related to all of the resident's pertinent health conditions, like wounds or skin issues. -The nurse should document if a resident has a specialized care need and it should have shown the resident had a hip fracture and repair. -Residents who have been admitted post-surgery should show pain (location, signs and symptoms and interventions) if they are taking pain medications and it should also be on the resident's baseline care plan. During an interview on 7/18/24 at 9:51 AM the Director of Nursing (DON) said: -The initial admission assessment should show all the information about the resident that they have upon admission. -The admitting nurse should complete a full body assessment, document vital signs of the resident and any/all of the health areas the resident may have or that they know about. -Residents with wounds or any skin issues should be documented on the initial nursing assessment and if the health issue is not documented on the form, the nurse can add it in the comments. -The risk assessments were completed in addition to the initial assessment on separate forms. -All of the risk assessments should be completed within 24 hours of the resident's admission (pain, falls, skin, elopement). -The Charge Nurse on duty at the time of the resident's admission is responsible for completing the initial admission assessment and risk assessments unless the resident comes to the facility in the evening. In this case, the Charge Nurse on the shift the resident is admitted on should complete the initial assessment and the following shift Charge Nurse should complete all of the risk assessments.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 46519 Based on interview and record review, the facility failed to ensure one sampled resident (Resident #22) who had a diagnosis of Post-Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) received trauma based interventions or develop a care plan that showed interventions for the staff to provide to protect the resident and prevent trauma from recurring out of 15 sampled residents. The facility census was 53 residents. Review of the facility's undated policy titled Comprehensive Care Plans showed: -Trauma-informed care was an approach to delivering care that involved understanding, recognizing, and responding to the effects of all types of traumas. -A trauma-informed approach to care delivery recognized the widespread impact, and signs and symptoms of trauma in residents, and incorporated knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. -The care planning process would include an assessment of the resident's strength and needs. -Services provided or arranged by the facility, as outlined by the comprehensive care plan should be culturally competent and trauma-informed. -The comprehensive care plan would describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, metal, and psychosocial well-being. -The comprehensive care pan would describe the individualized interventions for trauma survivors that would recognize the interrelation between trauma and symptoms of trauma, as indicated. -Trigger-specific interventions would be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. 1. Review of Resident #22's face sheet showed he/she admitted to the facility with the following diagnoses: -PTSD. -Generalized Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats). -Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/19/24 showed: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was moderately cognitively impaired. -The resident had little interest or pleasure in doing things 2-6 days in the seven days look back period of the assessment. -The resident felt socially isolated sometimes. -The resident had PTSD. Review of the resident's care plan dated 7/1/24 showed: -No care plan related to the resident's diagnosis of PTSD or trauma-informed care. -The resident required a Level II Pre-Admission Screening and Resident Review (PASARR- a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment) related to the resident's intellectual disability. -The resident had met the federal definition of intellectual disability/related conditions but had not required specialized services. During an interview on 7/15/24 at 12:02 P.M. the resident said: -His/Her PTSD affected him/her some of the time. -He/She had not had any services provided by the facility related to his/her diagnosis of PTSD. -He/She would like to see a therapist related to his/her diagnosis of PTSD. During an interview on 7/16/24 at 12:46 P.M. the resident said: -He/She felt lonely. -In the past, his/her family provided most of his/her mental support, but most of his/her family was gone now. -He/She felt that seeing a therapist would be beneficial for all aspects of his/her mental health. -He/She had told a Certified Nursing Assistant (CNA) about wanting to see a therapist. Review of the resident's medical record on 7/16/24 at 1:06 P.M. showed no documentation the resident had received psychiatric and/or mental health services related to his/her PTSD diagnosis. During an interview on 7/16/24 at 1:10 P.M. the Director of Nursing (DON) said: -The resident was not receiving any psychiatric or mental health services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No notes could be provided related to his/her mental health services. During an interview on 7/17/24 at 10:38 A.M. CNA E said: -He/She was unaware of the resident's PTSD diagnosis. -He/She was unsure of how the PTSD affected the resident or of the resident had any specific triggers. -He/She thought the resident's diagnosis of PTSD and any interventions should be on the resident's care plan. During an interview on 7/17/24 at 11:46 A.M. Licensed Practical Nurse (LPN) C and LPN E said: -They were unaware of the resident's PTSD diagnosis. -They were unsure of how the PTSD affected the resident or if any interventions were in place for the resident. -They thought the resident's diagnosis of PTSD should be on the care plan. -The MDS Coordinator was the staff person who updated the care plans, the nurses only had access to view the care plans. During an interview on 7/17/24 at 12:49 P.M. the Social Services Designee (SSD) said: -He/She was aware of the resident's PTSD diagnosis. -When he/she performed the trauma-informed care assessment on the resident on 9/22/23, the resident reported no problems. -The resident had not asked him/her about seeing a therapist. -The resident's guardian was willing to do whatever was needed for the resident to maintain his/her highest practicable physical, mental, and psychosocial well-being. -He/She thought the care plan should address the resident's PTSD, so the staff would have the access and knowledge of the resident's diagnosis. -The MDS Coordinator was responsible for updating care plans. -Anyone had access to care plans and could edit the care plan as needed. During an interview on 7/18/24 at 8:29 A.M. the MDS Coordinator said: -He/She had not remembered the resident's diagnosis of PTSD. -The resident was not receiving any psychiatric or mental health services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's diagnosis of PTSD should be on the care plan. -Anyone, including therapy, SSD, dietary, activities and nursing services, had access and could update care plans as needed. -He/She was responsible for reviewing the care plans after the initial care plan was completed and quarterly. -He/She was also responsible for ensuring the completion and accuracy of the care plans. During an interview on 7/18/24 at 9:06 A.M. the Assistant Director of Nursing (ADON) said: -He/She was unaware of the resident's PTSD diagnosis. -The resident's diagnosis of PTSD should be on the care plan and include any triggers or interventions needed to care for the resident. -Nurses did have access to place interventions in resident care plans. -The MDS Coordinator was responsible for updating the care plans and ensuring the completion of care plans. During an interview on 7/18/24 at 9:51 A.M. the DON said: -He/She was unaware of the resident's PTSD diagnosis. -He/She was unsure of any triggers the resident had related to the PTSD. -He/She was unsure what interventions the resident had in place related to the PTSD. -The care plan should have reflected the resident's PTSD diagnosis to ensure appropriate and trauma-informed care to the resident. -He/She would have expected the care plan to have been updated by the MDS Coordinator. -Nurses were able to place interventions and update resident care plans. -The MDS Coordinator was responsible for the accuracy of care plans and ensuring the completion of care plans.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50579 Based on observation, interview and record review, the facility failed to ensure nursing staff had the proper skills and competencies to promote resident safety when a Certified Medication Technician (CMT) who was not certified to administer insulin (a drug used to manage blood sugar levels) injections administered insulin to two residents (Resident #156 and Resident #157) sampled for insulin administration. The facility census was 53 residents. Review of an undated facility policy titled Medication Administration showed medications were to be administered by staff who were legally authorized to administer those medications and in accordance with professional standards of practice. Review of an undated facility policy titled Insulin Pen showed staff were to: -Perform hand hygiene prior to the insulin administration. -Prime the insulin needle by dialing the pen to two units of insulin and pushing the plunger until at least one drop of insulin appears on the tip of the needle. -Administer the insulin. -Perform hand hygiene after the administration. Review of the Certified Medicine Technician (CMT) job description, dated 2024, showed: -CMTs prepared, administered, and charted oral, topical and suppository drugs. -No mention of the administration of insulin. 1. Review of the July 2024 Physician Order Summary (POS) for Resident #157 showed orders for Humalog (a rapid acting insulin) four units subcutaneously (in fatty tissue via injection) three times per day. Observation on 7/16/24 at 10:47 A.M., showed CMT A retrieved an insulin pen from the medication cart containing Humalog insulin. CMT A entered the resident's room without performing hand hygiene, donned gloves, cleansed an area on the resident's upper arm for insulin administration, applied a needle to the insulin pen, set the pen to four units, then administered the insulin to the resident without priming the needle. Review of the resident's July 2024 POS showed orders for Novolog (a rapid acting insulin) at a dose that was blood glucose level dependent (4 units for the resident's blood glucose at that time), three times per day. Observation on 7/16/24 at 10:52 A.M., showed CMT A returned to the medication cart, took out a second insulin pen and applied the needle to the pen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 10:53 A.M., CMT A donned gloves, cleansed an area on the resident's upper arm, set the pen to four units, which was consistent with physician orders for the resident's blood glucose level at the time, then administered the insulin to the resident without priming the needle. -At 10:55 A.M., CMT A returned to the medication cart without sanitizing his/her hands and began further preparation of medications. During an interview on 07/16/24 at 11:21 A.M., CMT A said: -When administering insulin to residents, he/she would apply the needle, clean the area, set the insulin pen to the correct dose and administer the drug. -He/She thinks he/she had primed insulin pens in the past. -He/She usually tried to prime insulin pens before administration, but the problem was if he/she waited too long after priming, the pen would not work correctly. -He/She primed the insulin pens prior to administration of the insulin doses to both residents. -He/She was unable to describe the method used to prime the insulin pens. -He/She performed hand hygiene before and after each insulin administration. -Administering insulin was part of his/her daily duties. During this interview CMT A did not state whether he/she was certified to administer insulin on the Missouri Nurse Aide Registry. Review of the Missouri Nurse Aide Registry showed CMT A did not hold an insulin administration certification. Review of the employee file for CMT A did not show certification or specialized training on insulin administration, but did show a competency evaluation dated 5/14/24, showing he/she administered insulin using proper technique. During an interview on 7/17/24 at 11:24 A.M., Licensed Practical Nurse (LPN) A said: -Hand hygiene must be performed before and after insulin administration because staff may come into contact with blood or other pathogens. -The insulin pen needle must be primed prior to administering insulin to residents to ensure the proper dose. -CMTs can give insulin at the facility as long as they have the proper certification. During an interview on 7/18/24 at 9:50 A.M., the Director of Nursing (DON) said: -He/She would expect staff to perform hand hygiene before and after insulin administration. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would expect the needle to be primed with insulin prior to administration to ensure the proper dosage of medication. -CMTs who administer insulin in the facility must have the certification to do so. -He/She was unaware CMT A was not certified to administer insulin.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46519 Based on interview and record review, the facility failed to provide sufficient proof of the Registered Nurse (RN) eight consecutive hours a day coverage during the Fiscal Year Quarter Two 2024 Payroll Based Journal (PBJ- a report that provides staffing dataset information submitted by nursing homes on a quarterly basis) for all the dates triggered within the quarter equaling 26 total days. This deficient practice had the potential to affect all residents within the facility. The facility census was 53 residents. Review of the facility's undated policy titled Nursing Services- Registered Nurse showed: -The intent of the policy was for the facility to comply with Registered Nurse staffing requirements. -The facility would utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week. -The facility was responsible for submitting timely and accurate staffing data through the CMS PBJ system. 1. Review of the PBJ Fiscal Year Quarter Two PBJ data report showed the facility had no RN coverage for the following dates: -Eight out of 31 days in January 2024: --1/6/24, 1/7/24, 1/13/24, 1/14/24, 1/20/24, 1/21/24, 1/27/24, 1/28/24, -Eight out of 29 days in February 2024: --2/3/24, 2/4/24, 2/10/24, 2/11/24, 2/17/24, 2/18/24, 2/24/24, 2/25/24. -Ten out of 31 days in March 2024: --3/2/24, 3/3/24, 3/9/24, 3/10/24, 3/16/24, 3/17/24, 3/23/24, 3/24/24, 3/30/24, 3/31/24. Review of a Daily Staffing Roster dated 1/6/24 and 1/7/24 showed no assigned RN coverage in the building. Review of a Payroll Detail Sheet dated 1/7/24 showed the Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) who was also an RN was in the building for 4.98 hours. Review of a Daily Staffing Roster dated 1/13/24 showed no assigned RN coverage in the building. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an undated RN Coverage Data Sheet showed the Director of Nursing (DON) was the assigned RN coverage for 1/13/24. Review of a Payroll Detail Sheet dated 1/13/24 showed the MDS Coordinator was in the building for 3.75 hours. Review of a Daily Staffing Roster dated 1/20/24 showed the MDS Coordinator was the assigned RN coverage in the building for that day. Review of a Payroll Detail Sheet dated 1/20/24 showed the MDS Coordinator had no work hours for that date. Review of a Daily Staffing Roster dated 1/21/24 showed the MDS Coordinator was the assigned RN coverage in the building for that day. Review of a Payroll Detail Sheet dated 1/21/24 showed the MDS Coordinator was in the building for four hours. Review of a Daily Staffing Roster dated 1/27/24 and 1/28/24 showed no assigned RN coverage in the building. Review of a Payroll Detail Sheet dated 1/28/24 showed the MDS Coordinator was in the building for four hours. Review of a Daily Staffing Roster dated 2/3/24 showed no assigned RN coverage in the building. Review of an undated RN Coverage Data Sheet showed the Director of Nursing (DON) was the assigned RN coverage for 2/3/24. Review of a Daily Staffing Roster dated 2/4/24 showed RN Supervisor A was the assigned RN coverage in the building. Review of a Payroll Data Sheet dated 2/4/24 showed RN Supervisor A had no work hours for that date. Review of an undated RN Coverage Data Sheet showed the DON was the assigned RN coverage for 2/4/24. Review of a Daily Staffing Roster dated 2/10/24 showed no assigned RN coverage in the building. Review of a Daily Staffing Roster dated 2/17/24 showed RN Supervisor A was the assigned RN coverage in the building. Review of an undated RN Coverage Data Sheet showed RN Supervisor A was the assigned RN coverage for 2/17/24. Review of a Payroll Data Sheet dated 2/17/24 showed RN Supervisor A was in the building for 1.37 hours. Review of a Daily Staffing Roster dated 2/18/24 showed no assigned RN coverage in the building. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Payroll Data Sheet dated 2/18/24 showed the MDS Coordinator was in the building for three hours. Review of a Daily Staffing Roster dated 2/24/24 showed no assigned RN coverage in the building. Review of an undated RN Coverage Data Sheet showed the DON was the assigned RN coverage for 2/24/24. Review of a Daily Staffing Roster dated 2/25/24, 3/2/24, 3/3/24, and 3/9/24 showed no assigned RN coverage in the building. Review of a Payroll Data Sheet dated 3/9/24 showed the MDS Coordinator was in the building for four hours. Review of a Daily Staffing Roster dated 3/10/24 showed no assigned RN coverage in the building. Review of a Payroll Data Sheet dated 3/10/24 showed the MDS Coordinator was in the building for two hours. Review of a Daily Staffing Roster dated 3/16/24, 3/17/24, and 3/23/24 showed no assigned RN coverage in the building. Review of a Payroll Data Sheet dated 3/23/24 showed the MDS Coordinator was in the building for 5.45 hours. Review of a Daily Staffing Roster dated 3/24/24, 3/30/24, and 3/31/24 showed no assigned RN coverage in the building. During an interview on 7/14/24 at 11:56 A.M. the DON said: -From the end of last year into the springtime the facility lacked RN coverage. -He/She had started to work at the facility some time in February this year and provided most of the RN coverage. During an interview on 7/17/24 at 10:34 A.M. Certified Nursing Assistant (CNA) E said: -The RN coverage was usually marked on the Daily Staffing Roster. -The DON provided the RN coverage most of the time. During an interview on 7/17/24 at 1:40 A.M. Licensed Practical Nurse (LPN) C said: -The MDS Coordinator and the DON provided most of the RN coverage. -The RN coverage was usually marked on the posted staffing sheets, but the sheet would not indicate who was the assigned RN. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She had been aware that the building lacked RN coverage in the past and it seemed to improve once the DON started. During an interview on 7/18/24 at 8:25 A.M. the MDS Coordinator said: -He/She and the DON provided the RN coverage in the building. -Whenever he/she was the assigned RN, he/she would stay in the building for at least eight consecutive hours. -He/She was unsure how the facility would indicate the RN coverage hours provided by the DON on the PBJ report due to the DON being a salaried employee. During an interview on 7/18/24 at 9:01 A.M. the Assistant Director of Nursing (ADON) said: -The DON and the MDS Coordinator were the RN coverage for the building. -He/She was unsure how the facility would indicate the RN coverage hours provided by the DON on the PBJ report due to the DON being a salaried employee. During an interview on 7/18/24 at 9:36 P.M. the Administrator said: -He/She thought the PBJ data report for Fiscal Year Quarter Two was accurate and reflected the facilities actual RN coverage in the building. -The facility had gone through multiple staffing coordinators, and they would have been the ones to mark the RN coverage on the Daily Staffing Roster during that time frame.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on interview and record review, the facility failed to ensure resident's attending physicians documented their review of and response to irregularities identified by the facility's consulting pharmacist during monthly Medication Regimen Reviews (MRRs) for two residents (Resident #8 and Resident #32) of five residents reviewed for unnecessary medications. The facility census was 53. Review of an undated facility policy titled Psychotropic Medications showed effects of psychotropic medications on a resident's well-being would be monitored on an ongoing basis including during the pharmacist's monthly medication review but provided no other information on pharmacist medication reviews. A policy on pharmacist medication reviews was requested, but not provided prior to exit. 1. Review of Resident #8's Quarterly Minimum Data Set (MDS-a federally mandated comprehensive assessment), dated 4/15/24, showed the resident had: -Diagnoses including dementia with behavioral disturbance, bipolar disorder (a mental disorder associated with mood swings ranging from depression to manic highs), depression, and anxiety. -Received antipsychotic, anticoagulant, and diuretic medications. Review of the resident's Physician Order Summary (POS), dated 7/17/24, showed orders for: -Eliquis, an anticoagulant medication used to prevent blood clots, 5 milligrams (mg) twice daily. -Furosemide, a diuretic medication used to treat fluid buildup in the body, 20 mg daily. -Risperidone, an antipsychotic used to treat bipolar disorder, 0.5 mg daily. Review of the resident's care plan on 7/17/24 showed: -The resident was at risk for bleeding related to long term use of anticoagulant medications. -The resident was at risk for changes in mood and behavior as well as adverse reactions related to psychotropic medication use. -The resident exhibited verbal behavioral symptoms directed at others. -The resident was at risk for a hydration deficit related to diuretic use. -Staff were to obtain a pharmacy consult. Review of the resident's progress notes made by Consultant Pharmacist (PH) A, from the previous six months, showed pharmacist MRR's were completed on: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/25/24 with recommendations to the physician. -2/20/24 with no recommendations. -3/26/24 with recommendations to the physician. -4/19/24 with recommendations to the physician. -5/14/24 with no recommendations. -6/6/24 with no recommendations. Review of the resident's medical record showed one Consultant Pharmacist Recommendations to Physician sheet, dated 4/19/24, with a response from the physician. No MRR reports were provided for 1/25/24, or 3/26/24 which had unknown recommendations to the resident's physician. 2. Review of Resident #32's Quarterly MDS, dated [DATE], showed the resident had: -Diagnoses including degeneration of the brain, dementia with behavioral disturbance, anxiety and depression. -Received antianxiety and antidepression medications. Review of the resident's POS, dated 7/17/24, showed orders for: -Divalproex, a medication used to treat seizures and the manic phase of bipolar disorder, listed in the POS as prescribed for mood stabilization, 125 mg two times daily. -Lorazepam, an antianxiety medication, 0.5 mg two times daily. -Zoloft, an antidepressant medication, 50 mg once daily. Review of the resident's care plan on 7/17/24 showed: -The resident had impaired cognitive function. -The resident needed a pharmacy consult for antipsychotic and antidepressant medication use. Review of the resident's progress notes made by Consultant Pharmacist (PH) A, from the previous six months, showed pharmacist MRR's were completed on: -1/25/24 with recommendations to the physician. -2/20/24 with recommendations to the physician. -3/26/24 with no recommendations. -5/14/24 with no recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/6/24 with recommendations to the physician. -No note was found for the month of April, 2024. Review of the resident's medical record showed three Consultant Pharmacist Recommendations to Physician sheets: -A sheet dated 1/25/24, showed pharmacist recommendations, a physician response, and a change made by the facility. -A sheet dated 2/20/24, showed pharmacist recommendations to attempt a dose reduction for Divalproex, Lorazepam and Zoloft, no physician response, and no further documentation by the facility. -A sheet dated 6/6/24, showed pharmacist recommendations to attempt a gradual dose reduction for Divalproex 125 mg twice daily, recommended a dose of 125 mg once daily, and had a reminder that the dose reduction was due. The sheet from 6/6/24 contained no physician response and no further documentation by the facility. 3. During an interview on 7/18/24 at 9:50 A.M., the Director of Nursing (DON) said: -The consulting pharmacist performed a monthly review of resident's medication regimen and made recommendations to the physician. -The physicians should have responded within two to three weeks to the recommendations. -The Assistant Director of Nursing was responsible for sending the MRR to the physician and ensuring a response. -He/She expected physician responses to each MRR to be in the resident's medical record. -He/She did not expect MRRs to go without a response from the physician. -Staff should have followed up with the physician to receive a response to the MRRs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on observation, interview, and record review, the facility failed to ensure staff administered medications to residents with a medication error rate of less than 5%. Facility staff made five medication errors out of 27 attempts, for a medication error rate of 18.52%. This affected five out of ten residents observed during medication pass (Resident #156, #157, #6, #33, #47). The facility census was 53 residents. Review of an undated facility policy titled Medication Administration showed medications in accordance with professional standards of practice. Review of an undated facility policy titled Medication Errors showed: -The facility should have ensured medications were given per physician orders, according to manufacturers specifications regarding the preparation and administration of the drug, and in accordance with professional standards of practice. -The facility must have ensured a medication error rate of less than 5%. -The facility considered factors indicating medication errors to include: --Medication omission. --Incorrect dose, route, dosage form, or timing. --Incorrect medication. Review of an undated facility policy titled Insulin Pen showed staff were to: -Prime the insulin needle by dialing the pen to two units of insulin and pushing the plunger until at least one drop of insulin appears on the tip of the needle. -Administer the insulin. Review of the product insert for Humalog dated 2023 showed: -Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. -To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Novolog product insert dated 2/2023 showed: -Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. 1. Review of Resident #157's Physician Order Summary (POS) showed orders for Humalog (a rapid acting insulin) four units subcutaneously (in fatty tissue via injection) three times per day. Observation on 7/16/24 at 10:47 A.M., showed Certified Medication Technician (CMT) A retrieved an insulin pen from the medication cart containing Humalog insulin. CMT A entered the resident's room, applied a needle to the insulin pen, set the pen to four units, then administered the insulin to the resident without priming the needle. 2. Review of Resident #156's POS showed orders for Novolog (a rapid acting insulin) at a dose that was blood glucose level dependent (4 units for the resident's blood glucose at that time), three times per day. Observation on 7/16/24 at 10:52 A.M.,showed CMT A returned to the medication cart, took out an insulin pen and applied the needle to the pen. Observation on 7/16/24 at 10:53 A.M., CMT set the pen to four units, which was consistent with physician orders for the resident's blood glucose level at the time, then administered the insulin to the resident without priming the needle. During an interview on 07/16/24 at 11:21 A.M., CMT A said: -When administering insulin to residents, he/she would apply the needle, set the insulin pen to the correct dose and administer the drug. -He/She thought he/she had primed insulin pens in the past. -He/She usually tried to prime insulin pens before administration, but the problem was if he/she waited too long after priming, the pen would not work correctly. -He/She primed the insulin pens prior to administration of the insulin doses to both residents. -He/She was unable to describe the method used to prime the insulin pens. -Administering insulin was part of his/her daily duties. During an interview on 7/17/24 at 11:24 A.M., Licensed Practical Nurse (LPN) A said the insulin pen needle must be primed prior to administering insulin to residents to ensure the proper dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/24 at 9:50 A.M., the Director of Nursing (DON) said he/she would expect the needle to be primed with insulin prior to administration to ensure the proper dosage of medication. 46519 3. Review of the Food and Drug Administration (FDA) detailed instructions for Calcitonin (Salmon) Nasal Spray Solution (used to treat bone loss in women with postmenopausal osteoporosis) dated September 2017 showed: -The pump did not need to be primed before each use of the solution. -To administer the solution, the nozzle needed to be carefully placed into the resident's nostril, while the resident's head was in an upright position. Review of Resident #6's face sheet showed he/she admitted to the facility with a diagnosis of Age-Related Osteoporosis (a condition in which the bones become brittle and fragile from loss of tissue). Review of the resident's Annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/9/24 showed the resident was cognitively intact. Review of the resident's Physician Order Sheet (POS) dated July 2024 showed an order for Calcitonin Nasal Spray Solution 200 Unit (U), one spray in alternating nostrils during the day shift. Observation on 7/16/24 at 9:27 A.M. of the resident's Calcitonin administration completed by Licensed Practical Nurse (LPN) D showed: -He/She told the resident he/she would spray the medication into the resident's left nostril. -He/She then inserted the tip of the bottle into the resident's left nostril and instructed the resident to lean his/her head backwards. -He/She sprayed the medication into the nostril without agitating the solution, occluding the right nostril, or instructing the resident to inhale with his/her mouth closed. -He/She then sprayed a second dose of the medication into the same nostril due to not hearing the solution spray into the left nostril without agitating the solution, occluding the right nostril, or instructing the resident to inhale with his/her mouth closed. -The resident stated that he/she had not felt the medication go into his/her nose, so LPN D sprayed a third dose of the medication into the resident's left nostril without agitating the solution, occluding the right nostril, or instructing the resident to inhale with his/her mouth closed. 4. Review of Resident #33's face sheet showed he/she admitted to the facility with the following diagnoses: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Right-Sided Heart Failure (when the heart's right ventricle is too weak to pump enough blood to -the lungs). -Gastro-Esophageal Reflux Disease (GERD- a digestive disease in which stomach acid or bile irritates the food pipe lining). -Long-Term Use of Anticoagulants (blood thinners) (used to reduce the risk of blood clots and/or stroke). -Edema (fluid retention). -Vitamin Deficiency (a long-term lack of a vitamin). Review of the resident's Quarterly MDS dated [DATE] showed the resident was cognitively intact. Review of the resident's POS dated July 2024 showed: -An order for Eliquis (Apixaban- used to treat people who have had a health problem caused by a blood clot) 2.5 milligrams (mg), give one tablet by mouth two times a day. -An order for Furosemide (Lasix- used to remove excess fluid from the body to decrease the workload of the heart) 40 mg, give one tablet by mouth in the morning every other day. -An order for Famotidine (used to treat GERD) 20 mg, give one tablet by mouth during the day shift. -An order for Spironolactone (used to treat edema) Oral Tablet 25 mg, give one tablet by mouth during the day shift. -An order for Multivitamin Oral Tablet, give one tablet by mouth during the day shift. Observation on 7/16/24 at 9:36 A.M. of the resident's medication administration completed by LPN D showed: -He/She reviewed the resident's orders and took the resident's medication strip pack out of the medication cart. -He/She placed the Furosemide, Eliquis, Spironolactone, and the Multivitamin into a medication cup. -He/She was unable to find the resident's Famotidine on the resident's medication strip pack. -He/She entered the resident's room and administered the Furosemide, Eliquis, Spironolactone, and Multivitamin to the resident, without indicating the Famotidine was missing. Review of an Orders-Administration Note dated 7/16/24 at 9:46 A.M. completed by LPN D showed the medication was not available at that time. NOTE: No other notes were made related to the omission of the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #47's face sheet showed he/she admitted to the facility with the following diagnoses: -Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats). -Primary Hypertension (high blood pressure). -Hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone). Review of the resident's Quarterly MDS dated [DATE] showed the resident was severely cognitively impaired. Review of the resident's POS dated July 2024 showed: -An order for Lexapro (Escitalopram Oxalate- used to treat certain mental/mood disorders such as anxiety) 5 mg, give 5 mg by mouth in the morning. -An order for Amlodipine Besylate (used to treat high blood pressure) 5 mg, give two tablets by mouth one time a day. -An order for Atenolol (used to treat high blood pressure) 50 mg, give one tablet by mouth in the morning. -An order for Calcium-Vitamin D Oral Tablet (used to treat a vitamin deficiency or taken as a supplement) 600-3.125 mg-micrograms (mcg), give one tablet by mouth one time a day. -An order for Losartan Potassium (used to treat high blood pressure) 100 mg, give one tablet by mouth in the morning. -An order for Cholecalciferol (Vitamin D3- used to treat a vitamin deficiency or taken as a supplement) Oral Tablet, give one tablet by mouth one time a day. Observation on 7/16/24 at 9:49 A.M. of the resident's medication administration completed by LPN D showed: -He/She reviewed the resident's orders and took the resident's medication strip pack out of the medication cart. -He/She placed the Lexapro, Amlodipine, Calcium-Vitamin D, Losartan Potassium, and Cholecalciferol into a medication cup. -He/She had attempted to place the Atenolol in the medication cup but had missed the medication cup and the tablet spilled onto the medication cart. -He/She then entered the resident's room and administered the Lexapro, Amlodipine, Calcium-Vitamin D, Losartan Potassium, and Cholecalciferol, without indicating the Atenolol was missing. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Orders-Administration Note dated 7/16/24 at 10:02 A.M. completed by LPN D showed the medication had been dropped during medication pass. NOTE: No additional notes or follow-up had been completed related to the dropped medication. Review of Resident #47's vital signs in the Electronic Medical Record (EMR) on 7/17/24 at 9:52 A.M. showed: -LPN D had documented the resident's blood pressure on 7/16/24 at 10:03 A.M. as 147/75 millimeters of Mercury (mmHg). -LPN D had not recorded any other blood pressure during his/her shift into the resident's EMR. 6. During an interview on 7/16/24 at 10:04 A.M. LPN D said: -He/She thought the medication pass went okay. -The only thing he/she would have done differently was not drop the Atenolol during the medication administration to Resident #47. -He/She was going to waste the pill with another nurse after the medication pass was completed. During an interview on 7/16/24 at 11:20 A.M. LPN D said: -He/She had not wasted the Atenolol yet. -The nasal spray bottles could be tricky and not all of the medication would not come out sometimes during administration. -He/She would normally just administrate one spray of the Calcitonin Nasal Spray to Resident #6 but had been nervous during the medication administration. -Famotidine was normally in the medication packs for each resident provided by the pharmacy. -He/She would check Resident #47's blood pressure later on in the shift if Resident #47 let him/her do so. -No other follow-up needed to be completed related to the omitted medications during the medication administrations. During an interview on 7/17/24 at 11:29 A.M. LPN C said: -During nasal spray administration, the spray needed to be primed before the spray could be used and the resident's head needed be in a downward position. -The nurse had not given the nasal spray correctly and should have not sprayed three doses of medication into the nostril regardless of whether or not the nurse questioned if the resident had received the first dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Most medications, including Famotidine were included in the resident's medication strip pack. -If a medication was not found in the medication strip pack, he/she would contact pharmacy and see if the medication could be pulled from the facility's emergency supply or use a different day's dose of the medication. -Once contact with the pharmacy was made, he/she would then document a note related to the conversation with the pharmacy, including what instructions the pharmacy provided. -If a pill had been dropped during medication pass then the same process would be used for missing medication. -If any medication could not be given during medication pass, then he/she would contact the doctor and document a note related to the conversation and any new orders that were provided. -What the nurse had done related to the omitted medications was incorrect. -He/She would have additionally checked the resident's blood pressure throughout the shift if the Atenolol was not able to be given. During an interview on 7/18/24 at 8:42 A.M. the Assistant Director of Nursing (ADON) said: -During nasal spray administration, the spray needed to be primed before the spray could be used, the resident's opposite nostril needed to be held down, and the resident's head needed to be in an upright position only slightly tilted back. -The nurse had not given the nasal spray correctly. - The nurse should not have administered additional doses of the nasal spray even if the nurse thought the dose was not fully given during the first spray of the medication. -All medications given to residents were provided by the pharmacy. -The medications were either in the strip pack or in their own individual box for each resident. -If a medication could not be found on a medication strip pack, then he/she would expect the nurse to check other locations, contact pharmacy, and document a progress note with the inclusion of what the pharmacy instructed the nurse to do. -Only documenting a note that the medication was not available was not satisfactory and the nurse should have contacted the pharmacy. -If a pill were to be dropped during medication pass, he/she would expect the nurse to destroy the pill and a note be documented. -The nurse should have pulled the Atenolol for the end of the strip and contacted the pharmacy to inform them of the additional dose that had been used. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would have also expected the nurse to have contacted the facility's doctor and document a note. -The note the nurse documented related to the pill being dropped was not sufficient. During an interview on 7/18/24 at 9:51 A.M. the Director of Nursing (DON) said: -During the administration of nasal spray, the spray needed to be primed before the spray could be used and the resident's head should be in an upright position, not tilted too far back. -The nurse had not administered the nasal spray correctly. -The nurse should not have given the second and third dose of the medication even if he/she thought the full dose had not been administered. -If a medication could not be found on the resident's medication strip pack, then he/she would have expected the nurse to have pulled the medication from the facility's emergency supply. -The pharmacy should have also been contacted and informed to send any missing medication in a STAT (immediate) order. -He/She would have expected the nurse to document a note after the pharmacy was contacted. -Only documenting that the medication was missing was not sufficient. -If a medication were to be dropped during medication pass, then he/she would expect the nurse to pull the medication from the end of the medication strip pack. -He/She would have expected the nurse to contact the pharmacy and inform the pharmacy which day of the dose was used and to have documented a note related to the pharmacy contact. -He/She would have expected the nurse to have contacted the facility's doctor and inform the doctor of why the medication was not given. -The note the nurse documented was not sufficient related to the dropped medication.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on observation, interview, and record review, the facility failed to ensure two sampled residents (Resident #6 and #1) received routine dental services (an annual inspection of the oral cavity for any signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings, minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic (a specialized branch of dentistry dedicated to making artificial teeth) care and procedures) out of 15 sampled residents. The facility census was 53 residents. Review of the facility's undated policy titled Dental Services showed: -It was the policy of the facility to assist residents in obtaining routine and emergency dental care. -The dental needs of each resident were identified through physical assessment and the Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) assessment processes and were addressed in each resident's plan of care. -For residents or resident representatives who did not wish to be referred for dental services, the resident's care plan would be revised to reflect the preferences. -All actions and information regarding dental services, including any delay related to obtaining dental services, would be documented in the resident's medical record. 1. Review of Resident #6's face sheet showed an initial admitted [DATE] and was admitted to the facility with the following diagnoses: -Pain, Unspecified. -Age-Related Osteoporosis (a condition in which the bones become brittle and fragile from loss of tissue). Review of the resident's Annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/9/24 showed the resident was cognitively intact. He/She had no dental issues or concerns at that time. Review of the resident's care plan dated 6/24/24 showed no focus, goal, or interventions related to the resident's dental services or needs. Review of the resident's Physician Order Sheet (POS) dated July 2024 showed: -An order for Acetaminophen (Tylenol- used to treat mild pain or fevers) Oral Tablet 325 milligrams (mg), give 650 mg by mouth two times a day. -An order for Acetaminophen Oral Tablet 325mg, give two tablets by mouth as needed every four hours for mild pain or temperature greater than 100.0 degrees Fahrenheit (F). (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order for Tramadol (Ultram- used as a pain reliever) HCl Oral Tablet 50 mg, give 50 mg by mouth every eight hours as needed for pain. Review of the resident's Medication Administration Record (MAR) dated July 2024 showed: -The resident received Acetaminophen Oral Tablet 325 mg, give two tablets by mouth as needed every four hours for increased pain on: -7/11/24 with a pain scale rating of 4 out of 10 (0 indicating no pain, 10 being the worst pain). The documentation did not indicate where the resident's pain was located. -7/14/24 with a pain scale rating of 6 out of 10. The documentation did not indicate where the resident's pain was located. -7/15/24 the resident received two doses. One was for a pain scale of 6 out of 10 and the second dose was for a pain scale of 4 out of 10. The documentation did not indicate where the resident's pain was located. -The resident received Tramadol HCl Oral Tablet 50 mg on: -7/13/24 with a pain scale of 7 out of 10. The documentation did not indicate where the resident's pain was located. -7/14/24 the resident received two doses. Both were for a pain scale of 7 out of 10. The documentation did not indicate where the resident's pain was located. Observation on 7/15/24 at 10:05 A.M. showed the resident was holding his/her hand up to his/her lower lip and was grimacing. During an interview on 7/15/24 at 10:06 A.M. the resident said: -He/She had a toothache to one of his/her bottom teeth. -The toothache had started around three days prior. -He/She had not seen a dentist yet related to his/her toothache. -The staff were aware of the resident's toothache. -He/She was unsure of what the facility was doing for his/her toothache besides giving him/her pain medication. -The staff had not offered for him/her to see the dentist related to his/her toothache. -He/She had not seen a dentist since before he/she admitted to the facility. During an interview on 7/16/24 at 12:48 P.M. the resident said he/she was eating soup for lunch due to the toothache bothering him/her. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 7/16/24 at 1:06 P.M. of the resident's medical record showed no documentation related to dental services received while residing at the facility. During an interview on 7/16/24 at 2:00 P.M. the Director of Nursing (DON) said he/she could not find any dental notes for the resident. 2. Review of Resident #1's face sheet showed an initial admitted [DATE] and was admitted to the facility with the following diagnoses: -Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). -Gastro-Esophageal Reflux Disease (GERD- a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of the resident's care plan dated 6/24/24 showed no focus, goal, or interventions related to the resident's dental services or needs. Review of the resident's Quarterly MDS dated [DATE] showed the resident was cognitively intact. During an interview on 7/15/24 at 1:15 P.M. the resident said: -He/She had not been to a dentist in over a year. -He/She would like to see a dentist for a general check-up. Review on 7/16/24 at 1:06 P.M. of the resident's medical record showed no documentation related to dental services received while residing at the facility. During an interview on 7/16/24 at 2:00 P.M. the Director of Nursing (DON) said he/she could not find any dental notes for the resident. 3. During an interview on 7/17/24 at 10:46 A.M. Certified Nursing Assistant (CNA) E said: -He/She thought residents had to go out of the facility to see a dentist. -He/She was unsure of when Resident #1 or Resident #6 last saw a dentist. -He/She was aware of Resident #6's toothache. -Whenever Resident #6 needed any type of acute care, Resident #6 would request to see the facility's doctor. -The Social Services Designee (SSD) was responsible for setting up resident appointments. During an interview on 7/17/24 at 11:51 A.M. LPN C said: (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents were sent out of the facility to see a dentist. -He/She was unsure when Resident #1 and Resident #6 last saw the dentist. -He/She was aware of Resident #6's toothache. -He/She had not set up or scheduled Resident #6 to see a dentist. -Resident #1's and Resident #6's families were both really involved in the resident's care and would help with appointments. -He/She thought dentist appointments were scheduled based off resident preference. -The nurses or the SSD could set up a dentist appointment for any resident as needed. During an interview on 7/17/24 at 12:57 P.M. the SSD said: -Residents went out of the facility to see a dentist. -Residents were seen by a dentist as needed or upon family request. -He/She was not aware that Resident #1 or Resident #6 wanted to see the dentist. -Resident #1's and Resident #6's families were very involved in the residents' care and were on top of these things. -He/She would need to ask Resident #1's and Resident #6's families when they last saw a dentist. -Both Resident #1 and Resident #6 were still able to make their own medical decisions. -He/She was not aware of the facility's policy or regulation related to dental services. -Dental preferences should be added to all resident care plans. During an interview on 7/18/24 at 8:34 A.M. the MDS Coordinator said: -He/She was unsure how residents were seen for their dental care. -Dental needs and preferences were not discussed at care plan meetings. -He/She never included dental preferences on the care plans. -He/She was only just made aware of the facility's policy and the federal regulation related to dental services. During an interview on 7/18/24 at 9:13 A.M. the Assistant Director of Nursing (ADON) said: -Residents were sent out of the facility to see a dentist. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unsure how the facility ensures residents dental needs were met. -Dental needs and preferences should be on resident care plans. -He/She was unaware of Resident #6's toothache. -He/She was unaware of Resident #'1 want to go to a dentist. During an interview on 7/18/24 at 10:01 A.M. the DON said: -The residents were sent out of the facility to see a dentist. -The family members of residents would assist in making appointments including dentist appointments. -Nurses could also assist in scheduling appointments including dental appointments. -He/She was unaware of Resident #6's toothache. -He/She would have expected the staff to have set up a dental appointment for Resident #6 or at least checked in with Resident #6's family by now. -He/She was unaware of the facility's policy and the federal regulation related to dental services. -Dental preferences should be on care plans. -The SSD usually set up the facility's podiatry appointments, so he/she would also be responsible for setting up facility wide dental services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview, and record review, the facility failed to ensure the pureed (cooked food, that has been ground, pressed, blended or sieved to the consistency of a creamy paste or liquid) eggs were not bland; and failed to ensure that hot foods on room trays were at or close to 120 F (degrees Fahrenheit) at the time of delivery. This practice potentially affected one resident with a pureed diet and three residents who received room trays. The facility census was 53 residents. 1. Review of the recipe for five serving of pureed eggs, copyrighted 2024, showed: -Five boiled eggs and 1/4 cup of warm milk. -Directions included: Place prepared eggs and milk in a washed and sanitized food processor, blend until smooth. Reheat to 165 F for at least 15 seconds and maintain at 135 F. Observation on 7/17/24 from 7:01 A.M. through 7:04 A.M. showed the Dietary [NAME] (DC) A made the pureed eggs, by adding 2 boiled eggs and a small portion of cold milk to the food processor. During an interview on 7/17/24 at 7:04 A.M., DC A said he/she usually used milk with the pureed eggs. Observation on 7/17/24 at 7:36 A.M., during a taste test by the state surveyor, showed the pureed eggs were very bland. Observation on 7/17/24 at 7:37 A.M., during a taste test the Dietary Director (DD) tasted pureed eggs and observed the flavor was very bland. During an interview on 7/17/24 at 7:39 A.M. the DD said the following regarding the pureed eggs: -He/She only placed the recipe for hard boiled eggs and pureed eggs into the recipe book about 2 weeks prior to the survey. -He/She was not sure if anyone had tasted the hard-boiled eggs in a pureed form. -That day (7/17/24), was the first time they had hard-boiled eggs on the menu. During a phone interview on 7/17/24 at 12:31 P.M., the Consultant Registered Dietitian said: -The dietary staff has not contacted him/her about the flavor of the pureed eggs. -He/She had not looked at the egg recipe in a while. -The first thing they can do is change the recipe and then taste the recipe and find out what the recipe is like. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 7/17/24 at 8:35 A.M., showed the sausage on a test room tray for the 200 Hall room tray was 101.3 F. During an interview on 7/17/24 at 8:37 A.M., the DD said since he/she has been the DD he/she has not had her dietary staff check the temperatures of the food items on the room trays. During an interview on 7/17/24 at 9:18 A.M., the DD said he/she has not been taught to check room trays and some of the residents who received room trays have mentioned the food was cold in the past. Review of Resident #155's Admission's Minimum Data Set (MDS--a federally mandated assessment tool completed by the facility for care planning) dated 6/19/24, identified the resident as cognitively intact. During an interview on 7/18/24 at 9:51 A.M., the resident said about half the time when the food was delivered to him/her, it was cold. Review of Resident #49's Admission MDS dated [DATE], identified the resident as cognitively intact. During an interview on 7/18/24 at 9:53 A.M., the resident said, sometimes all the meals may be cold, but breakfast meals are the meals that are is cold the most.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 19916 Based on observation and interview, the facility failed to maintain the baffle vents (metal vents which trap oil and grease that would make it into a kitchen's atmosphere by passing air through a series of interlocking baffles, because the oil gets stuck to the stainless steel or aluminum interior walls of the range hood (an open metal enclosure over cooking surfaces through which air is drawn in from the surrounding spaces to exhaust heat and grease, and to control the flow of rising hot air)) over the deep fat fryer free of a heavy buildup of grease; failed to maintain the floor behind the deep fat fryer free of a heavy buildup of grease; failed to maintain packages of zucchini sticks, breaded okra and frozen meat patties with a date and closed in the freezer; failed to maintain two cutting boards in an easily cleanable condition; failed to ensure the food processor was washed in a 3-step process between uses in processing different foods; failed to maintain the milk in the dining room at or close to 41 F (degrees Fahrenheit). This practice potentially affected all residents. The facility census was 53 residents. 1. Observations during the initial kitchen tour on 7/14/24 from 12:54 A.M. through 1:16 P.M., showed: -A buildup of grease on the baffle vents over the deep fat fryer. -A buildup of grease and cooking debris around the rim of the deep fat fryer. -Three packages of zucchini sticks, one package of breaded okra, one package of breaded chicken tenders and one package of frozen meat patties, which were not labeled with a date the packages were opened and the packages were not sealed. -The presence of red and brownish stains under one shelf which held meat. During an interview on 7/14/24 at 1:05 P.M., Dietary [NAME] (DC) A said: -He/She worked every other weekend and during the week. -Items in the freezer should all be sealed, labeled and dated and identified the packages of breaded okra, chicken tenders and frozen chicken were unsealed and unlabeled with a date they were opened. -They have ordered a solution to get the stains up but it had not come in yet. 2. Observations during the breakfast meal on 7/17/24 from 5:46 A.M. through 8:12 A.M., showed: -Two blue cutting boards not in an easily cleanable condition. -A buildup of grease on the baffle vents over the deep fat fryer. -A buildup of grease and cooking debris around the rim of the deep fat fryer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-DC A used the food processor to process and puree eggs and just rinsed the food processor instead of washing the food processor in a 3-step process (washing, rinsing and sanitizing). -DC A then used the food processor to process mechanical soft and pureed sausage. -DC A then only rinsed out the food processor -At 8:26 A.M., the milk in the bottle in the main dining room was 51.4 F During an interview on 7/17/24 at 8:29 A.M., the Dietary Director (DD) said he/she was not sure if the dietary staff had checked the temperature of the milk and the milk was not on ice. During interviews from 9:08 A.M. through 9:16 A.M., the DD said: -He/She had not conducted any in-services regarding the cutting boards since he/she has taken over. -The dietary staff were supposed to clean behind the deep fat fryer every two weeks. -He/She did not have the dietary staff to clean the baffle vents because he/she thought the range hood cleaning company cleaned the baffle vents. - He/She expected the dietary staff to do a three-step process or run the food processor through the dishwasher after each food is processed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 33409 Based on observation, interview and record review, the facility failed to ensure to have monitoring and required documentation of Hospice care (a type of health care that focuses on comfort care of a terminally ill resident) visits and failed to obtain pertinent documentation of the the delivery of Hospice care services for one sampled resident (for one sampled resident (Resident #35) out 15 sampled residents. The facility resident census of 53 residents. Review of the facility's Hospice Agreement dated and signed on 8/2/18 showed: -Hospice and the facility shall each establish and maintain it's own clinical record for each resident in Hospice program. -All services performed directly by the Hospice or under arrangement by the facility shall be promptly entered into respective clinic record. -The Hospice nurse will complete a system assessment of each resident enrolled in the program, make recommendation interventions for resident and reviewed with the facility. 1. Review of Resident #35's Admission Record showed the resident was admitted to Hospice services. Review of the resident's Physician Order Sheet (POS) dated 7/16/24 showed the resident had a physician order to admit to Hospice services and recertified for Hospice Care dated 11/2/23. Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 6/16/24, showed he/she: -Was cognitively intact and able to make his/her need known. -admitted to Hospice services while a resident at the facility. Review of the resident's Care Plan revised on 6/24/24 showed the resident did not have a hospice care plan in his/her electronic medical record. During an interview on 7/15/24 at 10:48 A.M. the resident said: -He/She was on Hospice services. -Hospice staff assist the resident with bathing and cares as needed. -He/She was not sure how often the Hospice staff come to facility. Review of the resident's Hospice Binder on 7/17/24 at 9:35 A.M., showed the resident: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had Hospice staff sign-in form to include signature for Registered Nurse (RN) visit on 6/25/24 and on 7/15/24. -NOTE: did not have the documentation for RN visit on 6/25/24 and 7/15/24. -His/Her Hospice Plan of Care for certified period from 1/7/24 to 3/6/24 to include nursing visit one time a week for nine weeks, Hospice Aide visit for two times a week for nine weeks. --No documentation of a hospice certification after the certified period ending 3/6/24 and no documentation of an updated hospice care plan. -Most current resident's Hospice Nursing Visit Summary completed by Licensed Practical Nurse (LPN) was dated 6/19/24. Review of the resident's facility medical record dated 6/25/24 and 7/15/24 showed no communication documented related to Hospice nurse visit. During an interview on 7/17/24 at 9:58 A.M., Licensed Piratical Nurse (LPN) E and LPN C said: -The resident was on Hospice services. -Facility nursing would contact hospice by phone or address any concern with the Hospice nurse visiting that day. -Normally Hospice staff were at facility at least twice a week and Hospice staff document the visit in the resident hospice binder. -Facility nursing would document any new resident concerns and contact with Hospice staff in the resident's progress note . -Hospice case manager would be responsible for sending the nursing summary visit to the facility. -As the charge nurses, LPN E and LPN C did not monitor or review the resident's Hospice binder. -Hospice staff would inform the Assistant Director of Nursing (ADON) with any concern. During an interview on 7/17/24 at 12:24 P.M., the ADON said: -He/She would review any documentation provided by Hospice staff. -If the Hospice nurse received a change in physician orders, he/she would ensure to update the residents POS with the new physician order. -Medical records would be responsible for placing those Hospice documents in the resident's Hospice binder or scan the documents into the resident's Electronic Medical Record. During an interview on 7/17/24 at 12:58 P.M., Medical Records Staff said: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She received the resident's Hospice documentation from Hospice staff and would file that documentation in the resident's Hospice binder. -Hospice staff would be responsible to ensure a current assessment and care plan was in the resident's Hospice binder. -He/She just completed an audit of all residents on Hospice services, Hospice binders, including Resident #35's Hospice binder. -He/She had just received documentation from Hospice. -He/She was not aware the resident's Hospice certification and care plan were not current. -Medical Records staff would be responsible for scanning documents from Hospice or place Hospice documents into the resident's Hospice binder. During an interview on 7/18/24 at 9:51 A.M., the Director of Nursing (DON) said: -Hospice documentation: -Hospice documentation should be placed in the resident's Hospice binder or scanned into the resident's medical record. -The DON/ADON would be responsible for reviewing the Hospice binder for coordination of care and for missing Hospice documentation. -Resident #35 was on Hospice services, he/she was not sure the frequencies of the hospice visits. -He/She would expect to have current Hospice nursing summary in the Hospice binder binder. -Would expect to have current Hospice care plan and certification in Hospice binder. -He/She would expect nursing staff to document Hospice communication in the resident's progress notes. During an interview on 7/24/24 at 2:28 P.M., the Hospice Nurse/Case Manager said: -The resident was receiving Hospice services. -He/She would expect the resident's Hospice nurse visit summary be placed in the resident's Hospice binder weekly. -Hospice staff were responsible for ensuring the resident's Hospice binder was updated with the current certification, care plan and visit notes. -He/She was not aware until the week of 7/24/24 that the resident was missing nurse visit summaries and required an updated care plan and recertification to be completed.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to submit the required staffing data to the Payroll Based Journal (PBJ- a report that provides staffing dataset information submitted by nursing homes on a quarterly basis) for two of the last four quarters which had the potential to affect all residents. The facility census was 53 residents. Review of the facility's undated policy titled Payroll Based Journal showed: -It is the policy of the facility to electronically submit timely to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data in uniform format according to specifications established by CMS. -The facility would submit direct care staffing information on the schedule specified by CMS, but no less than quarterly. -The reporting deadlines included: --Fiscal Quarter One (October 1- December 31): [DATE]. --Fiscal Quarter Two (January 1- March 31): May 15. --Fiscal Quarter Three (April 1- June 30): August 14. --Fiscal Quarter Four (July 1- September 30): November 14. -Responsibilities for data submission included: --The Administrator, HR Director, and Director of Nursing were responsible for verifying accuracy of the staffing data that was submitted to CMS using various facility audit forms and/or payroll vendor reports. --The Business Office Manager was responsible for verifying the accuracy of census [NAME] and collaborating with the Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) for any needed corrections. --The Designated individual or vendor was responsible for submitting data and obtaining validation reports. --The Administrator was responsible for reviewing validation reports and ensuring that any needed corrections were made before the quarterly deadline. 1. Review of the Fiscal Year Quarter Three 2023 report showed the facility had failed to submit the required staffing data for the quarter. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Fiscal Year Quarter Four 2024 report showed the facility failed to submit the required staffing data for the quarter. During an interview on 7/18/24 at 8:27 A.M. the MDS Coordinator said he/she thought the admissions nurse, or the Administrator were the staff responsible for submitting the PBJ data. During an interview on 7/18/24 at 9:00 A.M. the Assistant Director of Nursing (ADON) said he/she thought Human Resources, or the Administrator were the staff responsible for submitting the PBJ data. During an interview on 7/18/24 at 9:33 A.M. the Administrator said: -He/She was responsible for submitting the PBJ staffing data. -The previous management company had not let him/her submit the PBJ data and it was the responsibility of someone higher up then him/her to submit the data. -He/She would not have been the one responsible for the data submissions for Fiscal Year Quarter Three 2023 or Fiscal Year Quarter Four 2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33409 Based on observation, interview, and record review, the facility failed to follow appropriate infection control practices during incontinence care for one sampled resident (Resident #20) who was on Enhanced Barrier Precaution (EBP - refer to an infection control intervention designed to reduce transmission of multi--resistant organisms that employs targeted gown and glove use during high contact resident care activities), who was at risk for infection due to an open wound on his/her coccyx (tail bone) area; failed to perform adequate hand hygiene during medication administration for one sampled resident (Resident #6) and two supplemental residents (Resident's #33 and #47) out of 15 sampled residents and nine supplemental residents; failed to screen all employees for tuberculosis (TB-a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, and abnormal lung tissue and function) and maintain documentation of all employees' tuberculin screening, and to ensure the facility policy and procedures for TB screening was followed for three of ten sampled employees. The facility census was 53 residents. Review of the facility's undated Enhanced Barrier Precautions Policy copyright 2024 showed: -Implement enhance barrier precaution for the prevention of transmission of multidrug resistant organisms. -Implementation of EBP: making gowns and gloves available immediately near or outside the resident's room. -Personal Protective Equipment (PPE) for EBP is only necessary when performing high contact care activities and may not need to be donned prior to entering the resident room. -High contact resident care include but not limited to: transferring a resident, bathing, providing hygiene, changing briefs or toileting and wound care. -EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound that placed the resident at higher risk. Review of the Center of Disease and Control (CDC), Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, Ref: QSO-24-08-NH updated on 3/20/24 showed: -(EBP) recommendations now include use of EBP for residents with chronic wounds during high-contact resident care activities regardless of their multidrug-resistant organism status. -Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound that placed them at higher risk. Review of the facility's undated policy titled Hand Hygiene showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors; this applied to all staff working in all locations within the facility. -Hand Hygiene was a general term for cleaning hands by handwashing with soap and water or the use of anti-septic hand rub, also known as alcohol-based hand rub (ABHR). -Hand hygiene with soap and water was to be performed under the listed conditions, but not limited to: --Hands being visibly soiled. --Hands being soiled with blood or other bodily fluids. -Hand Hygiene with ABHR was to be performed under the listed conditions, but not limited to: --Between resident contacts. --After handling contaminated objects. --Before applying and after removing personal protective equipment (PPE), including gloves. --Before preparing or handling medications. -The use of gloves did not replace hand hygiene; if a task required gloves staff were to perform hand hygiene prior to donning gloves, and immediately after removing gloves. 1. Review of Resident #20's Physician Order Sheet (POS) dated 7/1/24 showed: -Cleanse areas to right buttocks and coccyx with hypochlorous acid (is a solution that helps clean wounds and prevent infections). Apply Calmoseptine ointment (is barrier cream commonly used to treat and prevent minor skin irritations) to both areas and cover with an abdominal pad (ABD, is an extra thick primary or secondary dressing designed to care for moderate to heavily draining wounds pad). Change daily and as needed for Wound care. -No physician order found related to the resident on EBP. Review of the resident's Significant Change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 7/3/24, showed he/she: -Was severely cognitively impaired and had short term and long-term memory problems. -Had Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister) Pressure Ulcer/wound (PU, localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Had Stage III (a full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcer/wound. -Was always incontinent of bowel and bladder. -Was dependent on facility staff for all cares. Review of the resident's care plan revised on 7/9/24 showed the resident: -Was at risk for skin breakdown related to incontinent of bowel and bladder, impaired mobility, weakness. The resident had an open area on his/her buttocks and on his/her coccyx at that time. -Interventions included: --A sign on door indicating the need for EBP. --Staff member was to wear gown and gloves when providing care for the resident. -Initiated on 7/9/24, the resident had a Stage II wound to his/her right buttock; refer to POS for current treatment. -Initiated on 7/9/24, the resident had a stage III wound to coccyx, refer to POS for current treatment. Observation on 7/14/24 at 10:14 P.M., the resident room showed: -Had signage on the door stating a resident in that room was on Enhanced Barrier Precautions. -Staff were to wear gown and gloves when providing direct contact care for the resident, including incontinent care and wound care. Observation on 7/16/24 at 9:15 A.M., of resident care showed: -The resident had EBP signage posted on the door. -Certified Nursing Assistant (CNA) A and CNA B entered the resident's room washed their hands and applied gloves. They did not wear PPE gown prior to transferring the resident or when providing incontinent care. -CNA A and CNA B transferred the resident with a Hoyer lift (a mechanical transfer device) from his/her chair to the bed. -While in bed CNA A and CNA B removed the resident's pants and briefs. -CNA A provided incontinent care for the resident while CNA B assisted in holding/positioning the resident on his/her left side for cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The resident did not have a dressing on his/her coccyx wound at the time of incontinent care. -The resident had an open area on his/her coccyx. The open area was like a slit in buttocks crack area about 1/2 inch or less in length with white outer edges and reddish pink inside. -The buttocks had irritation on both side of cheeks, a with few spots with shearing (peeling of skin) observed. -He/She also had a dime sized scabbed over area on his/her right knee. -CNA A said the charge nurse would provide wound care and treatment later that morning. During an interview on 7/16/24 at 1:09 P.M., CNA A said: -He/She was not aware the resident was on EBP. -He/She went to ask the nurse if the resident was on EBP. -CNA A was informed by the nurse the resident was on EBP. -He/She should have worn a gown during the resident's incontinent care. -He/She did not realize the resident had open wound area on his/her coccyx prior to care. -He/She did not see the EBP signage on the resident's door. -EBP would be used when a resident had the potential of infection due to wounds or other risk factors. During an interview on 7/15/24 at 12:36 P.M., Licensed Practical Nurse (LPN) B said: -The resident was on EBP for wounds. -The resident only has a small open area on coccyx. -He/She would expect CNAs and nurses to wear gown and gloves when providing incontinent care or wound care. During an interview on 7/17/24 at 10:22 A.M., CNA C said: -The resident was on EBP for wounds and required gowning and gloving with direct care. -He/She had not had any recent training related to EBP. During an interview on 7/17/24 at 12:14 P.M., CNA D said he/she would wear gloves and gown with any direct contact care for any resident on EBP. During an interview on 7/17/24 at 1:16 P.M., the Infection Control Preventionist said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Enhanced Barrier Precaution would be used for those residents at risk for multi-drug resistant, to include residents with wounds. -For those residents on EBP, the PPE should be in the resident's room located in a drawer. -He/She would expect all care staff to wear gowns and gloves while providing incontinent care or other direct contact care for residents on EBP. -The resident was on EBP due to wounds. During an interview on 7/18/24 at 9:51 A.M., the Director of Nursing (DON) said: -Residents on EBP would be any resident with wounds and other risk factors. -Resident #20 was on EBP related to his/her wound. -He/She would expect nursing staff and care staff to wear PPE to include, gown and gloves when providing incontinent care or wound care for residents on EBP. -The Infection Control Preventionist would educate nursing staff and the facility nursing staff would educate CNAs or other care staff related to residents on EBP and what PPE required. -The resident on EBP should either have isolation cart outside room or staff can obtain gowns from the clean utility room. 46519 2. Review of an undated facility policy titled Nasal Spray Administration showed staff were to: -Wash hands thoroughly before beginning the procedure and don gloves. -Rinse the tip of the medication container in lukewarm water, and allow to dry. -Replace the cap. -Remove and discard gloves. Review of Resident #6's face sheet showed he/she admitted to the facility with the following diagnosis: -Age-Related Osteoporosis (a condition in which the bones become brittle and fragile from loss of tissue). -Nasal Congestion. Review of the resident's POS dated July 2024 showed an order for Calcitonin (Salmon) Nasal Spray Solution (used to treat bone loss in women with postmenopausal osteoporosis) 200 Units (U), one spray in alternating nostrils during the day shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 7/16/24 at 9:27 A.M. of the resident's medication administration completed by LPN D showed: -He/She did not perform hand hygiene before dispensing the medication into the medication cup. -He/She grabbed gloves before entering the resident's room. -He/She did not perform hand hygiene upon entry to the resident's room. -He/She handed the medication cup to the resident and donned the gloves that were in his/her hands without performing hand hygiene prior to donning the gloves. -He/She then administered the nasal spray into the resident's left nostril. -He/She re-capped the nasal spray solution without cleaning the tip of the medication container. -He/She removed his/her gloves and exited the resident's room without performing hand hygiene. 3. Review of Resident #33's face sheet showed he/she admitted to the facility with the following diagnoses: -Right-Sided Heart Failure (when the heart's right ventricle is too weak to pump enough blood the lungs). -Gastro-Esophageal Reflux Disease (GERD- a digestive disease in which stomach acid or bile irritates the food pipe lining). -Vitamin Deficiency (a long-term lack of a vitamin). -Diarrhea, Unspecified. Observation on 7/16/24 at 9:36 A.M. of the resident's medication administration completed by LPN D showed: -He/She did not perform hand hygiene before dispensing the medication into the medication cup. -He/She did not perform hand hygiene upon entry into the resident's room. -He/She handed the medication cup to the resident, making contact with the resident's hand. -He/She then exited the resident's room without performing hand hygiene. 4. Review of Resident #47's face sheet showed he/she admitted to the facility with the following diagnoses: -Carcinoma in Situ of Rectum (a precancerous condition characterized by the presence of abnormal cells in the inner lining of the rectum). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Primary Hypertension (high blood pressure). -Chronic Kidney Failure (a long-standing kidney disease based on kidney damage or decreased kidney function for three or more months), Stage 3 (an indication of mild to moderate kidney damage). -Diarrhea, Unspecified. Observation on 7/16/24 at 9:49 A.M. of the resident's medication administration completed by LPN D showed: -He/She entered the resident's room without performing hand hygiene. -He/She checked the resident's blood pressure with a wrist cuff making contact with the resident's left arm and hand. -He/She exited the resident's room without performing hand hygiene. -He/She then started to dispense the resident's medication from the resident's medication strip pack. -He/She then knocked his/her pen to the floor and picked it up from the ground and continued to dispense the resident's medication into the medication cup without performing hand hygiene. -He/She then re-entered the resident's room without performing hand hygiene upon entry. -He/She then handed the medication cup to the resident, making contact with the resident's hand. -He/She then exited the resident's room and applied ABHR to his/her hands. During an interview on 7/16/24 at 10:04 A.M. LPN D said: -He/She had not realized that he/she had not performed hand hygiene in between residents during the medication pass. -He/She would normally perform hand hygiene in between each resident during medication pass. 5. During an interview on 7/16/24 at 11:20 A.M. LPN D said: -He/She had been nervous during the nasal spray administration and had not realized he/she had not performed hand hygiene during the procedure. -He/She knew that he/she had worn gloves during the procedure. -He/She should have used hand sanitizer (ABHR) after picking up the pen from the floor during Resident #47's medication pass. During an interview on 7/17/24 at 11:37 A.M. LPN C said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hand hygiene should be performed before and after each resident's medication pass, when entering and exiting resident rooms, and before and after any type of resident procedure is completed. -Gloves were not a substitute for hand hygiene. -The nurse had not performed hand hygiene appropriately during the medication pass and when administering the nasal spray. -He/She would have sanitized his/her hands after picking up an item that was dropped on the floor. During an interview on 7/18/24 at 8:22 A.M., the MDS Coordinator said: -Hand hygiene should be performed anytime a person feels it should be completed. -Hand hygiene should be performed before and after each resident's medication pass, before and after resident contact is made, and before and after using gloves. -Gloves were not a substitute for hand hygiene. -The nurse had not performed hand hygiene adequately during the medication pass. During an interview on 7/18/24 at 8:55 A.M., the Assistant Director of Nursing (ADON) said: -Staff should perform hand hygiene by washing their hands before starting medication pass. -Staff were to use ABHR between each resident during medication pass. -After three residents, staff needed to wash their hands before continuing the medication pass. -Gloves were not a substitute for hand hygiene. -The nurse had not performed hand hygiene correctly during the whole medication pass procedure. -The nurse should have washed his/her hands after picking up the pen from the floor. During an interview on 7/18/24 at 9:51 A.M., the DON said: -Hand hygiene should be performed before the start of medication pass and in between each resident. -Gloves were not a substitute for hand hygiene. -The nurse had not performed hand hygiene correctly during the whole medication pass procedure. -He/She would have expected the nurse to have washed his/her hands after picking up the pen off the floor, before continuing the medication pass. 50579 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Review of an undated facility policy titled Insulin Pen showed staff were to: -Perform hand hygiene prior to the insulin administration. -Perform hand hygiene after the administration. 7. Review of Resident #157's POS showed orders for Humalog (a rapid acting insulin) four units subcutaneously (in fatty tissue via injection) three times per day. Observation on 7/16/24 at 10:47 A.M., showed Certified Medication Technician (CMT) A retrieved an insulin pen from the medication cart containing Humalog insulin. CMT A entered the resident's room without performing hand hygiene, donned gloves, applied a needle to the insulin pen, administered insulin and left the room without performing hand hygiene. 8. Review of Resident #156's the POS showed orders for Novolog (a rapid acting insulin) at a dose that was blood glucose level dependent (4 units for the resident's blood glucose at that time), three times per day. Observation on 7/16/24 at 10:52 A.M., showed CMT A returned to the medication cart, took out an insulin pen and applied the needle to the pen. CMT A, without washing or sanitizing his/her hands, donned gloves, cleansed an area on the resident's upper arm, administered the insulin and left the room without performing hand hygiene throughout the procedure. During an interview on 07/16/24 at 11:21 A.M., CMT A said he/she performed hand hygiene before and after each insulin administration. During an interview on 7/17/24 at 11:24 A.M., LPN A said hand hygiene must be performed before and after insulin administration because staff may come into contact with blood or other pathogens. During an interview on 7/18/24 at 9:50 A.M., the DON said he/she would expect staff to perform hand hygiene before and after insulin administration. 21003 9. Review of the facility's Infection Control policy and procedure updated 2024, showed direct care staff shall comply with physical examinations and immunization screening requirements upon employment and annually. Review of the following employee records showed there was no documentation showing these employees were given a two-step TB test upon hire or that there was documentation showing a previous TB test or X-ray to rule out TB had been completed prior to or upon employment: -Security A was hired on 10/21/23. Documentation showed the TB screening was not conducted until 4/13/24. There was no documentation showing the employee had a TB screening upon hire or provided documentation to rule out TB upon hire. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Housekeeper A was hired on 8/19/23. Documentation showed the TB screening was not conducted until 8/24/24. There was no documentation showing the employee had a TB screening upon hire or provided documentation to rule out TB upon hire. -Dietary Aide A was hired on 12/28/23. There was no documentation showing the employee had a 2 step TB test or provided documentation to rule out TB. This employee was no longer employed at the facility. During an interview on 7/18/24 at 8:38 A.M., the Human Resource Director said: -Some of the staff were hired under the former company and they were not completing the TB screenings correctly or timely. -He/She had been auditing employee files and making corrections but noticed there were several mistakes or missing information. -Regarding Housekeeper A, he/she thought the nurse mistakenly documented the year 2024 instead of 2023 on the 2 step TB form. -He/She did not know why Security A or Dietary Aide A was not completed upon hire but he/she was unable to find this documentation. During an interview on 7/18/24 at 9:51 A.M., the DON said: -Nursing completes employee TB testing and they try to complete it 3 days prior to hire. -The Human Resource Director tracks the TB tests and will bring the documentation to him/her so he/she can ensure they are completed correctly and timely. -He/She was aware that there were TB tests that were not done correctly under the prior owners and management and they were trying to correct those as they saw issues.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 33409 Based on interview and record review, the facility failed to have a Infection Control Surveillance process for monitoring and tracking the use of long-term antibiotic usage to be included in the monthly review and monitoring of the antibiotics for one sampled resident (Resident #17), who was on an antibiotic as a preventative measure for Chronic Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system) out 15 sampled residents. This failure had the potential to affect all residents at the facility. The facility census was 53 residents. Review of the Facility's undated Infection Prevention and Control Program showed: -An Antibiotic Stewardship program will be implemented as part of the overall infection prevention and control program. -Antibiotic use protocols and system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. Review of the facility Antibiotic Stewardship Program Policy dated 8/10/23 showed: -Infection Preventionist utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. -All prescription for antibiotics shall specify the does, duration, and indication for use. -The facility uses the Center of Disease Control (CDC's) National Healthcare Safety Network (NHSN, is the nation's most widely used healthcare-associated infection tracking system) surveillance definition, McGreer criteria ,or other surveillance tool to define infection. -Monitoring during each monthly Medication Regimen Review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen as requested by the Quality Assessment and Assurance (QAA) committee. -The Licensed Practical Nurse (LPN) participates in the program through assessment of the resident and following protocols as established by the program. -Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustment should be made. -All prescriptions for antibiotics shall specify the dose, duration and indication for use. -Clinical justification for the use of an antibiotic beyond the initial duration ordered such as a review of laboratory reports or cultures in order to determine if the antibiotic remains indicated or if adjustment to therapy should be made. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Review of Resident #17's Admission Face sheet showed the resident had a history of UTI. Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 6/3/24, showed he/she: -Was moderately cognitively impaired and had short term and long-term memory problems. -Received antibiotics during the look back assessment period. -His/Her diagnoses did not indicate the resident had a UTI in the last 30 days. Review of the resident's Physician Order Sheet dated 7/16/24 showed Nitrofurantoin Monohyd Macro (Macrobid, is an antibiotic used to treat or prevent a urinary tract infection,UTI), 100 milligrams (mg) capsule. Take one capsule by mouth every morning for treatment of candidiasis (yeast infection). (For long term use). Review of the resident's Medication Administration Record (MAR) dated 7/1/24 to 7/31/24 showed Macrobid 100 mg one cap to be give by mouth in morning, for Candidiasis, given daily as ordered. Review of the resident electronic medical record showed no current or past documentation of a Situation-Background-Assessment-Recommendation (SBAR, is technique provides a framework for communication between members of the health care team about a patient's condition) or McGreer Criteria (for Infection Surveillance Checklist) completed related to the resident's use of an antibiotic. During the facility Infection Control Surveillance review on 7/17/24 at 11:36 A.M. showed no documentation to demonstrate tracking of long-term antibiotic use for preventative measures for the resident. During an interview on 7/17/24 at 9:19 A.M., the Infection Control Preventionist (ICP) said: -The resident was on Macrobid antibiotic for long-term chronic UTI due to colonized bacteria in his/her body. -Review of the resident's physician order had the wrong diagnosis noted for use. -He/She does not review, record, or track monthly any residents on long-term antibiotics. During an interview on 7/17/24 at 10:00 A.M., Licensed Practical Nurse (LPN) D said: -The resident was on long-term antibiotics for colonized bacteria, prevent UTI's. -The charge nurse would review orders when placed in the resident's electronic medical record. -The nursing staff only document on the resident's Medication Admisnitstration Record (MAR) as given for long-term use of antibiotic. -The facility nursing staff does not complete monthly antibiotic review or reassessment for resident on long-term antibiotics. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/17/24 10:14 A.M., the Assistant Director of Nursing (ADON) said: -The resident was on a long-term antibiotic for UTI. -The facility nursing staff do not document antibiotic use for long-term usage. -Nursing staff only document antibiotic medication when given on the resident MAR. -If resident would get an UTI, then the physician would stop or hold the resident's Macrobid. At that time nursing staff would complete a new SBAR for the resident antibiotic use. -The physician would review the resident's Macrobid monthly during the medication review. -The facility does not track long-term antibiotic use. During an interview on 7/17/24 at 1:16 P.M., the ICP said: -For antibiotic surveillance, he/she runs a report from the facility electronic medical record and reviewed during the facility morning clinics for any residents on new antibiotics. -Any resident on any antibiotic or an infection were to be documented on the infection control spread sheet. -The facility nursing staff would complete an SBAR and McGreer prior to the resident's use of antibiotics. -The facility does not have a system in place to track or monitor long-term antibiotic use. -Residents on long-term antibiotics are on the report received but he/she does not include them as a new infection and does not monitor or track long-term use. During an interview on 7/18/24 at 9:51 A.M., the Director of Nursing (DON) said: -ICP would be responsible for Infection Control Surveillance and monitoring of the facility's antibiotic stewardship program. -ICP does not track long-term use of antibiotics as part of the Infection Control Surveillance program. -The facility Infection Control Surveillance only documents and tracks for any new antibiotic usage and new infections monthly. -The resident was on Macrobid when he/she was admitted to the facility for long-term preventative management UTI. He/she had colonized bacteria. -If the resident would get a new infection or UTI, then the facility would change the type of antibiotic and he/she would be included in the facility monthly Infection Control Surveillance and monitoring for antibiotics. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A diagnosis of fungal infection would not be an acceptable use for Macrobid. -He/she would expect the pharmacy monthly drug regimen review to ensure the correct use and diagnosis for all resident's medication. The ADON would be responsible for follow-up on pharmacy recommendations and physicians' response to the recommendation.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 19916 Based on observation and interview, the facility failed place a screen over the louvered vent in the basement boiler room to keep pests out of the boiler room area. This practice affected the boiler room area. The facility census was 53 residents. 1. Observation with the Maintenance Director on 7/16/24 at 9:45 A.M. showed the absence of a screen from the louvered vent in basement boiler room and the presence of dead insects, bird droppings and dried vegetation in the boiler room area. During an interview on 7/16/24 at 9:47 A.M., the Maintenance Director said birds have been in the boiler room in the past and he/she noticed there was no screen over the louvered vent.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) received 12 hours of in-service education (which was to include abuse, neglect, and dementia training) per year by not being able to produce documentation for five out of five CNAs employed with the facility for greater than 12 months reviewed and failed to monitor what education the CNAs had received. This had the potential to affect all residents within the facility. The facility census was 53 residents. Review of the facility's undated policy titled Continuing Education showed: -All levels of employees were expected to complete required trainings within the designated time frames. -It was the responsibility of each employee to complete the required training. -For training that was assigned as self-paced, the employee was responsible for completing the training by the deadline. Review of the facility's undated policy titled Required Training, Certification and Continuing Education of Nurse Aides showed: -The facility would provide at least 12 hours of in-service training annually, based on employment, not calendar date. -Documentation of in-services would be forwarded to the Human Resources (HR) Director and maintained in the employee's personnel file. -It was the responsibility of the employee to attend required in-service trainings to maintain employment status within the facility. -In-service training would be provided by qualified personnel and would be based on the needs of the residents in the facility and any areas of weakness determined in the nurse aide's performance reviews and facility assessment. -The minimum training included: --Effective communication. --Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses) management and care of the cognitively impaired. --Abuse, neglect, and exploitation prevention. (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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program. --Resident rights and facility responsibilities. --Written standards, policies, and procedures for the facility's infection prevention and control program. --Requirements under the facility's compliance and ethics program. --Safety and emergency procedures. --Behavioral health (e.g., mental, psychosocial, or substance use disorders, a history of trauma, and/or Post Traumatic Stress Disorder (PTSD), or other behavioral health conditions). --Identification of changes in condition. --Cultural competency. Review of the Facility's Facility assessment dated [DATE] showed: -15% of the resident population had diagnoses of Alzheimer's Disease (a progressive mental deterioration that can occur in the middle or old age, due to generalized degermation of the brain) or related dementias. -Two percent of the resident population had been diagnoses of mental illness. -65% of the resident population had falls within the previous 12 months. -Three percent of the resident population received anti-psychotic (a type of psychiatric medication used for certain mental health problems) medication. -Nursing services included: --Activities of Daily Living (ADL) care. --Mobility and fall prevention. --Bowel and bladder needs. --Skin integrity management. --Mental health and behavior management. --Medication management. --Pain management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265667	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meyer Care Center	1201 West 19th Street Higginsville, MO 64037

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Infection prevention and control. --Management of medical conditions. --Nutrition and hydration management. --Ostomy (an artificial opening in an organ of the body) care. --End of life care. 1. Review of an in-service training completed on 4/18/24 showed: -The in-service was related to communication with resident families and proper use of personal protective equipment (PPE). -CNA A and CNA G had attended the in-service training. -CNA E, CNA H, and CNA J had not attended the in-service training. Review of an in-service training completed on 5/9/24 showed had only been about medication pass/administration. None of the sampled CNA staff were documented as attending this in-service. Review of an in-service training completed on 6/13/24 showed: -The in-service was related to infection control and medication pass. -CNA A and CNA G had attended the in-service. -CNA E, CNA H, and CNA J had not attended the in-service training. During an interview on 7/15/24 at 9:21 A.M. the Administrator said: -The facility had been utilizing Relias (a provider of education and training within the workplace) for the monthly in-service education for all staff. -The company had filed for bankruptcy in December 2023. -Relias had let the facility continue to use their education services through March 2024 until they learned the facility had not been able to pay their bill from before the bankruptcy date. -Relias would not allow the facility access to the training records until the bill was paid. -He/She would work with the bankruptcy lawyer in order to attempt to gain access to the records. -After the facility was not able to access any Relias training, the facility started to do in person in-service training. Review of the Relias training report received 7/17/24 showed: (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA A had completed 36 out of 43 of courses assigned to him/her from 1/1/23-12/31/23 but did not indicate which courses were completed. -CNA E had completed zero out of three courses assigned to him/her from 1/1/23-12/31/23. -CNA G was not shown on the report. -CNA H was not shown on the report. -CNA J was not shown on the report. During an interview on 7/17/24 at 10:35 A.M. CNA E said: -He/She could not name any of the in-services he/she received in the last year. -The facility had been using the Relias learning as the only way to educate staff until about March 2024. -He/She thought the Administrator was responsible for keeping the in-service records and ensuring the completion of the Relias training. -He/She was unsure of the number of in-service hours he/she needed annually. During an interview on 7/17/24 at 11:44 A.M. LPN C said: -The facility had been doing monthly in-service training. -The facility also had been using the Relias training for staff education. -He/She thought the HR Director was in-charge of keeping the in-service records. During an interview on 7/18/24 at 8:27 A.M. the Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) Coordinator said: -He/She was not responsible for providing any education to staff. -The facility had been using the Relias learning as the only way to educate staff. -When the DON started in February, he/she had started monthly in-service training. During an interview on 7/18/24 at 9:03 A.M. the Assistant Director of Nursing (ADON) said: -He/She thought the 12 hours of required in-services for CNAs had not been provided due to the bankruptcy in December 2023. -The facility had only been utilizing Relias for the monthly in-service training. -The department heads were responsible for ensuring completion of the assigned in-services. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/18/24 at 9:43 A.M. the Administrator said the department heads were responsible for ensuring the completion of in-service trainings.