STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265690	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor Retirement & Nursing Center	3170 Highway 61 North Hannibal, MO 63401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to document and implement fall interventions to prevent falls for one resident (Resident #1), in a review of five sampled residents. On 07/06/25, staff failed to implement all interventions to prevent falls, including wedge cushions, while the resident was in bed. The resident rolled out of bed which resulted in a fracture of the tibia (a break of the larger of the two bones in the lower leg). The facility census was 55.Review of the facility's Fall Policy, dated 11/14/18, showed the following:-Purpose was to prevent a fall from occurring by identifying conditions and risk factors that typically lead to a fall. Protect the resident from injury in the event a fall does occur, and to provide care to a resident who has fallen by performing assessments, documentation, and early intervention;-Complete comprehensive care plan by day 20 (following admission) using information from Care Area Assessments along with resident and family discussion of interventions if necessary. More individualized risk mitigation techniques based on more comprehensive fall assessment. Update care plan quarterly with resident and family discussion;-Post fall without injury, staff are to utilize the fall investigation form and chart the circumstances of the fall in the electronic medical record;-Fall and injury prevention included keeping call lights and personal items within resident's reach;-Fall interventions include low beds, fall mats, cradle mattress, toileting program, physical therapy screening, increase in assistance, directed activities, and increased monitoring. 1. Review of Resident #1's Care Plan for falls, dated 1/21/25, showed the following:-The resident was at high risk for falls related to a history of falls and multiple disease processes;-An update, dated 4/18/25, for a bolster mattress on the resident's bed;-An update, dated 4/22/25, to make sure the resident's wheelchair cushion was tied to his/her chair or he/she had anti-slip material between cushion and wheelchair; Review of the facility's fall event report, dated 04/26/25, showed the following:-On 04/26/25 at 9:20 P.M., the resident was found on the floor at his/her bedside;-The resident said he/she rolled out of bed;-Staff transferred the resident to the bed and positioned him/her with wedge cushions. Review of the resident's care plan interventions, dated 04/26/25, showed for staff to assure the resident was positioned in the center of his/her bed. (Staff did not document to use wedge cushions to position the resident in bed.) During an interview on 07/24/25 at 11:50 A.M., the Care Plan Coordinator said the following:-The charge nurses documented immediate interventions after a resident fell;-When the interdisciplinary team (IDT) met, they reviewed the interventions that the charge nurse put into place and determined the appropriateness and/or made changes as needed;-Once the IDT determined interventions, they were added to the resident's care plan and verbally communicated to care staff;-After the resident's fall on 04/26/25, the charge nurse documented in the event report to use wedge cushions, but she did not document the use of them in the resident's care plan;-There was no IDT meeting documented to discuss the resident's fall on 04/26/25 or interventions added following the fall;-She was not aware the resident used wedge cushions while in bed. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 04/28/25, showed the following:-His/Her diagnoses included non-traumatic brain dysfunction, aphasia (loss of ability to understand or express speech caused by brain injury), dementia, and Parkinson's disease (a progressive disease of the nervous system marked by tremor muscular rigidity and slow imprecise movements);-He/She was usually understood;-His/Her cognition was moderately impaired;-He/She was dependent on staff for all transfers;-He/She had two non-injury falls since prior assessment (01/28/25);-He/She had one fall resulted in injury since prior assessment (01/28/25). Review of the resident's Fall Risk Assessment, dated 04/28/25, showed the following:-History of one or more falls within the previous six months;-Was on one or more high fall risk drugs;-Required assistance or supervision for mobility, transfer, or ambulation;-High risk for falls. Review of the resident's care plan intervention added on 05/01/25 showed to always keep the call light within the resident's reach in his/her room and to answer all calls for assistance promptly. Review of the facility's fall event report, dated 05/02/25, showed the following:-On 05/02/25 at 2:22 P.M., staff found the resident on his/her hands and knees beside the bed with his/her head resting on the chair cushion next to the bed;-The resident said he/she was trying to reach his/her water;-The resident's water was out of his/her reach;-The resident's call light was pinned to the top of the bed and out of reach. Review of the facility's fall event report, dated 07/06/25, completed by Registered Nurse (RN) F, showed the following:-On 07/06/25 at 9:45 A.M., staff found the resident on his/her right side on the fall mat next to his/her bed;-The resident had been in bed prior to the fall;-Staff noted the interventions were effective, but there was no documentation what