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	10/02/2025

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide oversight and prevent injury for two residents (Resident #1 and Resident #44) in a sample of 23 residents. Resident #1 was dependent on staff for transfers. When his/her electronic bed did not function properly, staff manually transferred the resident and caused a laceration to the resident's leg, which required emergency medical care, including sutures, antibiotic use to prevent infection, pain management medication, wound care and wound clinic appointments. Resident #44 had a history of falls and wandering and staff failed to provide oversight, resulting in an elopement that resulted in a fall with injury. The facility census was 55. The administrator was notified of a past noncompliance on 11/06/25, for Resident #44 which occurred on 08/28/25. The facility inserviced staff on wander guards and door alarms. This noncompliance was corrected on 08/29/25. Additionally, past noncompliance occurred for Resident #1 on 09/22/25. The facility inserviced staff on proper transfers, including the removal of wheelchair pedals prior to transfers and that a mechanical hand crank was available in resident closets should one be needed. The deficiency was corrected on 09/22/25. 1.Review of Resident #1's undated face sheet showed the resident's diagnoses included dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering and reasoning, to the point that it interferes with daily life), muscle weakness, difficulty in walking, reduced mobility, need for assistance with personal care, and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high).Review of the resident's care plan, revised 07/18/25, showed the following:-Potential for alteration in skin integrity related to incontinence, decreased mobility, and multiple disease processes;-Avoid shearing resident's skin during positioning, transferring and turning;-Monitor skin during routine care and notify nurse of any abnormalities;-Provide assist of two staff using a mechanical lift for all transfers;-At risk for bleeding due to daily use of antiplatelet medication;-Avoid hitting/bumping extremities during activities of daily living (ADL's) to prevent injury;-Maintain a safe environment to decrease risk of injury;-Observe for signs of active bleeding: sudden changes in mental status, lethargy.Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/04/25, showed the following:-Intact cognition;-The resident was dependent on staff for toileting, bathing, dressing, transfers and mobility;-The resident required a wheelchair for mobility and was dependent on staff for wheeling about. Review of the resident's progress note, dated 09/22/25 at 10:00 A.M., showed the following:-At 6:50 A.M., staff call Licensed Practical Nurse (LPN) P to the resident's room. The certified nurse assistant (CNA) was holding the resident's left lower extremity. A moderate amount of blood was seen on the towel. The resident had a large open laceration through several layers of skin and muscle. Staff applied pressure and called 911;-At 7:00 A.M., the resident's bleeding had stopped. The staff reported that the injury occurred with a transfer from the bed to the wheelchair. Staff do not know what could have caused the injury;-At 7:10 A.M., emergency medical services (EMS) arrived, report given and paperwork provided. Staff assisted the resident to the gurney via a mechanical lift. EMS bandaged the resident's left lower extremity;-At 7:15 A.M., EMS left the building. Staff placed a call to the resident's durable power of attorney (DPOA) to notify and to the physician on call for the medical director. Agreeable to send the resident to the hospital emergency room for evaluation and treatment;-At 7:20 A.M., called director of nursing (DON) to update and notify. Review of the facility incident reported, dated 09/22/25, showed the following:-Staff were in the resident's room to get him/her up out of bed for breakfast;-Staff noticed that the bed was not functioning appropriately and were unable to move the bed up and down;-The resident was a mechanical lift;-Staff were unable to get the mechanical lift underneath the bed for proper alignment to safely get the resident out of bed;-Staff provided a two person transfer to his/her wheelchair. During the transfer, the resident received a large open laceration to the left lower extremity;-Physician was notified and received an order to transfer the resident to the hospital for further treatment;-EMS notified and transferred to hospital emergency room (ER);-The resident received a laceration measuring 15 centimeters (cm) long with a depth of 10 millimeters (mm);-The resident will follow up with the wound clinic. Review of the resident's progress note, dated 09/22/25 at 10:06 A.M., showed the following:-Assessment of surroundings from LPN P with assistant director of nursing (ADON), CNA C and CNA S, revealed that injury possibly occurred while transferring the resident from the bed to the wheelchair;-Left lower extremity could have caught onto the wheelchair pedal while pedal was extended outward, and the lock piece was pointed outward. Review of the

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to update and document a facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The facility census was 55. Review of the facility's Daily Census Report, dated 09/29/25, showed the facility census was 55. Review of the facility provided, facility assessment, showed the following:-The updated facility assessment of 10/01/25 only included page one that had the facility contact information and facility licensing information;-The remaining facility assessment for review was from 05/01/23 that listed information relating to residents for that date. During an interview on 10/01/25 at 3:30 P.M., the administrator said the following:-He had not updated the facility assessment since he had been at the facility as he was taking care of other things that needed attended to first;-Page one was updated on 10/01/25, after the annual survey began, and nothing else had been addressed on the facility assessment.

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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. Based on interview and record review, the facility failed to ensure nurse aides received the required 12 hours of in-service education annually. The facility census was 55. The facility was not able to provide a policy regarding required in-service training for Nursing Assistants upon request. Review of the facility assessment, dated 05/01/23, showed the following: -Staff competencies and annual training requirements per regulatory authority and/or facility policy: 1. Abuse, neglect, exploitation and misappropriation;2. Advanced directives;3. Behavioral health;4. Communication;5. Compliance and ethics;6. Cardiopulmonary resuscitation;7. Dementia care management;8. Equipment and assistive device training;9. Infection Control;10. -Other areas identified as areas of weakness during annual performance review/competency evaluation;11. Promoting resident's independence;12. Quality assurance and performance improvement;13. Resident rights including confidentiality of resident information, right to dignity, privacy and property;14. -Safety and emergency procedures;15. Job responsibilities and lines of authority;16. Emergency preparedness;17. Facility policies and procedures;18. Change in condition. During an interview on 10/02/25 at 4:05 P.M., the Director of Nursing (DON) said the following: -She and the nurse educator do in-services and education for the Certified Nursing Assistants (CNAs);-The nurse educator provides education during CNA classes;-She does not have documentation of inservices;-She does not track the CNA in-services to ensure they have 12 hours of annual education;-She was aware of the required 12 hours of mandatory training for CNA's, but was not aware of what specific education needed to occur within those twelve hours;-She had not seen a facility assessment indicating what in-service education was identified within that document.