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. **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 (continued on next page)

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	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 resident's progress note, dated 09/22/25 at 1:04 P.M. showed the following:-At 12:30 P.M., report received from hospital nurse that the resident will be returning with new orders for the resident to be seen at the wound clinic and to start antibiotic for 10 days, nursing facility to transport;-At 12:45 P.M., the resident returned to the facility via nursing facility transport, call placed to physician for pain management, new orders received for Tylenol (pain medication) 500 milligram (mg) two tablets every six hours as needed (PRN). Review of the resident's hospital record, dated 09/22/25, showed the following:-Patient presented to the emergency department via EMS with a laceration, onset prior to arrival;-Reportedly, staff was helping the resident out of the bed and got his/her leg tangled up with the railing/bar, causing a laceration to the left leg;-Patient had wound repaired;-Patient was given Cefdinir (antibiotic) 300 milligrams (mg) PO (by mouth) to initiate treatment of skin defect;-The wound had a three centimeter (cm) x two cm skin defect with subcutaneous (under the skin) tissue exposed;-Xeroflo packing (a type of dressing that keeps a wound moist) was placed and this will need to be changed twice daily;-Resident will be referred to the wound center for follow up;-Resident will need to have suture removal in 10 days approximately;-The resident will be transported back and is stable for discharge. Review of the resident's progress note, dated 09/23/25 at 12:11 P.M. showed the following:-Continues antibiotic therapy for left leg laceration;-Leg remains bandaged at this time, left leg elevated to decrease swelling;-Received call from resident's daughter this morning with questions regarding left leg laceration and explained incident occurred with transfer and that possibly occurred from leg pushing against the wheelchair pedal lock as the wheelchair pedal was extroverted at the time of the incident, explained orders from the hospital, informed we are treating any possible infection with oral antibiotics, explained interventions put in place to prevent reoccurrence. Review of the resident's progress note, dated 09/29/25 at 10:12 A.M., showed the following:-A call was placed to the wound clinic to receive and update on his/her appointment;-Education was provided to all nursing staff that if a bed malfunctions, there is a manual crank arm in all closets within the rooms;-Education will be provided to staff that when transferring a resident, the pedals of the wheelchair need to be removed for transfer then placed back on for transport. Review of the resident's care plan, revised 09/29/25, showed the following:-The resident was on antibiotic therapy related to a laceration of the left lower extremity;-The resident had alterations to his/her skin integrity related to a laceration to his/her left lower extremity;-The resident had 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;-Use lifting device when moving him/her in bed;-Provide assist with two staff using a mechanical lift (mechanical (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lift device) for all transfers;-Use wheelchair for mobility;-The resident is at risk for falls related to history of falls and multiple disease processes;-At risk for bleeding due to daily use of antiplatelet medication (medications used to help prevent blood clots from forming in the arteries);-Avoid hitting/bumping extremities during activities of daily living (ADL's) to prevent injury;-Maintain a safe environment to decrease risk of injury;-No documentation of a manual crank being in the resident's closet if the bed would not raise or lower;-No documentation regarding pedals needing to be removed when transferring the resident into the wheelchair or pedals being put on prior to transport. Observation on 10/01/25 at 11:15 A.M. showed there was a manual crank in the resident's closet. Observation on 10/01/25 at 11:15 A.M. showed the following:-LPN P completed the resident's wound treatment to his/her left leg with the assistance of CNA O;-LPN P removed the resident's old dressing (dated 09/30/25) from the resident's LLE that was saturated with serosanguineous dressing (a type of fluid that contains both serum (clear, watery fluid) and blood) and placed it in the trash;-The wound had several sutures and an area at the end of the sutures that had some serosanguineous drainage, measuring 13.5 centimeters (cm.) long. Review of CNA C's written statement, dated 09/22/25, showed the following:-He/She and CNA S transferred the resident from the bed to the wheelchair due to the bed not raising;-Once the resident was in the wheelchair, he/she noticed the resident's leg bleeding. Review of CNA S's written statement, dated 09/22/25, showed the following:-He/She was working with CNA C and when getting the resident up, his/her bed wouldn't move, he/she then tried to unplug and replug the bed in and the bed still wouldn't move;-He/She and CNA C decided to two man the resident and somehow the resident's leg got cut open;-He/She and CNA C instantly started to apply pressure to the area and yelled for the nurse. Review of a written statement by LPN P, dated 09/22/25, showed the following:-He/She was called to the resident's room by staff at 6:50 A.M.;-He/She observed CNA holding the resident's left lower leg, a moderate amount of bleeding seen;-Staff reported that while transferring the resident from the bed to the wheelchair that the resident obtained a large, separated laceration, multiple skin layers seen;-Staff were unable to identify what caused the laceration;-Pressure applied and call placed to 911;-The resident denied pain until pressure was applied;-Bleeding stopped;-At 7:10 A.M., EMS arrived, report and paperwork given;-Staff assisted to gurney and resident left facility;-Assessment of surroundings with ADON and CNA C and CNA S revealed that injury possible occurred while transferring the resident from his/her bed to the wheelchair;-Left lower extremity could have caught onto the wheelchair pedal while pedal was extroverted outward and lock piece of foot pedal was sticking out near where laceration is located;-Orders received to send to ER for evaluation and treatment. During an interview on 10/02/25 at 6:56 P.M., the Director of Nursing (DON) said the following:-She would not expect staff to manually transfer a resident that should be a mechanical lift transfer;-She would expect staff to use the manual crank in the resident's closet if the bed would not raise or lower;-Wheelchair pedals should be removed prior to transferring the resident into the wheelchair to avoid catching in the wheelchair pedals that could cause injury. 2. The facility did not have a policy for wander guards/alarms that addressed ensuring an alarm being loud enough to be heard throughout the building. 3. Review of Resident #44'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), Alzheimer's disease (a progressive and irreversible brain disorder that gradually destroys memory and thinking skills, eventually leading to the inability to carry out simple daily tasks).Review of the resident's significant change MDS, dated [DATE], showed the following:-The resident had intact cognition;-The resident used a walker mobility device;-The resident required supervision or touching assistance with walking;-Wander/Elopement alarm used daily. Review of the resident's care plan, revised 07/28/25, showed the following:-The resident requires wander guard secondary to increased instances of wandering and increased confusion related to dementia progression;-Check function of alarm every shift;-Personal alarm placed on resident. Review of the resident's nursing note, written by Licensed Practical Nurse (LPN) B, dated 08/28/25 at 5:00 (continued on next page)

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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. Based on observation, interview, and record review, staff failed to store, prepare, and serve food in a safe and sanitary manner. Staff failed to ensure the temperature of a refrigerator used to store resident food was maintained at or below 45 degrees Fahrenheit (F) and the freezer was maintained at or below 0 degrees F. Staff failed to ensure food was discarded when it showed signs of deterioration. Staff did not practice proper handwashing, glove hygiene or hair restraint usage when preparing and serving food in the kitchen. Staff failed to ensure the facility's ice machine was clean and sanitary. The facility census was 55. The facility did not provide policies for food storage, dietary handwashing/gloving, hair restraints, ice machine cleaning, or storing resident food items. 1. Record review of the September 2025 Refrigerator/Freezer Temperature Log for the Family Room refrigerator located on the 300 hall, showed the following: -9/1/25: 49 degrees F (refrigerator) /23 degrees F (freezer); -9/2/25: 50 degrees F / 32 degrees F; -9/3/25: 49 degrees F / 26 degrees F; -9/4/25: 48 degrees F / 22 degrees F; -9/5/25: 48 degrees F / 24 degrees F; -9/6/25: 42 degrees F / 20 degrees F; -9/7/25: 42 degrees F / 20 degrees F; -9/8/25: 44 degrees F / 20 degrees F; -9/9/25: 44 degrees F / 22 degrees F; -9/10/25: 49 degrees F / 28 degrees F; -9/11/25: 48 degrees F / 27 degrees F; -9/12/25: 49 degrees F / 29 degrees F; -9/13/25: 50 degrees F / 29 degrees F; -9/14/25: 49 degrees F / 28 degrees F; -9/15/25: 49 degrees F / 27 degrees F; -9/16/25: 48 degrees F / 27 degrees F; -9/17/25: 48 degrees F / 27 degrees F; -9/18/25: 49 degrees F / 28 degrees F; -9/19/25: 46 degrees F / 21 degrees F; -9/20/25: 45 degrees F / 20 degrees F; -9/21/25: 45 degrees F / 20 degrees F; -9/22/25: 48 degrees F / 24 degrees F; -9/23/25: 49 degrees F / 26 degrees F; -9/24/25: 48 degrees F / 26 degrees F; -9/25/25: 49 degrees F / 28 degrees F; -9/26/25: 48 degrees F / 21 degrees F; -9/27/25: 48 degrees F / 21 degrees F; -9/28/25: 49 degrees F / 21 degrees F; -9/29/25: 49 degrees F / 22 degrees F; -9/30/25: 50 degrees F / 30 degrees F. -On 24 of 30 days, the refrigerator temperature was above 45 degrees F; -On 30 of 30 days, the freezer temperature was above 0 degrees F. Observation on 9/29/25 at 3:10 P.M., of the Family Room refrigerator, showed the following: -Slices of pizza in an unlabeled pizza box;-An unknown food item, with fuzzy gray mold-like substance on the surface of the food item, in a black container with a clear lid labeled with a resident's name;-The thermometer in the refrigerator read 50 degrees F.;-No items were stored in the freezer. During an interview on 9/29/25 at 3:10 P.M., the Maintenance Supervisor said the Family Room refrigerator was used to store residents' food items. The refrigerator was starting to get warm, and the facility was looking into replacing it. During an interview on 9/29/25 at 4:28 P.M., the Administrator said he was unaware the Family Room refrigerator was not cooling properly. Observation on 9/30/25 at 6:26 P.M., in the Family Room refrigerator, showed the following: -Slices of pizza in an unlabeled pizza box;-An unknown food item, with fuzzy gray mold-like substance on the surface of the food item, in a black container with clear lid labeled with a resident's name;-A sandwich (labeled with a resident's name) wrapped in a fast food wrapper;-The thermometer in the refrigerator read 50 degrees F; -In the freezer compartment, there was a partially melted ice pack, and the thermometer read 30 degrees F. 2. Observation on 9/29/25, from 11:37 A.M. to 12:18 P.M., in the kitchen, showed the following: -Cook BB served residents' food at the steam table for the lunch meal service; -He/She used his/her gloved hands to touch serving utensil handles and grasp breadsticks and placed them on residents' plates;-He/She adjusted his/her clothes with gloved hands and continued serving food to residents and touching breadsticks with his/her gloved hands; -He/She removed his/her gloves, discarded one glove in the trash can by the handwashing sink, and dropped the other glove on the floor by the trash can by the handwashing sink; -He/She picked up the glove from the floor and put it in the trash can by the handwashing sink; -Without washing his/her hands, he/she put on new gloves and continued serving food to residents, including picking up breadsticks with his/her gloved hands and placing them on residents' plates. Observation on 9/30/25 from 4:45 (continued on next page)

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	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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	P.M. to 5:07 P.M., in the kitchen, showed the following: -Cook Y served residents' food at the steam table for the dinner meal service; -He/She did not wear a hairnet and had 3-inch long sections of hair that hung down by his/her face. During an interview on 10/1/24 at 2:45 P.M., [NAME] Y said staff should wear hair restraints when preparing or serving food and should wash their hands in between glove changes, after picking up items from the floor, and after taking breaks. During an interview on 10/1/25 at 2:15 P.M., the Dietary Manager said he expected staff to wear hair restraints and wash their hands frequently while working in the kitchen, such as prior to conducting clean tasks, after conducting dirty tasks, and when changing gloves. 3. Observation on 9/30/25 on 6:22 P.M., of the ice machine located in the facility's dining room, showed the following:-Moist, black speckled debris on the ice dispensing spout;-Various splatters and drips across the surface of the ice dispensing area;-Brown crusty debris above the metal grate located directly below the ice dispensing area. During an interview on 10/1/25 at 12:02 P.M., Maintenance Staff R said maintenance staff cleaned the interior of the ice machine monthly. Dietary staff were responsible for cleaning the exterior of the ice machine. During an interview on 10/1/25 at 2:15 P.M., the Dietary Manager said dietary staff cleaned the exterior of the ice machine weekly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) buy using gowns and gloves during high-contact resident care activities) and properly handle dirty linens for two residents (Resident #1 and #6) in a review of 23 sampled residents. Additionally, the facility failed to complete a required Legionella (a type of bacteria found in [NAME] that cased Legionnaires' disease, a severe form of pneumonia, when inhaled in water droplets or mist) program. The facility census was 55. Review of the facility policy, EBP Policy and Procedure, revised 08/05/25, showed the following: -Purpose: To reduce the risk of transmission of MDROs in the facility;-EBP refers to an infection control intervention designed to reduce transmission of targeted MDROs that employs targeted gown and glove use during high contact resident care activities. EBPs are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high contact resident care activities;-High contact activity: activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel and occur in the resident's room, shower/bathroom, or therapy room and include: c. Transferring;d. Providing hygiene;e. Changing linens;f. Changing briefs or assisting with toileting;h. Wound care: any skin opening requiring a dressing;-Wounds that require EBP: include, but are not limited to, chronic/open wounds that typically require dressing changes such as pressure injuries (PIs), venous/arterial/diabetic/neuropathic ulcers, open or blistered burns;-Policy statement: The facility will identify, report, investigate and control the transmission of MDROs to other staff and residents;-Procedure: b. Residents with a history of, or who are known to be colonized with, a targeted MDRO will be placed in EBP for the duration of their stay;c. Residents with an indwelling medical device, or an open wound and no history of MDROs will be placed in EBP until their wound heals or the device is removed;f. The need for EBP will be included in each resident's care plan;g. The Infection Preventionist (IP) will communicate the need for EBP and maintain a list of residents on EBP. 1.Review of Resident #1's undated face sheet showed the resident had diagnoses that included laceration (a tear or ragged cut in skin or flesh), of the left lower leg. Review of the resident's physician orders, dated 09/24/25, showed the following:-Clean left lower leg laceration with normal saline; apply Xeroform (fine-mesh gauze dressing) and non-stick dressing; twice a day, morning and bedtime;-No order for EBP. Review of the resident's care plan, updated 09/29/25, showed the following:-Antibiotic therapy related to laceration of left lower extremity (LLE);-The resident's laceration will heal without complications through the next review date;-Alteration in skin integrity related to laceration to LLE;-No update/revision regarding EPB. Observation on 10/01/25 at 11:15 A.M. showed the following:-No EBP signage or supplies outside or inside of the resident's room;-Licensed Practical Nurse (LPN) P washed hands, donned gloves, wiped down the bedside table with purple top Sani-wipes, applied a barrier towel to the top of the bedside table, and placed all supplies on top of barrier;-LPN P doffed gloves, washed hands, donned new gloves;LPN P did not don a gown;-Certified Nurse Assistant (CNA) O washed hands, donned gloves but did not don a gown; -CNA O removed the resident's blankets and lifted the resident's left leg off the bed;-LPN P removed the resident's old dressing from the resident's LLE that was saturated with serosanguineous drainage (a type of fluid that contains both serum (clear, watery fluid) and blood) and placed it in the trash;-LPN P doffed gloves, hand sanitized, and donned gloves;-LPN P used non-woven sponges sprayed with wound cleanser to cleanse the wound, doffed gloves, hand sanitized and donned gloves;-The wound had several sutures and an area at the end of the sutures that had some serosanguineous drainage;-LPN P covered the wound with Xeroform dressing on the end of the wound that was open without sutures, wrapped the LLE with gauze, applied tape to the gauze to secure the dressing, dated and initialed the dressing, doffed gloves and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	washed hands;-CNA O placed the resident's leg back on the bed, doffed gloves, washed hands, and covered the resident back up with a blanket. During an interview on 10/01/25 at 11:38 A.M., CNA O said the following:-Staff should wear PPE (gown and gloves) if there was a sign to do so on the resident's door;- The Assistant Director of Nursing (ADON) puts the signs and supplies on the doors; that was how he/she knew who required EBP;-PPE should be worn if the resident has an infection, urinary tract infection (UTI) or if they commonly get infections;-The facility had not educated him/her on all of the reasons to wear PPE. During an interview on 10/01/25 at 11:20, LPN P said the following:-He/She would wear full PPE with a gown if the resident was on precautions or if it were a sterile treatment;-The ADON usually completed wound treatments and placed the EBP signage and supplies on the resident's doors;-All residents that required EBP have the supplies and signage on their doors and that was how he/she knew which residents required EBP. 2. Review of Resident #6's undated Continuity of Care Document (CCD) showed the resident had a diagnoses that included extended spectrum beta lactamase/ESBL (a type of enzyme made by some bacteria that break down and destroy antibiotics making it hard to treat infections caused by ESBL and is considered an MDRO). Review of the resident's admission MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for transfers, personal hygiene, toileting hygiene and bathing;-Always incontinent of bowel and urine;-Diagnoses of MDRO infection and urinary tract infection;-Special treatment of isolation or quarantine for active infectious disease. Review of the resident's care plan, updated 07/16/25, showed the following: -Requires EBP for high contact activities related to history of ESBL UTI;-PPE per facility protocol. Observation on 09/30/25 at 9:07 A.M., showed the following: -EBP signage and supplies located hanging on the outside of the resident's door indicated use for bed A & B. Also indicated uses of gown and gloves for high-contact resident care activities; -EBP supplies of gown and gloves available in the hanging supplies container on the outside of the resident's door; -CNA F and CNA G completed hand hygiene with alcohol-based hand sanitizer and applied gloves prior to entering the resident's room and initiating care; -CNA F and CNA G attached a mechanical lift pad to the lift and transferred the resident from the wheelchair to his/her bed;-The resident was incontinent of urine;-CNA G assisted the resident to turn to his/her left side with the resident leaning against CNA G, touching his/her uniform top;-CNA F provided pericare to the resident's buttocks, removed gloves, completed hand hygiene with hand sanitizer and applied a clean pair of gloves;-CNA F assisted the resident to turn to his/her back and completed peri care to the resident's genitalia;-CNA F assisted the resident to turn to his/her right side to place an incontinent product on the resident and the resident was touching CNA F's uniform top;-CNA G and CNA F attached the incontinent product, remove his/her gloves and completed hand hygiene with hand sanitizer;-CNA G and CNA F provided all resident cares without wearing a gown. During an interview on 09/30/2025 at 7:05 P.M., the resident said the following:-Staff do not always wear a gown when providing cares but always wore gloves;-He/She was unsure why staff use the gown and gloves when care is provided but thought it was due to something in his/her urine. During an interview on 10/02/25 at 1:37 P.M., CNA G said the following:-If a resident had an EBP sign, staff should wear a gown, gloves and mask;-Staff know who was on EBP by the signs on the door, charts and care plans;-Wounds and catheters need EBP;-He/She did not use a gown when caring for the resident because the EBP was for the resident's roommate;-He/She was unaware that the EBP sign was for both residents in the room and just thought bed B was the one that needed EBP;-After looking at the signage posted for the resident's room, a gown and gloves should have been used to provide care. During an interview on 10/02/25 at 1:38 P.M., CNA F said the following: -If a resident had an EBP sign on the door, staff should wear a gown and gloves to provide resident care;-Staff know who was on EBP by the sign on the door and by the chart;-EBP was worn for wounds, catheters and infections like C-Diff (an infection in the bowel);-He/She did not use a gown to provide cares for the resident because he/she thought the EBP was for the resident's roommate;-After seeing that the sign on the resident's door said bed A and B, a gown should have been used to protect his/her clothing from germs. During an (continued on next page)

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During an interview on 10/02/25 at 6:56 P.M., the Director of Nursing (DON) said the following:-EBP would depend on the situation;-EBP should be worn if there is a sign on the door indicating to use and the IP has determined it necessary;-If an EBP sign was posted on the outside of a resident's door, she would expect staff to wear a gown and mask if necessary;-The sign on the door indicates which resident bed needed the EBP. 4. Review of the facility's policy, Handling Contaminated Linen by nursing staff, reviewed 12/29/16, showed the following: -Nursing staff will collect all contaminated linens out of the resident room and transport to housekeeping with minimum agitation to avoid contamination of air, surfaces and persons;-Place all soiled linen in a plastic bag in laundry barrels at the point of use. 5. Observation on 09/30/25 at 6:30 P.M., showed the following:-LPN B walked down the 200-hallway with dirty linens in his/her gloved hands;-The dirty lines were not contained in a plastic bag;-He/She put the dirty linens in a dirty linen cart in the 300-hallway bathroom. During an interview on 10/02/25 at 2:33 P.M., LPN B said the following:-All dirty linens should be put in a plastic bag before leaving the residents' room;-He/She had carried loose dirty linens to the soiled laundry cart and put them in the cart without them being in a plastic bag;-There were no plastic bags in the resident's room to use. 6. Observation on 09/30/25 at 6:55 P.M., showed the following:-CNA J walked down the 300 hallway with dirty clothing items in his/her gloved hands; -The dirty linens were not contained in a plastic bag;-He/She put the dirty linens in a dirty linen cart in the 300-hallway bathroom. During an interview on 09/30/25 at 7:05 P.M., CNA J said the following:-He/She had carried the dirty linens down the hall without a trash bag;-The dirty linens did not need to be placed in a trash bag because they were not soiled; -The clothes had been worn by a resident;-If a clothing item was slightly wet, staff could still carry it down the hall without placing the items in a trash bag;-Dirty clothes could be placed in the soiled linen cart without being in a trash bag;-He/She was not aware the facility policy required all soiled linen was to be placed in a plastic bag in laundry barrels at the point of use. 7. Observation on 09/30/25 at 7:15 P.M. of the soiled linen cart in the 300 hall bathroom, showed the cart had loose clothes laying in the cart. Observation on 09/30/25 at 7:22 P.M., showed the following:-Housekeeper M had a blue laundry cart;-He/She emptied the soiled linen cart from the 300 hall bathroom;-Several loose items were emptied from the soiled linen cart in the bathroom to the blue laundry cart;-The loose items included clothes and bed linens;-The loose bed linens had a strong smell of urine. During an interview on 09/30/25 at 7:22 P.M., Housekeeper M said the following:-There were loose clothing items and bed linen in the soiled linen cart he/she had just emptied;-There was normally a mixture of loose clothing items and in plastic bags;-Dirty linens were supposed to be placed in a plastic bag before going in the soiled linen cart. During an interview on 10/02/25 at 2:20 P.M., the housekeeping supervisor said the following:-A blue cart was used to empty the laundry carts on the hallways;-Usually, dirty linens were put into plastic bags, but there had been loose clothing items placed into the soiled linen carts;-There have been loose clothing items in the blue laundry cart when it arrived back in the laundry room;-There should be no loose linens in the hallway soiled linen carts;-All soiled linens needed to be placed in a plastic bag. During an interview on 10/02/25 at 1:26 P.M., the Assistant Director of Nursing/Infection Preventionist, said the following:-All linens should be placed in plastic bag before leaving the resident's room;-No dirty loose linens should be carried down the hall to the soiled linen carts. During an interview on 10/02/25 at 6:56 P.M., the DON said contaminated linens should not be carried down the hall without being in a trash bag. 8. Review of the undated facility policy, Legionella Water Management Policy, showed the following: -Purpose: a. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Identify where Legionella and other opportunistic waterborne pathogens could grow and spread;b. Specifies testing protocols;c. Maintains compliance with federal, state and local requirements;-Scope: The maintenance and housekeeping departments are to carry out all actions outlined by this plan throughout the facility;-Guideline: A. Conduct a facility risk assessment;1. Plan for cleaning water sources: water heaters, pipes/valves/fittings, expansion and cooling tanks, water dispensers, ice machines, faucets, shower heads, whirlpool, hoses, any decorative fountains, humidifiers, medical equipment (concentrators, CPAP machines, hydrocollator), eyewash stations and cooling towers;B. Address items labeled at risk for the facility risk assessment;C. Possible infection: send samples out to be tested to the local board of public works. 9. Review of the undated facility water management plan showed the following: -A copy of the Center for Disease Control (CDC) tool kit for development of a water management Legionella plan;-No evidence of a water management team;-No evidence of a plan that follows the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) guidelines for development of a legionella water management plan;-No evidence of a water flow diagram;-No evidence of any water testing;-No evidence of flushing of areas with stagnant water, whirlpool in the therapy room and bathtub/shower on the 300 hall (both of which have not been used for quite some time and are acting as a storage room);-No evidence of testing cold water temperatures;(the plan was the CDC toolkit and there was no specific facility plan with expectations available for review). During an interview on 10/02/25 at 1:07 P.M., the maintenance director said the following: -He had been with the facility for 14 years and the maintenance director for the last three years;-He was not part of the water management team;-He was currently taking hot water temperatures weekly but not taking any cold-water temperatures; -He did not know a lot about legionella;-There were two bathtubs and one whirlpool at the facility;-The bathtub on 300 hall and the whirlpool in the therapy room has not been used for years and he has not flushed those lines for quite some time. During an interview with the administrator on 10/02/25 at 1:15 P.M. and 7:07 P.M., showed the following: -He has been at the facility since December 2024;-Since he had been the administrator they have not had an active water management team or had any meetings;-He would expect the water management team to consist of himself, the DON, maintenance director and the housekeeping/laundry supervisor;-He was unaware of ASHRAE guidelines regarding a water management team or legionella.

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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.

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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. Based on interview and record review, the facility failed to maintain individual resident ledgers for two residents (Resident #3 and #34) of two residents the facility held funds for, failed to send quarterly statements to the resident or the resident's representative and failed to distribute the accrued interest in the resident trust fund between the residents' accounts. The facility census was 55. Review of the facility policy, Personal Funds Policy and Procedures, updated 11/11/24, showed the following:-Upon written authorization of a resident, a resident may deposit personal funds for safekeeping with the facility if they so desire. Each resident will have their own personal ledger accounting of all transactions; -Deposit of funds:- Bank interest shall be accrued and credited to each individual account at least quarterly;-A written account shall be provided to each resident, showing receipts in and will be signed by the resident or their representative; -Withdrawal of funds:-A written account shall be provided to each resident, showing disbursements out and will be signed by the resident or their representative;-Facility responsibility: -All residents' funds will be brought current monthly, and a statement shall be given to the resident or representative noting all transactions at least quarterly. Additional statements may be requested at any time. Review of the facility policy, Nursing Home Resident Rights, updated 11/12/24, showed the following:-Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law; -Rights Regarding Financial Affairs: Personal funds of more than $100 ($50 for residents whose care is funded by Medicaid) deposited by the facility in a separate interest-bearing account and financial statements quarterly or upon request. 1. Review of a facility provided document, showing accounting transactions for the resident fund account, showed the facility held funds for two residents, Resident #3 and #34. 2. Review showed there was no documentation of each resident's, (Resident #3 or #34), own ledger accounting for all transactions as directed by facility policy. 3. Review showed there was no documentation to show the residents, or the resident's responsible party, received quarterly resident fund statements or documentation of a written account provided to each resident, showing receipts in or out, signed by the resident or their representative as directed by facility policy. 4. Review of the facility's monthly resident fund bank statements and resident trust fund records, for September 2024 through August 2025 showed the following:-Resident fund bank statement dated 09/30/24 showed interest added $3.86;-Resident fund bank statement dated 10/31/24 showed interest added $2.41;-Resident fund bank statement dated 11/29/24 showed interest added $1.00;-Resident fund bank statement dated 12/31/24 showed interest added $1.04;-Resident fund bank statement dated 01/31/25 showed interest added $0.99;-Resident fund bank statement dated 02/28/25 showed interest added $1.01;-Resident fund bank statement dated 03/31/25 showed interest added $1.00;-Resident fund bank statement dated 04/30/25 showed interest added $1.04;-Resident fund bank statement dated 05/30/25 showed interest added $1.30;-Resident fund bank statement dated 06/30/25 showed interest added $1.67;-Resident fund bank statement dated 07/31/25 showed interest added $1.42;-Resident fund bank statement dated 08/29/25 showed interest added $1.47;-There was no documentation to show the facility disbursed the interest occurred to the two residents the facility held funds for. 5. Review of Resident #34's face sheet showed the resident's family member listed as his/her durable power of attorney. During an interview on 09/30/25 at 10:22 A.M. and 10/02/25 at 11:49 A.M., the resident's representative said the following:-He/She had not received any statements from the facility showing how much money was going in or out of the resident's fund;-He/She received no quarterly statement from the facility for money in the resident's trust fund;-He/She had verbally requested a resident trust fund statement, and it had not been provided;-The resident had been putting money into the resident trust fund account for about two years;-The resident had money direct deposited into the resident trust fund account. 6. During an interview on 10/02/25 at 9:19 A.M., the Accounts Receivable (in training) staff said the (continued on next page)

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	265690	A. Building B. Wing	10/02/2025

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:-There were no quarterly statements for the resident funds that were held by the facility sent to the resident and/or their representatives;-No resident with money in the resident funds account had been given a statement showing a breakdown of their account. During an interview on 10/02/25 at 9:12 A.M., the Accounts Payable/Accountant said the following:-There were no quarterly statements for the resident funds that were held by the facility sent to the resident and/or their representatives;-Since there were no resident fund statements, she had not been distributing the accrued interest into each resident's account;-The residents did not have individual ledgers. During an interview on 10/02/25 at 7:07 P.M., the administrator said the following:-He would expect residents to know how much money was in their account with a breakdown of credits and debits to their account;-He would expect quarterly statements to be sent to the resident or representative.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff indicated in the resident's medical record their wishes for Cardiopulmonary Resuscitation (CPR - an emergency life-saving procedure for someone whose breathing or heartbeat has stopped) and documented the residents' choice of code status in such a way to be readily accessible to staff in the event of an emergency. This affected five residents (Resident #1, #18, #19, #60 and #61) in a sample of 23 residents. The facility census was 55. Review of the undated facility policy, Full Code vs. Do Not Resuscitate (DNR) Protocol, showed the following:-Upon finding a resident with an absence of pulse and respirations, the first actions should be to notify a nurse and determine the resident's code status;-The code status was in the Electronic Medical Record (EMR); the policy did not specify where;-If a resident was listed as a Full Code, or no code status or DNR form was on file, a full code would be initiated by direct care staff. 1. Review of Resident #1's undated face sheet showed the following:-The resident admitted to the facility on [DATE];-The resident's family member was his/her durable power of attorney (DPOA)/personal representative. Review of the resident's care plan, revised [DATE], showed the resident's advance directive as full code status. Review of the resident's physician order sheet (POS) for [DATE], did not show an active order for code status. Review of the full code list posted at the nurse's station on [DATE] at 9:05 A.M. showed the resident as a full code. During an interview on [DATE] at 9:51 A.M., the resident's representative/DPOA said he/she thought the resident was a DNR but wasn't sure and advised to contact the resident's second DPOA. During an interview on [DATE] at 10:08 A.M., the resident's second listed representative/DPOA said he/she was told the resident was a DNR. 2. Review of Resident #18's face sheet showed the following:-The resident admitted to the facility on [DATE];-No code status was documented on the face sheet;-No advanced directives were selected for this resident;-The resident's family member was listed as his/her responsible party. Review of the resident's baseline care plan, dated [DATE], showed the code status was left blank. Review of the physician's orders, dated [DATE], showed no order for code status. Review of the resident's care plan, revised/reviewed on [DATE] at 11:37 A.M., showed the following:-No code status was listed at the top of the document by the residents' name;-Documentation showed no code status. Review of the residents' undated Continuity of Care Document (CCD) showed there was no advance directives on file for the resident. Observation on [DATE] at 9:05 A.M. and 11:05 A.M., at the nurses' station showed the following:-A piece of paper listing residents who were full codes was affixed to the nurses' station countertop;-There was no date on the paper;-The resident was not listed on the full code sheet, indicating the resident was a DNR. During interview on [DATE] at 4:17 P.M., the resident's responsible party said the facility asked him/her when the resident admitted about code status. He/She told the facility he/she would have to get back with them. 3. Resident #19's face sheet showed the following: -The resident admitted to the facility on [DATE];-No code status was documented on the face sheet;-No advanced directives were selected for this resident;-The resident's family member was listed as his/her responsible party. Review of the resident's base line care plan, dated [DATE], showed the code status was left blank. Review of the physician's orders, dated [DATE], showed no order for code status. Review of the resident's care plan, revised/reviewed on [DATE] at 1:44 P.M., showed the following:-No code status was listed at the top of the document by the residents' name;-Documentation showed no code status. Review of the residents' undated CCD showed there was no advance directives on file for the resident. Observation on [DATE] at 9:05 A.M. and 11:05 A.M., at the nurses' station showed the following:-A piece of paper listing residents who had elected a full code status was affixed to the nurses' station countertop;-There was no date on the paper;-The resident was not listed on the full code sheet, indicating the resident was a DNR. During interview on [DATE] at 4:17 P.M., the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's responsible party said the facility asked him/her when the resident was admitted about code status. He/She told the facility he/she would have to get back with them 4. Review of Resident #60's undated face sheet showed the following:-The resident admitted to the facility on [DATE];-The resident was his/her own person. Review of the resident's undated base line care plan showed the code status was left blank. Review of the resident's physician order sheet (POS) for [DATE], showed no order for code status. Review of the resident's comprehensive care plan, dated [DATE], showed the advance directive as full code status. Review of the full code list at the nurse's station on [DATE] at 9:05 A.M. did not have the resident listed as a full code. During an interview on [DATE] at 12:22 P.M., the resident said he/she would not want CPR performed and wished to be a DNR code status. 6. Resident #61's face sheet showed the following: -The resident admitted to the facility on [DATE];-The resident was his/her own responsible party;-No code status was documented on the face sheet;-No advanced directives were selected for this resident. Review of the resident's base line care plan, dated [DATE], showed the code status was left blank. Review of the physician's orders, dated [DATE], showed no order for code status. Review of the resident's care plan, revised/reviewed on [DATE] at 9:50 A.M., showed the following:-No code status listed at the top of the document by the residents' name;-The resident had been admitted to hospices services on [DATE] due to decline in status. Review of the residents' undated CCD showed there was no advance directives on file for the resident. Review of the resident's hospice records showed no documentation of an elected code status. Review of the full code list at the nurse's station showed it did not have the resident listed as a full code, indicating the resident was a DNR. During an interview on [DATE] at 9:37 A.M. the resident said he/she would not want to have CPR if his/her heart stopped beating. 7. During an interview on [DATE] at 6:15 P.M., the care plan coordinator said the following:-She would expect a resident's code status to be listed on their face sheet upon admission; -She would expect the resident to have a physician order signed showing their code status upon admission; -She would expect the residents' code status to be listed on his/her baseline care plan upon admission; -She would expect the residents' code status to be updated on his/her care plan; -Social services was responsible for obtaining code status orders on all newly admitted residents. During an interview on [DATE] at 10:43 A.M., Licensed Practical Nurse (LPN) A said in the event of an emergency, he/she would check the resident's face sheet and the full code sheet at the nurse's station to verify their code status. During an interview on [DATE] at 10:41 A.M., Registered Nurse (RN) D said the following:-There were no hard charts in the building. All documentation was completed in residents' EMRs;-Code status should be listed on each resident's face sheet; -All full code residents were listed on a sheet at the nurse's station-The resident's face sheets were always accurate;-In the event of an emergency, he/she would check the resident's face sheet and the full code sheet at the nurse's station to verify code status. During an interview on [DATE] at 10:46 A.M., the Assistant Director of Nursing (ADON) said the following:-The full code sheet at the nurse's station was updated upon a resident's admission;-The full code sheet at the nurse's station was updated when there were any changes and the resident's code status was reviewed at all care plan meetings; -Nurses could check the code status sheet or face sheet in the event of an emergency. During an interview on [DATE] at 6:59 P.M. the Director of Nursing (DON) said the following:-She would expect to have a signed physician's order showing a residents' code status; -She would expect a residents' code status to be listed on their face sheet; -She would expect a residents' code status to be listed on their baseline care plan; -She would expect the resident's code status be listed on their care plan and for the care plan to be up to date;-Code status should be entered on the resident's face sheet, baseline care plan and have a physician's order within twenty-four hours after a resident has been admitted .

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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. Based on interview and record review, the facility failed to complete required background screenings including the criminal background check (CBC) and employee disqualification list (EDL) checks, prior to employment for four of ten newly hired employees (Administrator, Housekeeper M, Registered Nurse (RN) JJ and Activity Assistant KK) who were hired since the last annual survey. The facility policy failed to address the Nurse Aide (NA) registry check as part of employment screening. The facility failed to complete the NA Registry check for five of ten employees (Administrator, Maintenance/Driver DD, Dietary [NAME] EE, Certified Nursing Assistant (CNA) GG and Caregiver II). The facility census was 55. Review of the undated facility policy, Employment Procedures, showed the following: -Prior to employment, the facility is required by state regulation to check the state EDL, run a criminal record check, and file application to the Family Care Safety Registry (FCSR). An applicant will not be placed on the schedule until the criminal record check is returned and approved by the administrator;-The policy did not address NA registry checks. Review of SentryLink National Criminal Background Check website, sentrylink.com, showed the criminal background check was comprehensive but not guaranteed to include the Missouri State Highway Patrol (MSHP) checks unless it was a specialized, state-mandated check or involved MSHP fingerprinting. SentryLink's standard national checks access state and county records, but for specific MSHP checks, typically need to initiate a state-level request through the MSHP directly. 1. During an interview on 10/06/25 at 1:47 P.M., the administrator said he checked with SentryLink to see if they included the MSHP in the CBC and they do not. 2. Review of the Administrator's employee file showed the following: -Date of hire 12/02/24;-FCSR letter date 12/10/24 (eight days after hire, requested on 12/05/24, three days after hire);-EDL check 12/05/24 (three days after hire);-NA registry check 12/05/24 (three days after hire). 3. Review of Dietary Aide FF's employee file showed the following: -Date of hire 01/23/25;-SentryLink CBC check 01/20/25;-No documentation of CBC that would include MSHP CBC prior to hire;-No documentation of a FCSR letter. 4. Review of Housekeeper M's employee file showed the following:-Date of hire 09/22/25;-SentryLink CBC check 09/12/25; -No documentation of CBC that would include MSHP CBC prior to hire;-NO documentation of a FCSR letter. 5. Review of Caregiver II's employee file showed the following: -Date of hire 03/12/25;-NA registry check 09/30/25 (203 days after hire). 6. Review of RN JJ's employee file showed the following: -Date of hire 07/11/25;-SentryLink CBC check 07/07/25;-No documentation of CBC that would include MSHP CBC prior to hire;-No documentation of a FCSR letter. 7. Review of Activity Assistant KK's employee file showed the following:-Date of hire 08/15/25;-SentryLink CBC check 08/08/25;-No documentation of CBC that would include MSHP CBC prior to hire;-No documentation of a FCSR letter. 8. Review of Maintenance/Driver DD's employee file showed the following:-Date of hire 05/20/25;-NA registry check 09/30/25 (134 days after hire). 9. Review of Dietary [NAME] EE's employee file showed the following:-Date of hire 05/14/25;-NA registry check 09/30/25 (140 days after hire). 10. Review of CNA GG's employee file, on 10/01/25, showed the following:-Date of hire 05/21/25;-No date of NA registry check (134 days after hire). 10. During an interview on 10/01/25 at 5:36 P.M., the unit secretary said the following:-She was responsible for completing the required checks for employment;-Required checks included the criminal background check, EDL and NA registry and should be completed prior to hire;-She was told by the previous administration that the SentryLink included everything required for the CBC;-She noticed on a review, after the state agency asked for the employee files, that some of the NA registry checks had not been completed, so she completed those after the state agency asked for the employee files. During an interview on 10/01/25 at 6:00 P.M., the Administrator said the following: -He was not aware SentryLink did not include the MSHP to complete the CBC;-He expected staff to complete the CBC check, EDL check and NA Registry check prior to the employee's hire date.

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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. Based on observation, interview, and record review, the facility failed to provide each resident with a palatable meal served at appetizing temperatures. The facility census was 55. 1. During an interview on 09/29/25 at 2:35 P.M., Resident #34 said the following:-He/She normally ate his/her dinner in his/her room;-The meal was cold by the time staff served him/her in his/her room. During an interview on 09/29/25, at 2:09 P.M., Resident #52 said the following:-Some evenings he/she ate in his/her room;-The food was warm, but did not taste good at all. During the resident council meeting on 09/30/25 at 1:10 P.M., several residents in attendance said their food was cold at dinner when served as a room tray. 2. Review of the facility's Resident Diet Orders, printed 9/30/25, showed the following: -Forty-seven residents with a physician-ordered regular diet; -Four residents with a physician-ordered mechanical soft diet. Review of the facility's temperature logs, taken prior to serving the dinner meal on 9/30/25, showed the following: -Regular entree (sloppy joe on a bun): 168 degrees F; -Mechanical soft entree (ground meat): 160 degrees F; -Starch (steak fries): 170 degrees F; -No recorded temperature for mechanical soft starch (mashed potatoes) or mechanical soft vegetable (carrots). Observation on 9/30/25, in the kitchen at the steam table, showed the following: -From 4:45 P.M. to 5:07 P.M., [NAME] Y served food from the steam table to residents in the dining room; -From 5:08 P.M. to 5:17 P.M., [NAME] Y plated hall meal trays, added a plate cover to each plate of food, and staff placed the trays of food on a cart; -At 5:18 P.M., [NAME] Y plated a test tray of regular and mechanical soft food. Dietary Aide Z placed the test tray on the cart with the resident hall meal trays and wheeled the cart to each of the resident halls. Observation on 9/30/25 from 5:22 P.M. to 5:38 P.M., showed Dietary Aide Z and Dietary Aide AA served trays from the cart to residents' rooms on the 100-300 halls. Observation on 9/30/25, at 5:39 P.M., of the test tray, after all residents had been served on the halls, showed the following: -The temperature of the mechanical soft ground meat was 96.1 degrees Fahrenheit (F). The meat tasted bland and was cool; -The temperature of the mechanical soft mashed potatoes was 100.7 degrees F. The mashed potatoes tasted bland and were cool; -The temperature of the mechanical soft carrots was 107.4 degrees F. The carrots were cool to taste; -The temperature of the regular sloppy joe was 114.1 degrees F. The meat tasted like chili powder and was cool; -The temperature of the steak fries was 104.7 degrees F. The fries tasted bland and were cool. During an interview on 10/1/25 at 2:15 P.M., the Dietary Manager said he expected hot foods to be served hot and cold foods to be served cold. He expected staff to take temperatures of food items before serving food and to log the temperatures on the food temperature log sheets. During an interview on 10/1/24 at 2:45 P.M., [NAME] Y said hot foods should be at 160 degrees F on the steam table and served to residents at a temperature of least 140 degrees F.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility staff failed to implement an effective quality assessment and assurance (QAA) committee to develop and track any identified concerns for resolution. The facility census was 55. Review of the undated facility policy, Quality Assurance Performance Improvement (QAPI) Plan, showed the following: -Purpose statement: The purpose of QAPI is the organization is to take a proactive approach in improving the way the facility cares for and engages with residents, caregivers and other partners. To do this, employees will participate in ongoing QAPI efforts which support the mission of caring and sharing in the resident's home away from home;-The QAPI program encompasses all segments of the facility, including resident/family feedback, individualized resident care plans, information technology, facility assessment and QAPI;-Aspects of service and care are measured against established performance goals;-Key monitors are measured and trended on a regular basis;-The QAPI committee monthly prioritized activities, endorses or re-endorses policies and procedures, and continually monitors for improvement using a QAPI self-assessment;-In addition, the QAPI committee will implement Performance Improvement Plan (PIP) topics indicated by data analysis;-The facility will use data at QAPI meetings to ensure performance measures are meeting QAPI goals. 1. Review of the last three QAA notes, provided by the administrator on 10/01/25 at 3:30 P.M., showed the last meeting minute notes were dated 09/30/25. No identification of any identified or addressed quality assurance deficiencies in the meeting minutes noted. During an interview on 10/01/25 at 3:30 P.M., the administrator said the following: -He started in December 2024;-He had a QAA committee meeting monthly and had sign in sheets and minutes documented;-QAA members present during QAA meetings included himself, the Director of Nursing at times, the Medical Director, dietary manager, maintenance director, social services director, sand sometimes the Minimum Data Set nurse;-During QAA, the department heads discussed issues that needed to be addressed or taken care of, but that discussion was only verbal, with no written performance improvement plans (PIP) documented;-He had not identified any areas of widespread deficient practice in any area related to quality of care or quality of life.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to provide incontinent care consistent with acceptable standards of practice to prevent urinary tract infections (UTI) and failed to follow proper infection control procedures for one sampled resident (Resident #46). The facility census was 55. Review of the undated facility policy, Policy for Performing Catheter Care with Peri Care, showed the following: -Check catheter (flexible tube inserted into the bladder to drain urine) and drainage bag for leaks, kinks, level of bag, color and character of the urine, and make sure bedside drainage bag is attached to the frame of the bed;-Make sure catheter is secure, coiled and draining properly. 1. Review of Resident #46's undated Continuity of Care Document diagnoses included chronic kidney disease (longstanding disease of the kidneys leading to renal (kidney) failure) and benign prostatic hyperplasia without lower urinary tract symptoms/BPH (a condition in which the prostate gland enlarges but does not cause any noticeable problems with urination). Review of the resident's care plan, revised 09/29/25, showed the following: -Alteration in elimination related to indwelling catheter;-Keep catheter bag below the level of the bladder to prevent reflux (back flow of urine into the bladder);-Minimize contamination. Keep collection bag in a dignity bag when outside the room;-Use leg bag as appropriate. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/30/25, showed the following:-Cognitively intact;-Partial to moderate staff assistance needed for toileting hygiene;-Dependent on staff for toileting transfer;-Indwelling catheter present;-Diagnosis of BPH and neurogenic bladder (nerve damage that keeps the bladder from working properly). Observation on 09/30/25 at 5:30 P.M., showed the resident self-propelled himself/herself in a wheelchair from the dining room. The resident's urinary drainage bag was in a dignity bag fastened under the seat of the resident's wheelchair, with the catheter tubing dragging the floor. The urine in the tubing was cloudy yellow with a moderate amount of white sediment (normal urine is clear yellow without sediment). Observation on 09/30/25 at 6:30 P.M., showed the following: -Certified Nurse Assistant (CNA) H and CNA I attached a mechanical lift pad to the mechanical lift;-CNA H retrieved the urinary drainage bag from the dignity cover on the resident's wheelchair and raised it above the level of the resident's bladder to attach it to the lift pad for transfer;-CNA H and CNA I transferred the resident to bed;-CNA H removed the resident's sweatpants and threaded the urinary drainage bag through his/her pant leg and raised the drainage bag higher than the bladder, causing urine to back flow toward the bladder;-CNA H and CNA I assisted the resident to turn to his/her left side;-CNA I raised the drainage bag above the level of the bladder, causing urine to back flow up the tubing and toward the bladder;-The urine was cloudy yellow with moderate white sediment. Observation on 10/01/25 at 10:05 A.M., showed the resident sat in his/her wheelchair in the solarium. The resident's urinary drainage bag was in a dignity bag under the resident's wheelchair. The catheter tubing touched the floor. The resident's urine was cloudy yellow with a small amount of white sediment. During an interview on 10/22/25 at 10:58 A.M., Certified Nurse Aide (CAN) H said the following:-He/She helped transfer and care for the resident on 9/30/25;-He/She was not aware he/she raised the resident's catheter bag above the level of the resident's bladder during care. During an interview on 10/02/25 at 6:56 P.M., the Director of Nursing (DON) said the following:-Catheter tubing should be stored in the dignity bag and never drag the floor;-A catheter bag should never be raised above the level of the bladder to decrease the risk of back flow that could potentially cause a UTI.

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	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

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide a written notice of transfer/discharge to three residents (#1, #2 and #3) or the representatives, in a sample of 23 residents reviewed that include the required information: reason for discharge/transfer, location being discharged /transferred to, resident's appeal rights and who to contact for an appeal hearing request, the contact information for the Ombudsman, the contact information for the advocacy agency for residents with intellectual and developmental disabilities or the contact information for the agency that is an advocate for residents with mental illness. The facility also failed to communicate transfer and discharges to the Ombudsman (a trained advocate, often a volunteer, who works to protect the rights and improve the quality of life for residents in long-term care facilities, such as nursing homes and assisted living facilities). The facility census was 55. Review of the undated facility policy, Policy and Procedure for Resident Discharge, showed the following: -Policy statement: The resident who resides at the facility will be discharged from the home in a safe and organized fashion with adequate follow-up arrangements per physician order;-Resident discharge to hospital:-Consult with the physician to obtain discharge to hospital of resident choice. Address and transcribe any following orders that the physician has ordered;-Notify the family to inform of resident change in status and physicians orders;-Obtain the following paperwork to transport resident to the hospital: fill out transfer sheet with physicians' orders to transport, print out or send the last history and physical, progress note, physician order sheets, code status, Durable Power of Attorney (DPOA) papers, medication administration sheets, and last two days of nursing notes;-Obtain vital signs and notify the ambulance department giving information required;-Call the emergency department to give report on resident condition;-Notify the Director of Nursing (DON) and administrator regarding resident's trip to the emergency department;-If emergency discharge from the facility is needed or likely the charge nurse will populate the discharge form letter and deliver to the resident or resident representative as soon as practicable. 1.Review of Resident #1's undated face sheet showed the resident had a family representative/DPOA.Review of the resident's progress notes, dated 09/01/25 at 12:02 A.M., showed staff documented the resident was not acting himself/herself, has very spacey look, resident cannot blink or close eyes, speech very slurred, right sided weakness and a droop to the right side of his/her mouth; call made to DPOA; in agreement to sending to the emergency department for evaluation. Review of the resident's progress notes, dated 09/01/25 at 12:28 A.M., showed the following:-Call placed to 911 at 12:10 A.M.;-Emergency Medical Services (EMS) arrived at 12:15 A.M., face sheet, Continuity of Care Document (CCD), and most recent vital signs sent with EMS;-EMS took resident out of the facility at 12:21 A.M.;-Fax sent to physician notifying him/her of change in condition. Review of the resident's Notice of Transfer/Discharge, dated 09/01/25, and authored by the Social Services Director (SSD), showed the following:-Notice was given verbally to the resident's DPOA; -The document did not include the reason for discharge/transfer, resident's appeal rights and who to contact for an appeal hearing request, the contact information for the Ombudsman, the contact information for the advocacy agency for residents with intellectual and developmental disabilities of the contact information for the agency that is an advocate for residents with mental illness. 2. Review of Resident #2's face sheet showed he/she had a DPOA listed. Review of the resident's census report, dated 05/06/25 at 12:07 A.M., showed the resident was transferred to the hospital. Review of the resident's progress notes, dated 05/06/25 at 12:07 A.M., showed the following:-The resident was not acting like his/herself, he/she very confused and very lethargic and he/she had pain in his/her back and flank area;-During the shower, the resident had another bout of liquid diarrhea with blood;-911 was contacted;-12:02 A.M. resident left with EMS to local hospital;-The family and the DON were notified. Review of the resident's progress notes, dated 05/06/25 at 11:04 A.M., showed the following:-Progress note discipline: Social services;-This writer notified early this morning that the (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	resident went out to the hospital. Copy of the transfer/bed hold policy was emailed to the resident's DPOA. Informed the resident will return to the facility when medically ready and no bed hold charge. Review of the resident's Notice of Transfer/Discharge, dated 05/06/25, showed the following:-Notice was provided to the resident's DPOA;-The document did not include the reason for discharge/transfer, resident's appeal rights and who to contact for an appeal hearing request, the contact information for the Ombudsman, the contact information for the advocacy agency for residents with intellectual and developmental disabilities or the contact information for the agency that is an advocate for residents with mental illness. Review of the resident's census report, dated 05/08/25 at 10:14 A.M., showed the resident returned from the hospital. Review of the resident's progress notes, dated 05/08/25 at 6:02 P.M., showed the resident was readmitted to the facility (from the hospital). Review of the resident's progress notes, dated 07/01/25 at 5:46 P.M., showed the following:-At 5:00 P.M., the resident became lethargic while sitting on the toilet;-He/She was placed on bed with the help of staff;-His/Her blood pressure was 82/38; -He/She reported his/her stomach hurt and pointed to his/her lower abdomen;-An order was obtained to send the resident to the hospital emergency room for evaluation and treatment;-The Assistant Director of Nurses (ADON) and the resident's family member were notified;-EMS arrived and transported the resident to the hospital. Review of the resident's progress notes, dated 07/01/25 at 8:30 P.M., showed the following:-Staff spoke with the emergency room and the resident was going to be transferred to another hospital; Review of the resident's census report, dated 07/01/25 at 11:03 P.M., showed the resident transferred to the hospital. Review of the resident's Notice of Transfer/Discharge, dated 07/01/25, authored by the SSD, showed the following:-Notice was provided to the resident's DPOA (documentation did not specify if the notice was verbal or written); -The document did not include the reason for discharge/transfer, resident's appeal rights and who to contact for an appeal hearing request, the contact information for the Ombudsman, the contact information for the advocacy agency for residents with intellectual and developmental disabilities or the contact information for the agency that is an advocate for residents with mental illness. Review of the resident's progress notes, dated 07/07/25 at 1:10 P.M., showed the resident readmitted to the facility (from the hospital). 3. Review of Resident #3's undated face sheet showed he/she had a family representative/DPOA. Review of the resident's progress notes, dated 03/25/25 at 6:06 A.M., showed the following:-The resident put his/her call light on and said he/she wasn't feeling well;-Staff took vital signs as temperature 102.6 (normal 98.6 F. orally), heart rate 113, respirations 22, oxygen saturation 90% and blood pressure 115/73;-At approximately 5:30 A.M., vital signs were re-taken, and they were 101.4, 103, 20, 91% and 125/88;-Phone call made to provider on call who ordered to have resident transported by EMS due to hypoxia (low oxygen saturation);-Resident prepared for transport, paperwork completed and 911 called;-EMS arrived at approximately 5:35 A.M.;-DPOA notified. Review of the resident's Notice of Transfer/Discharge, dated 03/25/25, showed the following:-Written notice was provided to the resident's DPOA; -The document did not include the reason for discharge/transfer, resident's appeal rights and who to contact for an appeal hearing request, the contact information for the Ombudsman, the contact information for the advocacy agency for residents with intellectual and developmental disabilities or the contact information for the agency that is an advocate for residents with mental illness. 4. During email communication on 09/22/25 at 4:35 P.M., the Ombudsman said the facility has not been sending them the information on residents transferred or discharged from the facility. During an interview on 10/02/25 at 11:55 A.M., the Social Services Director (SSD) said the following: -She was not aware that transfer/discharge notices needed to be sent to the ombudsman monthly and had not been sending them;-She was not aware of some of the specific information that needed to be on the transfer/discharge notice and bed holds; -She gives the bed holds personally if she is available on the transfers, and if not, she will follow up the next day to make sure it has been given, but nursing can also give a bed hold.

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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.