

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45563</p> <p>Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of individual needs by ensuring call lights were in reach at all times for two residents (Resident #31 and #70), in a review of 23 sampled residents, and failed to accommodate Resident #31's need for an alternative means to contact staff when the resident could not physically use the type of call light provided in his/her room. The facility census was 95.</p> <p>Review of the facility's undated policy, Use of Call Light, showed the following:</p> <ul style="list-style-type: none"> -When providing care to residents, be sure to position the call light conveniently for the resident's use; -Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. <p>1. Review of Resident #31's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility, dated 12/19/23, showed the following:</p> <ul style="list-style-type: none"> -The resident was cognitively intact; -He/She had functional limited range of motion to bilateral upper extremities; -He/She was dependent on staff for bed mobility and transfers. <p>Review of the resident's care plan, last updated 1/25/24, showed the staff were to keep the resident's call light accessible when in the room.</p> <p>Observation on 3/19/24 at 8:22 A.M., showed the following:</p> <ul style="list-style-type: none"> -The resident lay in bed with carrot cones in both of his/her contracted hands; -The resident's call light lay on the floor on the left side of the bed out of the resident's reach. <p>Observation on 3/19/24 at 11:03 A.M., showed the following:</p> <ul style="list-style-type: none"> -The resident lay in bed with carrot cones in bilateral contracted hands; <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident's call light lay on the floor out of the resident's reach.</p> <p>During an interview on 3/19/24 at 11:03 A.M., the resident said the following:</p> <p>-He/She cannot use the call light due to his/her hands being contracted, so he/she had to holler out for staff and wait for hours for help;</p> <p>-He/She would prefer to do something other than hollering, because it did not work well.</p> <p>Observation on 3/20/24 at 8:20 A.M., showed the following:</p> <p>-The resident lay in bed with carrot cones in bilateral contracted hands;</p> <p>-The call light was on the floor next to the wall out of the resident's reach.</p> <p>During an interview on 3/21/24, Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident was unable to use a traditional call light, because of contractures in bilateral hands;</p> <p>-He/She didn't know if the resident would use a different type of call light because the resident preferred to yell for staff when he/she needed something.</p> <p>2. Review of Resident #70's care plan, updated 11/28/23, showed the following:</p> <p>-He/She required assistance from two staff for bed mobility and transfers;</p> <p>-He/She was at risk for falling and staff should continue to round on resident frequently for safety and ensure call light is within reach;</p> <p>-Keep call light in reach at all times.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-He/She was dependent on bed mobility and transfers.</p> <p>Observation on 3/20/24 at 4:45 A.M. showed the following:</p> <p>-The resident sat in his/her geri chair in his/her room;</p> <p>-The resident's call light lay on the floor near the foot of the bed and was not within the resident's reach.</p> <p>Observation on 3/20/23 at 7:45 A.M. showed the following:</p> <p>-The resident lay in bed;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident's call light lay on the floor near the foot of the bed and was not within the resident's reach.</p> <p>Observation on 3/20/24 at 3:35 P.M. showed the following:</p> <p>-The resident lay in bed;</p> <p>-The resident's call light lay on the floor near the foot of the bed and was not within the resident's reach.</p> <p>During interview on 3/20/24 at 4:45 A.M., the resident said he/she can use the call light if and when staff leave it within his/her reach.</p> <p>During interview on 3/21/24 at 6:00 P.M., LPN H said the following:</p> <p>-The resident was able to use his/her call light and was able to let staff know his/her needs;</p> <p>-All call lights should be within the resident's reach at all times, even if the resident was unable to use it.</p> <p>3. During an interview on 3/21/24 at 7:35 P.M., the Director of Nursing said the following:</p> <p>-The call light should be within the resident's reach at all times;</p> <p>-Residents should have a call light they can use;</p> <p>-Resident #31 should have a soft touch call light due to contractures on both of his/her hands.</p> <p>46506</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45563</p> <p>Based on observation, interview, and record review, the facility failed to create an environment respectful of the rights of each resident to make choices about significant aspects of their life for four residents (Residents #6, #34, #58, and #70), in a review of 23 sampled residents, and for one additional resident (Resident #89), who were cognitively impaired and dependent on staff for assistance with activities of daily living. Staff woke and dressed the residents early in the morning based on a get up list without consideration of the resident's preferences for waking and for staff convenience. The facility census was 95.</p> <p>Review of the facility's undated Policy for Resident Rights showed the following:</p> <ul style="list-style-type: none"> -It was the intent of the facility to promote and ensure that highest standards of conduct and reliability by it's employees and consultants to in turn produce environments in the facility that promoted the highest standards of care and security for the residents and the families of who they served; -Residents would be provided with the highest level of care and services; -Each resident shall be afforded the opportunity to participate in their own care planning and allowed to refuse treatment; -Each resident shall be treated with consideration, respect a full recognition of his/her dignity and individuality; <p>Review of Patient [NAME] of Rights provided by the Long Term Care Ombudsman Program showed the nursing home resident had the right to the following:</p> <ul style="list-style-type: none"> -Participate in their care; residents are entitled to take part in planning care and being informed of all aspects of care; -Residents may refuse any treatment they do not want. <p>1. Review of Resident #34's undated continuity of care document (CCD) showed the following:</p> <ul style="list-style-type: none"> -The resident had a legal guardian; -Medical diagnoses included Alzheimer's disease, anxiety disorder, dementia, unspecified lack of coordination, and cognitive communication deficit; -His/Her wishes would be followed. <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 3/9/24, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cognitively impaired;</p> <p>-Required supervision or touching/steadying with bed to chair transfers, dressing upper and lower body, and putting/taking off footwear.</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the following:</p> <p>-The resident required assistance of one staff with dressing;</p> <p>-The resident required set up assistance with bed mobility and transfers.</p> <p>(The resident's care plan did not include his/her preference for wake-up time.)</p> <p>Observation on 3/20/24 at 5:15 A.M. showed the following:</p> <p>-The resident lay in his/her bed with his/her eyes closed;</p> <p>-Nurse Aide (NA) D entered the room, turned on the light, and told the resident, We are going to get up, okay.</p> <p>-The resident mumbled, but did not wake up or open his/her eyes;</p> <p>-NA D asked the resident if he/she was ready to get up and the resident again mumbled with his/her eyes closed;</p> <p>-NA D sat the resident up on the side of the bed, dangled the resident's legs, and placed a shirt and gait belt on the resident;</p> <p>-With the resident's eyes closed, NA D dressed the resident;</p> <p>-NA D assisted the resident to his/her wheelchair and pushed the resident to the activity/TV room.</p> <p>During an interview on 3/20/24 at 5:15 A.M., NA D said sometimes the resident did not like to get up in the morning.</p> <p>Observation on 3/20/24 at 5:38 A.M. showed the resident sat in the activity/TV room with his/her head resting on the table and his/her eyes closed.</p> <p>2. Review of Resident #89's admission MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-He/She was independent with transfers, ambulation, dressing, and personal hygiene.</p> <p>Review of the resident's care plan, last revised on 10/9/23, showed the care plan did not include the resident's preference for wake-up time.</p> <p>Review of the resident's undated CCD showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-His/Her diagnoses included dementia, major depressive disorder and pain;</p> <p>-His/Her wishes would be honored.</p> <p>Observation on 3/20/24 at 5:30 A.M. showed NA D entered the resident's room, told the resident it was time to get up and exited the room (because the resident was able to get him/herself dressed without assistance).</p> <p>During an interview on 3/20/24 at 5:46 A.M., the resident said he/she did not necessarily like to get up early. He/She got up early because of his/her living location and was forced to get up. He/She did not normally sleep late, but did not like to get up this early before he/she came to this facility.</p> <p>During an interview on 3/20/24 at 6:13 A.M., NA D said the evening staff told him/her that all the residents needed to get up before day shift got there. The day shift staff liked to have everyone up by the time they got there at 6:30 A.M. He/She started waking residents up around 5:15 A.M.</p> <p>3. Review of Resident #70's care plan, last reviewed on 11/28/23, showed the following:</p> <p>-The resident required assistance of two staff for transfers, toileting, bed mobility, and dressing;</p> <p>-Encourage resident to voice preferences with daily care;</p> <p>-Invite resident to care plans to assess preferences of care.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognitively intact;</p> <p>-Dependent on staff for bed mobility, transfers, and dressing.</p> <p>During an interview on 3/18/24 at 12:05 P.M., the resident said the following:</p> <p>-He/She had been sitting out in the main TV room since 6:00 A.M. or so;</p> <p>-Staff get him/her up by 5:00 A.M. every morning, and he/she doesn't like to get up that early;</p> <p>-He/She would prefer to sleep in until closer to 8:00 A.M. when it's time for breakfast;</p> <p>-He/She has told staff and staff told him/her that they have several other residents to get up and get ready, so that's why they have to get him/her up so early.</p> <p>Observation on 3/20/24 at 4:45 A.M. showed the resident was awake and fully dressed. He/She sat in his/her geri chair in his/her room.</p> <p>During an interview on 3/20/24 at 4:45 A.M., the resident said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She was sleepy and didn't like to get up this early;</p> <p>-He/She would prefer to sleep in and get up at 7:00 A.M. at the earliest.</p> <p>During an interview on 3/20/24 at 5:00 A.M., Certified Medication Technician (CMT) I said he/she was taking the resident down to the dining room. The resident didn't mind getting up this early.</p> <p>During an interview on 3/20/24 at 5:30 A.M., CMT I said night staff usually get the residents up who use the Hoyer lift (mechanical lifting device) and require assistance of two staff members. He/She has to go to another hall to find someone to assist him/her on the 100 hall which takes a lot of time when he/she is trying to get people up.</p> <p>4. Review of Resident #58's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-Dependent on staff for bed mobility, transfers, and dressing.</p> <p>Review of the resident's care plan, last reviewed on 3/20/24, showed the following:</p> <p>-Anticipate needs such as comfort, perineal care, warmth, positioning: address timely;</p> <p>-Allow sufficient uninterrupted rest periods.</p> <p>Observation on 3/20/24 at 5:00 A.M. showed the resident was fully dressed and sat in his/her geri chair. NA B pushed the resident in the geri chair to the dining room.</p> <p>During interview on 3/21/24 at 12:30 P.M., the resident said staff get him/her up really early and he/she would prefer to sleep in later.</p> <p>During an interview on 3/21/24 at 8:58 A.M., Certified Nurse Assistant (CNA) P said the following:</p> <p>-He/She gets a run down from night shift on any resident who still needs to get up if they are not already up for day shift;</p> <p>-Day shift begins at 6:00 A.M.</p> <p>5. Review of Resident #6's care plan, last updated 11/28/23, showed the following:</p> <p>-The resident was able to make his/her needs known;</p> <p>-He/She had muscle weakness and left sided hemiparesis (weakness or the inability to move on one side of the body);</p> <p>-He/She required assistance of one staff member for transfers, walking, dressing, grooming, and personal hygiene;</p> <p>-Remind resident not to transfer without assistance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(The resident's care plan did not identify the resident's preference for wake-up time.)</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The resident had moderately impaired cognition; -He/She had functional limitations in range of motion to one side of upper and lower extremities; -He/She was independent with upper body dressing and chair/bed-to-chair transfers; -He/She required supervision for lower body dressing. <p>Observation on 3/20/24 at 4:45 A.M., showed the resident sat at the dining room table in his/her wheelchair with his/her eyes closed.</p> <p>During an interview on 3/20/24 at 4:45 A.M., the resident said he/she didn't want to get up this early, but the staff came in his//her room this morning and told him/her it was time to get up.</p> <p>During an interview on 3/20/24 at 5:32 A.M., NA B said the following:</p> <ul style="list-style-type: none"> -The staff were supposed to get everyone up; -If a resident didn't want to get up, then the staff would return upon the resident's request; -The resident said he/she didn't want to get up this morning, so NA B left the room and returned later to get him/her up. <p>During an interview on 3/20/24 at 5:35 A.M., CNA C said the following:</p> <ul style="list-style-type: none"> -The facility had a cheat sheet for staff showing when residents get up; -The resident was on the list to get up; -The resident didn't want to get up this morning, so they left and returned to get him/her up. <p>6. During an interview on 3/21/24 at 7:35 P.M., the Director of Nursing said the following:</p> <ul style="list-style-type: none"> -Residents' rights should be honored regarding when a resident gets up in the morning; -If the guardian specifies the resident's get up time, then it should be placed on the care plan; -4:30 A.M. was too early for staff to get residents up for breakfast. <p>46506</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on interview and record reviews, the facility failed to notify three residents (Resident #4, #24, and #48), in a review of 23 sampled residents, or their representatives in writing of transfer to the hospital, including the reasons for the transfer. The facility failed to send a copy of the transfer notice to a representative of the Office of State Long-Term Care Ombudsman. The facility census was 95.</p> <p>Review of the facility's undated policy, Discharge/Transfer of Resident, showed the following:</p> <ul style="list-style-type: none"> -Explain transfer and reason to the resident and/or representative and give copy of signed transfer or discharge notice to the resident and/or representative or person responsible for care; -If emergency transfer, transfer or discharge notice form may be completed later, but as soon as possible; -Explain and give copy of bed hold form to the resident and/or representative. <p>1. Review of Resident #48's face sheet showed his/her family member was his/her responsible party.</p> <p>Review of the resident's nurse notes, dated 11/17/22 at 2:43 P.M., showed the following:</p> <ul style="list-style-type: none"> -The resident was very lethargic and was not able to respond like baseline; -The nurse checked his/her blood sugar and it was 405 (normal random adult blood sugar is less than 140 milligrams/deciliter), oxygen saturation was 87% (normal range is between 92% and 100%), respirations were 19 breaths per minute (normal range is 12-18 breaths per minute), pulse was 105 beats per minute (normal range is between 60 to 100 beats per minute); blood pressure was 142/78 millimeters of mercury (mm/Hg); -Insulin (hormone that lowers the level of sugar in the blood) was given and oxygen was put on at 3 liters per minute via cannula. Oxygen saturation came up to 94% and the resident opened his/her eyes a little more; -The resident had no urine output all night shift nor this morning; -At 10:45 A.M., the nurse checked the resident again and his/her oxygen saturation had dropped to 85% and his/her blood sugar was 400. The oxygen liter flow was bumped up to 5 liters per minute; -The physician's office was contacted, who ordered give two DuoNeb (medication used to treat wheezing, shortness of breath, and other breathing problems) back-to-back and give 9 units of regular insulin, recheck the resident in one hour; <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-At 12:10 P.M., the nurse checked the resident again and his/her oxygen saturation was at 82% and his/her blood sugar was 422. Called the physician's office again and the physician gave the order to send the resident to the emergency department.</p> <p>Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative a written notice of transfer when the resident was transferred to the hospital on 11/17/22.</p> <p>Review of the resident's census showed the resident returned to the facility on [DATE].</p> <p>Review of the resident's nurse notes, dated 6/3/23 at 11:51 AM, showed the resident's temperature was 98.8 degrees Fahrenheit (normal range is 96.4 to 98.5 degrees Fahrenheit), oxygen saturation of 85% on room air. The resident sounded congested, lungs were coarse throughout, but no coughing.</p> <p>Review of the resident's nurse notes, dated 6/4/23 at 1:45 PM, showed the following:</p> <ul style="list-style-type: none"> -The resident was afebrile (no fever) with temperature of 97.7 degrees Fahrenheit and has been lethargic; -The resident kept falling asleep repeatedly and hand hanging in food; -His/Her oxygen saturation was 82- 86% on 4 liters per minute of oxygen; -He/She was very confused with arms and hands shaking; -The nurse received a new order to send the resident to the hospital emergency department for evaluation. <p>Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative a written notice of transfer when the resident was transferred to the hospital on 6/4/23.</p> <p>2. Review of Resident #24's face sheet showed his/her family member was his/her responsible party for health care, and the resident was his/her own responsible party for finances.</p> <p>Review of the resident's progress note, dated 7/1/23 at 8:10 A.M., showed the following:</p> <ul style="list-style-type: none"> -The resident was assisted up for breakfast. Once in the wheelchair and stable, nursing staff noted he/she was leaning to the right in his/her wheelchair. He/She was having trouble with eating/taking pills, appeared drowsy, and his/her facial expression appeared to droop slightly to the right. When asked to smile, facial features appeared symmetrical; -The resident was arousable when talked to but drowsy while sitting. He/She was able to hold both arms out with slight resistance, hand grips strong, pedal push strong, pedal pull moderate/weak, speech slightly slurred; -Paged the resident's physician with update and order to send to emergency room (ER) for evaluation; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-Will place call to family member for update;</p> <p>-Emergency medical services (EMS) is taking resident to hospital for evaluation.</p> <p>Review of the resident's progress note, dated 7/1/23 at 8:20 A.M., showed staff left a voicemail with the resident's family member with update on the resident's condition, why he/she is being transported and that he/she is going to hospital for a stroke workup.</p> <p>Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative a written notice of transfer when the resident was transferred to the hospital on 7/1/23.</p> <p>Review of the resident's progress note, dated 7/6/23 at 10:26 P.M., showed the the resident returned from the hospital via ambulance.</p> <p>3. Review of Resident #4's face sheet showed he/she was his/her own responsible party.</p> <p>Review of the resident's nurse notes, dated 12/29/23 at 11:33 P.M., showed the following:</p> <p>-At approximately 8:45 P.M., the resident had a sudden change in condition. He/She become short of breath with decreased oxygen saturation level, mucus coming from his/her nose and mouth, and audible congestion and wheezing;</p> <p>-The physician was contacted and an order was obtained to send him/her to the emergency room for evaluation and treatment;</p> <p>-He/She was transported to the hospital via ambulance at 9:00 P.M.</p> <p>Review of the resident's medical record showed no documentation the facility staff provided the resident a written notice of transfer when the resident was transferred to the hospital on 12/29/23.</p> <p>Review of resident's nursing progress note dated 1/1/23 at 6:12 P.M. showed he/she returned to the facility.</p> <p>4. During an interview on 3/21/24 at 1:00 P.M., the administrator said she could not locate transfer notices. The charge nurses were supposed to provide the transfer notice upon transfer. The Social Service Director (SSD) was supposed to follow up to ensure they were completed. The SSD was also responsible for notifying the State Ombudsman of transfer/discharges.</p> <p>During an interview on 3/21/24 at 11:22 A.M., the SSD said she was not aware she was to follow up with transfer notices. She was unaware she was responsible for notifying the State Ombudsman of transfer/discharges.</p> <p>32899</p> <p>45563</p> <p>46506</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>32530</p> <p>Based on interview and record review, the facility failed to provide a written notice of bed hold with required information to the resident and/or resident representative when the facility initiated a transfer to the hospital for three residents (Resident #4, #24, and #48), in a review of 23 sampled residents. The facility census was 95.</p> <p>Review of the facility's undated policy, Discharge/Transfer of Residents, showed staff was to explain and give a copy of the bed hold form to the resident and/or representative.</p> <p>1. Review of Resident #48's face sheet showed his/her family member was his/her responsible party.</p> <p>Review of the resident's nurses notes, dated 11/17/22 at 2:43 PM, showed the physician gave the order to send the resident to the emergency department.</p> <p>Review of the resident's census showed the resident returned to the facility from the hospital on 11/21/22.</p> <p>Review of the resident's nurse notes, dated 6/4/23 at 1:45 PM, showed the nurse received a new order to send the resident to the hospital emergency department for evaluation.</p> <p>Review of the resident's census showed the resident returned to the facility from the hospital on 6/14/23.</p> <p>Review of the resident's medical record showed no documentation the facility provided the resident or his/her representative with a bed hold policy when the resident was transferred to the hospital on 11/17/22 or 6/4/23.</p> <p>2. Review of Resident #24's face sheet showed his/her family member was his/her responsible party for health care, and the resident was his/her own responsible party for finances.</p> <p>Review of the resident's progress note dated 7/1/23 at 8:10 A.M. showed the following:</p> <p>-The resident was assisted up for breakfast. Once in the wheelchair and stable, nursing staff noted he/she was leaning to the right in his/her wheelchair. He/She was having trouble with eating/taking pills, appeared drowsy, and his/her facial expression appeared to droop slightly to the right. When asked to smile, facial features appeared symmetrical;</p> <p>-The resident was arousable when talked to but drowsy while sitting. He/She was able to hold both arms out with slight resistance, hand grips strong, pedal push strong, pedal pull moderate/weak, speech slightly slurred;</p> <p>-Paged the resident's physician with update and order to send to emergency room (ER) for evaluation ;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-Will place call to family member for update;</p> <p>-Emergency medical services (EMS) is taking resident to the hospital for evaluation.</p> <p>Review of the resident's progress note, dated 7/1/23 at 8:20 A.M., showed staff left a voicemail with the resident's family member with an update on the resident's condition, why he/she was being transported and that he/she was going to the hospital for a stroke work-up.</p> <p>Review of the resident's medical record showed no documentation the facility provided the resident or his/her representative with a bed hold policy when the resident was transferred to the hospital on 7/1/23.</p> <p>Review of the resident's progress note, dated 7/6/23 at 10:26 P.M., showed the resident returned from the hospital via ambulance.</p> <p>3. Review of Resident #4's face sheet showed he/she was his/her own responsible party.</p> <p>Review of the resident's nurse notes, dated 12/29/23 at 11:33 P.M., showed the following:</p> <p>-At approximately 8:45 P.M., the resident had a sudden change in condition. He/She become short of breath with decreased oxygen saturation level, mucus coming from his/her nose and mouth, and audible congestion and wheezing;</p> <p>-Physician was contacted and an order was obtained to send him/her to the emergency room for evaluation and treatment;</p> <p>-He/She was transported to the hospital via ambulance at 9:00 P.M.</p> <p>Review of the resident's medical record showed no documentation facility staff provided the resident a bed hold policy when he/she was transferred to the hospital on 12/29/23.</p> <p>Review of resident's nursing progress note dated 1/1/23 at 6:12 P.M. showed he/she returned to the facility.</p> <p>4. During an interview on 3/21/24 at 11:22 A.M., the Social Services Director (SSD) said she was not aware that she was to follow up to ensure bed hold notices were provided to residents and/or resident representatives upon transfer.</p> <p>During an interview on 3/21/24 at 1:00 P.M., the administrator said she could not locate documentation to show residents and/or resident representatives were provided bed hold notices upon transfer. The charge nurses were supposed to provide bed hold policies when sent to the hospital and the SSD was supposed to follow up to ensure they were completed.</p> <p>45563</p> <p>46506</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive care plan, specific to the resident, for one resident (Resident #27), in a review of 23 residents. The facility census was 95.</p> <p>Review of the facility undated policy for comprehensive care plans showed the following:</p> <ul style="list-style-type: none"> -An individualized comprehensive care plan that included measurable goals and time frames would be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being; -The comprehensive care plan would be based on a thorough assessment that included, but was not limited to, the minimum data set (MDS; a federally mandated assessment to be completed by the facility); -A well developed care plan was designed to prevent avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence, manage risk factors to the extent possible or indicating the limits of such interventions, addressing ways to try to preserve and build upon resident strengths, applying current standards of practice in the care planning process, evaluating treatment of measurable goals, timetables and outcomes of care, respecting the resident's right to decline treatment, offering alternative treatments, as applicable, using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities, involving resident, resident's family, and other resident representative as appropriate, assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs, involving the direct care staff with the care planning process relating to the resident's expected outcomes, and addressing additional care planning areas that are relevant to meeting the resident's needs in long-term care setting; -The interdisciplinary care plan team was responsible for the periodic review and updating of care plans when a significant change in the resident's condition has occurred, at least quarterly, and when changes occur that impact the resident's care. <p>1. Review of Resident #27's undated continuity of care document (CCD) showed the following:</p> <ul style="list-style-type: none"> -Diagnoses included dementia and depression; -He/She would have social needs met by staff or directed by staff. <p>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/26/23, showed the following:</p> <ul style="list-style-type: none"> -Cognition was severely impaired; -He/She was depressed one-half or more of the days during the previous seven day look back period. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's physician's orders, dated 2/15/24, showed an order for Zoloft (antidepressant) 100 milligrams (mg), two tablets every evening for treatment of depression.</p> <p>Review of the resident's quarterly MDS dated [DATE] showed the following:</p> <ul style="list-style-type: none"> -Cognition was severely impaired; -He/She felt or appeared down, depressed, or hopeless nearly every day of the previous seven day look back period; -He/She required the use of an antidepressant. <p>Observation on 3/18/24 at 12:45 P.M., showed the resident was crying and said nobody cared about him/her.</p> <p>During an interview on 3/18/24 at 12:45 P.M., Activity Aide J said the resident cried all day, every day and said that nobody wanted him/her. Staff tried to provide reassurance that everything was okay and to keep him/her distracted by including him/her in activities, but these interventions did not work. The resident continued to cry and act depressed.</p> <p>During an interview on 3/18/24 at 1:04 P.M., the resident's family member said the resident was more tearful the last week and he/she thought the resident was giving up, but the resident seemed a bit better this week. The nurse told him/her the resident's depression medication was increased and it took a bit to get into the resident's system.</p> <p>Observation on 3/18/24 at 3:00 P.M., showed the resident appeared upset and was tearful as he/she said, nobody cared.</p> <p>During interview on 3/18/24 at 3:00 P.M., the resident was unable to communicate why he/she was upset and tearful.</p> <p>Review of resident's nursing progress note, dated 3/19/24 at 6:11 A.M., showed the resident continued to resist staff care and was crying earlier that morning while he/she clenched his/her hands together and repeated the word no over and over. He/She refused medication during administration attempt.</p> <p>Observation on 3/20/24 at 10:20 A.M., showed the resident sat in his/her wheelchair crying. No staff was present.</p> <p>Observation on 3/20/24 at 10:40 A.M., showed the resident began to cry.</p> <p>Observation on 3/20/24 at 11:43 A.M., showed the resident sat in his/her wheelchair at the end of the hall, near the nursing station/shower room area. The resident was crying.</p> <p>Observation on 3/20/24 at 12:00 P.M., showed Nurse Aide (NA) E and NA K attempted to provide incontinence care for the resident, but the resident became combative and rejected the care;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Licensed Practical Nurse (LPN) H entered the resident's room to encourage the resident, but the resident continued to be combative and reject the care;</p> <p>-LPN H instructed NA E and NA K to leave the resident alone and try again later after the resident had calmed down.</p> <p>Review of the resident's care plan, last reviewed/ revised 3/20/24, showed no documentation to address the resident's depression, rejection of care, or the use of an antidepressant.</p> <p>During an interview on 4/2/24 at 2:52 P.M., the Care Plan Coordinator said the resident's behaviors, including crying, should be documented on the care plan. She did not realize it was not on his/her care plan. Use of antipsychotic/antidepressant medications should be addressed on the care plan, but she did not realize the resident was on any of these medications.</p> <p>During an interview on 3/20/24 at 3:51 P.M., the Director of Nursing said the resident was always tearful. The resident's behaviors including crying and rejection of care, and use of antidepressants for treatment of depression should be on the resident's care plan.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on observation, interview, and record review, the facility failed to ensure five residents (Resident #1, #4, #34, #27 and #28) who required assistance with activities of daily living (ADL), in a review of 23 sampled residents, received the amount of assistance needed to complete ADL tasks. The facility census was 95.</p> <p>Review of the facility undated oral hygiene policy showed the following:</p> <ul style="list-style-type: none"> -Purpose was to cleanse the mouth, teeth, and dentures; -Staff was expected to offer oral hygiene before breakfast, after each meal, and at bedtime. <p>Review of the undated facility shower policy, showed the following:</p> <ul style="list-style-type: none"> -Purpose was to maintain skin integrity, comfort and cleanliness; -Staff was expected to offer showers and encourage the resident to do as much of his/her own care as possible and supervise and assist as necessary. <p>1. Review of Resident #28's undated face sheet showed the resident's diagnoses included urinary tract infection, candidiasis (yeast infection), overactive bladder and panic disorder (anxiety disorder characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress.)</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 2/7/24, showed the following:</p> <ul style="list-style-type: none"> -Cognition was moderately impaired; -He/She required substantial to maximum assistance from staff for showering/bathing and for toileting; -He/She was frequently incontinent of bladder and was occasionally incontinent of bowel; -He/She rejected care one to three days of the seven day look back period. <p>Review of the resident's care plan, last reviewed/revised 3/20/24, showed the following:</p> <ul style="list-style-type: none"> -He/She will have positive experiences in daily routine without overly demanding tasks and without becoming overly stressed; -He/She is incontinent of urine at all times; -Keep clean and dry as possible, and minimize skin exposure to moisture; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Use absorbent, skin-friendly pads/briefs to maintain personal hygiene and dignity;</p> <p>-He/She requires extensive assist with toileting, personal hygiene and bathing.</p> <p>Record review of the facility shower sheet binder showed the resident was to receive a shower on Wednesdays and Sundays (twice a week).</p> <p>Record review of shower sheets for January 2024 showed the resident received a shower on 1/27/24.</p> <p>Record review of shower sheets for February 2024 showed the following:</p> <p>-No documentation the resident received or refused a shower on 2/1/24 through 2/12/24;</p> <p>-The resident refused a shower on 2/13/24;</p> <p>-No documentation the resident received or refused a shower on 2/14/24 through 2/27/24;</p> <p>-The resident received a shower on 2/28/24 (32 days after his/her last documented shower on 1/27/24).</p> <p>Record review of shower sheets for March 2024 showed the following:</p> <p>-No documentation the resident received or refused a shower on 3/3/24 through 3/8/24;</p> <p>-The resident received a shower on 3/9/24 (nine days after his/her last documented shower on 2/28/24);</p> <p>-No documentation the resident received or refused a shower on 3/10/24 through 3/18/24.</p> <p>Observation on 3/18/24 at 1:05 P.M., showed the following:</p> <p>-The resident lay in bed on top of two layers of urine-soaked chucks (absorbent pads) that lay on top of a sheet; a large, brown, urine stained ring was on the sheet;</p> <p>-The resident's hair was greasy and unkempt.</p> <p>During an interview on 3/18/24 at 1:05 P.M., the resident said the following:</p> <p>-He/She hasn't had a shower for two weeks;</p> <p>-He/She told the night shift aide last night that his/her bed was wet. Rather than change his/her sheets, the aide applied more pads over the top of the wet sheets;</p> <p>-He/She sits in urine all day;</p> <p>-Staff won't assist him/her with a sponge bath and tell him/her, You can do it;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She gets upset that staff think he/she is able to clean himself/herself and he/she needs staff help.</p> <p>During an interview on 3/19/24 at 9:55 A.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-Staff encourage the resident to do things on his/her own;</p> <p>-Staff offers the resident showers, but the resident has behaviors and often refuses;</p> <p>-The resident was fully capable of doing things and would refuse.</p> <p>Observation on 3/21/24 at 2:35 P.M. showed the resident's hair was greasy and unkempt.</p> <p>During an interview on 3/21/24 at 2:43 P.M., the resident said the following:</p> <p>-He/She asked the aide for a shower and aide told him/her, It's going to be a while, and never gave him/her a shower;</p> <p>-He/She had never refused a shower.</p> <p>Review of the resident's shower sheets showed no documentation the resident received a shower on 3/19/24 through 3/21/24.</p> <p>During an interview on 3/21/24 at 2:47 P.M., Certified Nurse Assistant (CNA) R said the following:</p> <p>-He/She was the assigned shower aide yesterday;</p> <p>-The resident did not ask him/her for a shower yesterday;</p> <p>-He/She did not give the resident a shower on 3/20/24;</p> <p>-The resident often refused showers;</p> <p>-Staff were supposed to fill out a shower sheet and mark Refused if the resident refuses.</p> <p>2. Review of Resident #4's undated continuity of care document (CCD) showed the following diagnoses:</p> <p>-Schizophrenia (a severe, lifelong brain disorder that causes people to interpret reality abnormally);</p> <p>-Dementia;</p> <p>-Need for assistance with personal care;</p> <p>-Dystonia (a movement disorder that causes the muscles to contract involuntarily).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cognition was severely impaired;</p> <p>-He/She required supervision, verbal cues, or touching/steadying assistance with oral hygiene.</p> <p>Observation on 3/18/24 12:15 P.M. showed the resident had missing and broken teeth.</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the following:</p> <p>-The resident required assistance from one staff with personal hygiene and dressing;</p> <p>-Staff were to encourage him/her to participate in ADLs to the best of his/her ability;</p> <p>(The care plan did not address the resident's dental status or assistance needed for dental care.)</p> <p>Observation on 3/20/24 at 6:05 A.M. showed Nurse Aide (NA) D and NA E entered the resident's room to wake him/her and told him/her it was time for breakfast. The resident asked if he/she could eat in his/her room. Staff did not provide oral care for the resident prior to leaving the resident's room.</p> <p>Observation on 3/20/24 at 8:20 A.M. showed the resident sat in his/her wheelchair eating breakfast. The resident had poor oral hygiene with a white substance on his/her mouth and missing/broken teeth.</p> <p>3. Review of Resident #34's undated CCD, showed the resident's diagnoses included Alzheimer's disease, dementia, unspecified lack of coordination, and cognitive communication deficit.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Cognitively impaired;</p> <p>-The resident required supervision, verbal cues, or touching/steadying assistance with oral hygiene.</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the resident required assistance of one staff with personal hygiene.</p> <p>Observation on 3/20/24 at 5:15 A.M. showed NA D assisted the resident to dress and then took the resident into the activity room. NA D did not provide oral care for the resident.</p> <p>Observation on 3/20/24 at 5:30 A.M. showed the resident had a white/yellow substance on his/her teeth and a crusted white substance around his/her mouth.</p> <p>4. Review of Resident #27's undated CCD showed his/her diagnoses included dementia.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She required substantial/maximal assistance with oral care;</p> <p>-He/She did not have any dental concerns.</p> <p>Review of the resident's care plan, last reviewed/revise on 3/20/24, showed the care plan did not address the resident's dental status or assistance needed for dental care.</p> <p>Observation on 3/20/24 at 6:30 A.M. showed NA D and NA E assisted the resident with incontinence care, dressed the resident and transferred him/her to the wheelchair. The resident had dentures in his/her mouth. Staff did not remove the dentures to brush them and did not provide oral care before assisting the resident out of his/her room for breakfast.</p> <p>During interview on 3/20/24 at 7:00 A.M., NA D said the resident's dentures should have been removed last night and placed in a denture cup. He/She did not know why the resident's dentures were in his/her mouth this morning as the resident was already in bed when he/she started his/her shift last night. Staff should have removed the resident's dentures this morning and brushed, rinsed, and placed them back in the resident's mouth.</p> <p>During interview on 3/20/24 at 7:00 A.M., NA E said the resident's dentures should be removed at night and placed in denture cups. Staff should rinse and brush dentures before placing them in the resident's mouth. Oral hygiene should be offered/provided to all residents when they get up in the morning. The resident had dentures and staff might not have been able to remove them last night. He/She was unaware that oral care had not been provided before staff took the resident to the activity room.</p> <p>5. Review of Resident #1's undated face sheet showed the resident's diagnoses included severe intellectual disabilities, dysphagia (difficulty swallowing) following other cerebrovascular disease, disorder of teeth and supporting structures, and quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-He/She was dependent on staff for oral hygiene;</p> <p>-He/She did not have a swallowing disorder;</p> <p>-His/Her oral/dental status was not assessed.</p> <p>Review of the resident's care plan, last reviewed/revise on 3/20/24, showed staff was to provide frequent oral care, and lubricate the resident's lips.</p> <p>Observation of the resident on 3/19/24 at 5:20 A.M. showed the following:</p> <p>-He/She lay asleep in bed in a gown;</p> <p>-The resident's lips were dry and cracked;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-His/Her teeth were covered in plaque.</p> <p>Observation on 3/19/24 at 3:40 P.M., showed the following;</p> <p>-The resident lay in bed and wore the same gown he/she wore at 5:20 A.M.;</p> <p>-His/Her lips were dry and cracked;</p> <p>-His/Her teeth were covered in plaque;</p> <p>-His/Her hair was uncombed.</p> <p>Observation on 3/21/24 at 3:50 P.M. showed the following:</p> <p>-He/She lay in bed awake in a gown;</p> <p>-His/Her lips were dry and cracked with chunks of dry skin on them;</p> <p>-His/Her teeth were covered in plaque;</p> <p>-His/Her hair was uncombed.</p> <p>During interview on 3/21/24 at 4:05 P.M., LPN S said staff should be providing oral care for the resident every two hours or more often if needed.</p> <p>6. During an interview on 3/21/24 at 7:35 P.M., the Director of Nursing said the following:</p> <p>-Staff was to perform oral care with morning cares, twice a day, and as needed;</p> <p>-Staff was expected to provide showers two days a week per the shower schedule and per the resident's request;</p> <p>-Staff should not place a clean pad over soiled sheets.</p> <p>32899</p> <p>45563</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on observation, interview, and record review, the facility failed to provide an ongoing program of meaningful activities on a daily basis to meet the interests and the physical, mental, and psychosocial well-being for three residents (Resident #4, #34, and #82) who resided in the facility's special care unit (SCU) and two residents who resided in the general population (Resident #1 and #58), of 23 sampled residents. The facility census was 95.</p> <p>Review of the facility policy, Activity, Volunteer, and Recreational Services, dated March 2012, showed the following:</p> <ul style="list-style-type: none"> -The activity director, assistants and volunteers of this facility, believe that everyone has the right to achieve the maximum of his or her potential; have opportunities for social involvement on an individual or group basis; and have outlets for creative abilities offering opportunities for self-development that would afford personal interest, enjoyment and satisfaction provided through an ongoing activity program; -The facility provides an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The activity program must be directed by a qualified professional who is directly responsible to the Administrator; -Religious, recreational, diversions, intellectual and educational activities are to be available to all residents. If a resident wishes to participate in an activity, the physician must state on the resident's chart if there were limitations to their participation. <p>1. Review of an activity calendar provided by the activity director, showed the planned activities for the month of March (dated 3/1/24 to 3/31/24) as follows:</p> <ul style="list-style-type: none"> -On 3/18/24, writing, craft, show bucket, and music; -On 3/19/24 craft, math, and music; -On 3/20/24 craft, color, and music; -There were no times noted to show when each activity was scheduled. <p>2. Review of Resident #1's undated face sheet showed the following:</p> <ul style="list-style-type: none"> -He/She resided in the general population of the facility; -He/She had diagnoses that included severe intellectual disabilities and quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down). <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/20/24, showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cognition was severely impaired;</p> <p>-Activity preferences and importance not assessed.</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the following:</p> <p>-Potential for increased sense of positivity/pleasure with restorative activity;</p> <p>-He/She enjoys sitting in recreational area by the window and having the TV on for viewing and listening pleasure;</p> <p>-Mix in physical restorative with the sensor stimulation;</p> <p>-Use sensory stimulating items including a night light with soft bright colors and a collection of small textured balls for him/her to hold and squeeze.</p> <p>Observation of the resident's room on 3/20/24 at 5:20 A.M. showed the resident in bed with a bright, overhead room light and a bright light over his/her bed both turned on.</p> <p>Observation of the resident and his/her room on 3/21/24 at 3:50 P.M. showed the resident awake in bed and holding a teddy bear; a bright, overhead room light and a bright light above his/her bed were both turned on.</p> <p>During the survey process, there was no observation of staff providing activities for the resident or as the care plan directed including:</p> <p>-Sitting in the recreational area by the window and having the TV on for viewing and listening pleasure;</p> <p>-Physical restorative with the sensor stimulation;</p> <p>-Sensory stimulating items including a night light with soft bright colors and a collection of small textured balls for him/her to hold and squeeze.</p> <p>During an interview on 3/21/24 at 4:35 P.M., the Activity Director said he/she will take a stuffed animal into the resident's room and sing or read to him/her for an activity.</p> <p>3. Review of Resident #58's face sheet showed the following:</p> <p>-He/She resided in the general population of the facility;</p> <p>-He/She had diagnoses that included cerebral infarction (stroke), contracture (permanent tightening of the muscles, tendons and skin that causes the joints to shorten and become stiff), muscle weakness, reduced mobility and major depressive disorder.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Moderately impaired cognition;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Preference for activities was not assessed;</p> <p>-Dependent on staff for bed mobility, transfers, and dressing.</p> <p>Review of the resident's care plan, last reviewed on 3/20/24, showed the following:</p> <p>-He/She enjoys activities directed by self or one on one;</p> <p>-He/She will have social needs met by staff or directed by staff;</p> <p>-Anticipate needs, address timely.</p> <p>Observation of the resident on 3/20/24 at 11:25 A.M., showed the resident in bed, with head of bed elevated 30 degrees, staring at the wall.</p> <p>During an interview on 3/21/24 at 12:30 P.M., the resident said the following:</p> <p>-Staff do not provide any in room, one on one activities;</p> <p>-He/She prefers 1:1 activities and staff never do that;</p> <p>-He/She would prefer more activities.</p> <p>During an interview on 3/21/24 at 4:35 P.M., the Activity Director said the resident did come to happy hour last Friday. When asked if any in room, one on one activities were offered, she said they sing and bring activity pages to residents in their rooms, and that was about it.</p> <p>4. Review of the large activity board, posted in the special care unit's (SCU) activity room, dated March 2024, showed the following:</p> <p>-Bingo scheduled as the activity on 3/18/24 at 2:00 P.M.;</p> <p>-Cafe scheduled on 3/19/24 at 10:00 A.M.;</p> <p>-Craft scheduled on 3/19/24 at 2:00 P.M.;</p> <p>-Meet the author scheduled for 3/20/24 with no time for the activity provided;</p> <p>-Exercise scheduled on 3/21/24 at 11:00 A.M.;</p> <p>-Special guest scheduled for 3/21/24 at 12:00 P.M.</p> <p>5. Review of Resident #82's undated continuity of care document (CCD) showed the following:</p> <p>-The resident resided in the SCU portion of the facility;</p> <p>-Diagnoses included vascular dementia, delusional disorder, depression and personal history of other mental and behavioral disorders;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She would receive socialization and activities to promote psychosocial well-being.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-It was somewhat important to him/her to do things with groups of people;</p> <p>-It was somewhat important to him/her to do his/her favorite activities.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-He/She showed verbal behaviors toward others one to three days out of the previous seven day look back period;</p> <p>-Preferences were not assessed.</p> <p>Review of the resident's care plan, last reviewed/revised on 3/20/24, showed the following:</p> <p>-He/She enjoyed activities in a group setting, watching TV and socializing with staff and residents;</p> <p>-He/She enjoyed bingo, coloring, arts and crafts, exercise, church, outings and ice cream social;</p> <p>-Ensure he/she has a monthly calendar available in room for activities and activities are posted on the large calendar.</p> <p>Observation of the resident on 3/19/24 at 2:15 P.M., showed he/she sat in the activity room and became upset and verbally aggressive with a peer. There was no activity in progress in the activity room at this time (the large activity board showed at 2:00 P.M. there was to be a craft activity; there was no math or music activity being done as the calendar provided by the activity director).</p> <p>Observation of the resident on 3/19/24 at 2:30 P.M., showed he/she walked up and down the hall and sat in the activity room. There was no activity taking place in the activity room except the TV was on for residents to watch (the large activity board showed at 2:00 P.M. there was to be a craft activity; there was no math or music activity being done as the calendar provided by the activity director showed).</p> <p>Observation of the resident on 3/20/24 at 10:00 A.M., showed he/she walked up and down the hall of the unit and then sat in the activity room. There was no activity taking place in the activity room except the TV was on for residents to watch (there was no meet the author activity, no craft, color or music activity being completed or offered as the large activity board or calendar indicated).</p> <p>6. Review of Resident #34's undated CCD showed the following:</p> <p>-The resident resided in the SCU portion of the facility;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses included Alzheimer's Disease, anxiety disorder and cognitive communication disorder:</p> <p>-He/She would receive socialization and activities to promote psychosocial well-being.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-It was important to him/her to do things with groups of people;</p> <p>-It was important for him/her to participate in his/her favorite activities.</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the following:</p> <p>-He/She enjoyed activities directed by self or one to one;</p> <p>-He/She would have his/her social needs met by staff and/or directed by self;</p> <p>-Provide an activity calendar in his/her room and posted by salon (resident resided in the SCU and did not have access to the salon);</p> <p>-Provide one to one visits; he/she enjoyed watching TV (news game shows, cooking shows) and reading magazines/newspapers; have books available in the activity room;</p> <p>-Activity director is setting up resident with an activity board as a distraction activity related to resident's impulsiveness to get up out of his/her wheelchair frequently.</p> <p>Observation of the resident on 3/20/24 at 11:01 A.M., showed he/she self-propelled in the hall in his/her wheelchair, up and down the hall of the special care unit. He/She stood up and began to walk across the hall. Nurse aide (NA) K redirected him/her to sit back in his/her wheelchair and pushed him/her to the dining room. There was no activity taking place in the activity room; the TV was on for the residents to watch. There was no meet the author activity, no craft, color or music activity being completed or offered as the large activity board or calendar indicated.</p> <p>7. Review of Resident #4's undated CCD showed the following:</p> <p>-The resident resided in the SCU portion of the facility;</p> <p>-Diagnoses included schizophrenia (a severe, lifelong brain disorder that causes people to interpret reality abnormally), dementia;</p> <p>-He/She would receive socialization and activities to promote psychosocial well-being.</p> <p>Review of the resident's annual MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Preferences were not assessed because he/she was rarely/never understood and he/she did not have family available to assist with assessment.</p> <p>Review of the resident's care plan, last reviewed/revised 3/20/24, showed the following:</p> <p>-He/She enjoyed one to one activities and self-directed activities and was not at ease in joining other residents in activities;</p> <p>-Staff would provide one to one activities while he/she was awake and alert.</p> <p>Observation of the resident on 3/19/24 at 3:15 P.M., showed he/she was in bed with eyes open. There were no staff on the unit conducting one on one activities.</p> <p>8. Observation of the SCU on 3/18/24 at 2:00 P.M. showed Bingo was not played per the activity schedule.</p> <p>9. Observation of the SCU on 3/19/24 from 9:00 A.M. until 4:30 P.M. showed there were no activities that took place as scheduled. Residents sat around a table in the dining room or in their wheelchairs with the TV on. There was no activity staff on the unit as scheduled. There was no music for the residents to listen to or snacks provided during this time.</p> <p>10. Observation of the SCU on 3/20/24 from 8:00 A.M. until 3:00 P.M. showed there were no activities that took place as documented on the activity calendar. Residents sat around a table or in their wheelchairs in the activity room with the TV on. There was no activity staff on the unit as scheduled. There was no music for the residents to listen to and/or snacks provided during this time.</p> <p>During an interview on 3/20/24 at 10:40 A.M. NA E said activities were completed when there was activity staff on the unit. Activity staff were not on the unit to conduct activities on 3/19/24 or 3/20/24. He/She would try to conduct activities with the residents when time allowed, but didn't have a lot of time because they were too busy.</p> <p>During an interview on 3/20/24 at 10:45 A.M., NA K said there was no activity staff to conduct activities on 3/19/24 or 3/20/24, therefore none of the scheduled activities were completed. He/She tried to assist residents with activities when time allowed, but they did not have a lot of time because they were too busy with other tasks.</p> <p>During an interview on 3/20/24 at 1:45 P.M., the Activity Director said there was no activity aide/assistant on the unit at this time, therefore no scheduled activities were being completed. There was an activity aide scheduled from 10:00 A.M. until 4:00 P.M., but he/she did not show up for the shift. She scheduled one full time activity aide on the SCU and one full time for all the other residents. She was unaware that the activity aide scheduled yesterday did not come to work and activities were not conducted. She expected staff to complete the same activities on the SCU as they do with all other residents. The SCU activity aide was supposed to complete a new calendar with daily activities for the residents, but he/she did not do as he/she was instructed. There were residents who were to have one to one visits, but they were not being conducted because they did not have the staff to complete them.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/24 at 7:35 P.M., the Director of Nursing said activity staff should always be staffed in the SCU. Residents should have one to one activities in their room if indicated.</p> <p>During an interview on 3/21/24 at 7:35 P.M., the Administrator said there should be activity staff scheduled on the SCU every day. One to one visits should be completed as indicated on the resident's plan of care.</p> <p>32899</p> <p>45563</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on interview, observation, and record review, the facility failed to ensure the safety of six residents (Resident #2, #4, #19, #34, #56, and #79), of 23 sampled residents. Staff failed to follow care plan interventions for fall prevention, including placement of proper footwear and fall mat use, and failed to ensure residents were transported safely in their wheelchairs when staff failed to place foot pedals on the wheelchair prior to transport. Staff also failed to prevent an elopement by not ensuring staff provided protective oversight for one resident (Resident #56), and failed to protect two residents (Residents #2 and #300) from Resident #79, who had a history of verbal and physical aggression toward other residents. The facility's census was 95.</p> <p>1. Review of the facility Resident Elopement policy undated showed the facility provides 24 hour protective oversight and maintains the quality of life for each resident.</p> <p>Guidelines:</p> <p>3. If a resident is admitted with no previous elopement potential, but verbalizes or attempts to leave the facility, the following criteria should be followed:</p> <ul style="list-style-type: none"> a. Evaluate the resident to see if they meet the criteria for a locked unit; b. Director of Nursing (DON) must notify the resident's physician as soon as possible; c. Have the Social Service Director (SSD) notify the resident's family for assistance and information; d. Address the potential in a care plan and implement the interventions listed on the care plan; e. Place resident in a room that is in the line of sight of the nurse's station; f. Instruct one CNA per shift in the care of the resident. The CNA must observe the resident at all times but especially during meal times, medication administration times, scheduled ADL, every time the door alarm sounds, and as indicated in the care plan. The charge nurse must indicate on the assignment sheet which CNA is responsible. <p>Review of Resident #56's elopement risk assessment, dated 8/24/23, showed a score of 0.0 (not at risk for elopement).</p> <p>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 2/20/24, showed the following:</p> <ul style="list-style-type: none"> -Severely impaired cognition; -No behaviors or wandering; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Moderate to maximum assist for transfers;</p> <p>-Very important to go outside for fresh air;</p> <p>-Manual wheelchair for mobility;</p> <p>-Somewhat important to do things with group of people and do his/her favorite activities;</p> <p>-No wander/elopement alarm.</p> <p>Review of the resident's elopement risk assessment, dated 2/21/24, showed a score of 2.0 (low risk).</p> <p>Review of the resident's Physician Order Sheet (POS) dated March 2024, showed the following:</p> <p>-Diagnoses included schizo-affective disorder (chronic mental health condition consisting of hallucinations (sensing things such as visions, sounds, or smells that seem real but are not) or delusions (false belief about reality) and mood disorders), depression, disorientation, shortness of breath, and history of falls;</p> <p>-admitted due to need for continuous care due to inability to live independently and the need for 24 hour assistance, observation and planning (11/15/18).</p> <p>Review of the resident's care plan, dated as last revised 3/5/24, showed the following:</p> <p>-Wandering: Resident is not at risk of wandering/elopement based on observation. He/She scored a zero;</p> <p>-The resident will remain within safe areas of facility;</p> <p>-Call Code [NAME] if unable to locate resident and elopement is suspected;</p> <p>-Provide distractive activities to deter resident from wandering when noted.</p> <p>Review of the resident's elopement risk assessment, dated 3/10/24, showed a score of 0.0 (not at risk). Further review showed the assessment was scored incorrectly. The resident actually scored a 3 (one point for each of the following: disorientation, depression, and taking medications that suppress the thought process (narcotics, sedatives, anti-seizure, psychotropics, hypnotics, tranquilizers and anti-depressants).</p> <p>Review of the resident's progress notes, dated 3/10/24 at 6:30 P.M., showed the resident left the facility with another resident without approval. Both residents returned to the facility without incident. Director of Nursing and Power of Attorney informed.</p> <p>During an interview on 3/18/24 at 1:30 P.M. the resident said he/she asked a person (who lived in the attached Assisted Living Facility (ALF) to take him/her for a walk and they went outside and down the road.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/24 at 10:35 A.M. Certified Medication Technician (CMT) Y said the following:</p> <ul style="list-style-type: none"> -He/She had worked the day shift on 3/10/24 on the 600 hall (attached ALF); -He/She was the only staff on the 600 hall; -He/She had never been told he/she could not leave the desk, but was told the 600 staff had to answer the phone; -He/She had left the 600 desk to go look for a resident's medication, in the 300 medication room; -While on the 300 unit a new nurse asked for assistance in finding medications; -He/She was gone from the desk about 15- 20 minutes; -He/She had not seen the resident or the ALF resident by the front door; -He/She knew the resident as he/she had passed medications on the unit where the resident resided; -At the time of the incident, the ALF resident was allowed to go outside on walks and knew the door code with facility approval; -He/She first learned of the missing residents when an unknown Certified Nurse Assistant (CNA) told him/her after he/she found the resident. <p>During an interview on 3/21/24 at 12:07 P.M., the Business Office Manager said the following:</p> <ul style="list-style-type: none"> -He/She had worked on 3/10/24 and was outside with the dietary manager on break when staff came out and informed them that an RCF resident had the resident at the bridge (over the highway); -CMT Y had worked the 600 desk that day, but had left to help a new nurse finds medications; -He/She had last seen the resident at lunch in the dining room around 12:00 or 12:15 P.M. <p>During an interview on 4/3/24 at 2:24 P.M. CNA BB said the following:</p> <ul style="list-style-type: none"> -Upon learning of the missing residents and the residents' location, he/she, CMT AA and CMT Z, drove his/her car to the duck pond (located across the highway approximately one mile away); -The ALF resident was still pushing the resident in his/her wheelchair; -The residents were not in any distress; -CMT AA and CMT Z walked and pushed the resident in his/her wheelchair back to the facility; -Upon re-entering the building, he/she did not know if CMT Y was at the 600 desk or not; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-All staff had been educated (prior to this incident) that if you worked the 600 hall, you did not leave the unit.</p> <p>During an interview on 4/9/24 at 10:41 A.M. CMT Z said the following:</p> <p>-He/She helped search for the missing resident outside the facility before traveling in a car with co-workers to the duck pond where they were found;</p> <p>-Upon finding the resident, he/she sat in his/her wheelchair and was dressed with pants, a hoodie, a light jacket and a knit-like cap;</p> <p>-He/She and CMT AA walked the resident (in his/her wheelchair) back to the facility which took approximately 30-40 minutes.</p> <p>Observation of the area traveled from the facility to the duck pond in the park showed the road from the facility to the main road was two lanes and went past a church and school and led to a stop sign. The residents turned right crossing over a bridge spanning a highway. They walked down a busy two lane road which did not have shoulders or sidewalks and walked until they would have approached a four way stop. There they crossed two lanes of traffic and entered the park. The distance was approximately one mile from the facility. The weather was sunny, 65 degrees Fahrenheit and windy at the time the residents were out of the facility.</p> <p>During an interview on 3/21/24 at 7:35 PM, the Director of Nursing (DON) said staff had been educated if they worked the 600 hall that they could not leave that hall. If they had to leave the hall they would be expected to find someone to cover the hall. They would not have expected the scheduled staff to leave the 600 hall.</p> <p>2. Review of email communication with the administrator on 4/11/24 at 12:28 P.M. showed the facility does not have a policy regarding behavioral and resident safety.</p> <p>Review of Resident #79's quarterly MDS, dated [DATE] showed the following:</p> <p>-Moderately impaired cognition;</p> <p>-No delirium, behaviors or rejection of care;</p> <p>-Partial to moderate assist with transfers;</p> <p>-Walker and wheelchair used.</p> <p>Review of the resident's progress notes, dated 2/26/24 at 4:42 P.M. showed the resident had an altercation with another resident in the dining room. The resident wanted coffee out of the community coffee dispenser and Resident #300 was blocking access. He/She first yelled at the resident (Resident #300) to get out of the way and then began to slap/hit him/her in the arm. The residents were separated and on 15 minute checks.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/24 at 11:35 A.M., Resident #300 said he/she recalled the incident between him/her and Resident #79. He/She had walked to the smoke room and as he/she approached, Resident #79 stuck his/her foot out in front of him/her. When he/she exited the smoke room, Resident #79 stood up and said, You think I'm messin' around and started throwing punches. Resident #79 punched him/her in the nose, arm, hand and chest. His/Her hand hurt for a while and he/she reported it to staff. There were no witnesses. Staff told them to stay away from each other.</p> <p>Review of the resident's care plan dated 9/12/23 showed the following:</p> <p>Problem: 2/26/24 -behavioral symptoms-resident has physical behavioral symptoms toward others including yelling, cursing, hitting and pushing. Resident is to be seen by psych nurse practitioner on 3/1/24, physician and psych aware of behaviors;</p> <p>-Goal: Resident will not harm others secondary to physical or verbal abusive behavior;</p> <p>-2/26/24 - when physically abusive, move to a quiet, calm environment; allow distance in seating other residents around resident; allow resident to discuss anger, avoid over-stimulation, crowds and other physically aggressive residents, provide consistent staff. Obtain psych consult, praise appropriate behavior, use calm approach.</p> <p>-3/1/24 - both residents seen by psych Nurse Practitioner (NPA) for evaluations.</p> <p>Review of the resident's POS, dated 3/2024 showed the following:</p> <p>-Diagnoses included dementia (thinking and social symptoms that interfere with daily functioning) and cerebral vascular accident (CVA-stroke- interruption in the flow of blood to the brain);</p> <p>-Urinalysis ordered (2/22/24);</p> <p>-Lexapro (anti-depressant) 10 milligrams (mg) one tablet by mouth daily (3/8/24);</p> <p>-Rexulti (major depressive disorders) 0.5 mg by mouth daily (3/16/24-3/23/24);</p> <p>-Terrazzo (antidepressant/sedative)50 mg (1/2 tablet) two times daily (10/19/23).</p> <p>Review of the resident's progress notes, dated 3/11/24 at 8:45 P.M. showed another resident accused Resident #79 of hitting him/her. The altercation occurred when both residents were by the smoking door. The other resident was attempting to go around the resident when Resident #79 hit Resident #2 three times.</p> <p>During an interview on 3/19/24 at 9:30 A.M., Resident #79 said he/she was going to the smoke room, Resident #2 was behind him/her and hit him/her with Resident #2's wheelchair and was trying to cut in front of him/her. Resident #2 went into smoke and he/she waited outside the room. When Resident #2 came out, he/she said, Are you ready? Resident #2 said, What? He/She repeated, Are you ready? and then swung at Resident #2 three times, hitting him/her in the nose one time.</p> <p>Review of the resident's care plan dated 9/12/23 showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-3/11/24 -residents separated and placed on 15 minute checks, state agency and police phoned. All parties notified. Resident will not have behaviors that could be harmful to themselves or others</p> <p>During an interview on 3/21/24 at 7:35 PM, the DON said they had not implemented any interventions for Resident #79 and #300 other than to stay away from each other to prevent further aggression among residents. Resident #79 had not been evaluated by psychiatry.</p> <p>3. Review of the facility's undated policy for wheelchair use showed the following:</p> <ul style="list-style-type: none"> -Purpose was to provide mobility for the non-ambulatory resident with a safety and comfort and to provide mobility for residents learning to become independent in activities of daily living; --Fold footrests up out of the resident's way for safety. Do not remove footrests unless resident use feet on floor to enable mobility; -Lower footrests and place resident's feet on the footrests if used; -The policy failed to instruct staff to ensure foot pedals were properly in place with resident's feet on them prior to transport. <p>4. Review of Resident #34's undated continuity care document (CCD) showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> -Alzheimer's Disease, -Lack of coordination; -Cognitive communication deficit; -Difficulty walking. <p>Review of the resident's annual MDS dated [DATE] showed the following:</p> <ul style="list-style-type: none"> -Cognition was severely impaired; -His/Her mobility devices included wheelchair and walker; -He/She required partial to moderate assistance with putting on and taking off socks and shoes, or other footwear that was appropriate for safe mobility; -He/She required supervision or touch assist with sitting to standing position and from chair to bed transfers; -He/She was independent with wheeling at least 150 feet in the corridor or similar area; -He/She had two or more falls with no injury; -He/She had two or more falls with injury. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's fall risk assessment dated [DATE] showed he/she was at high risk for falls.</p> <p>Review of the resident's care plan last reviewed/ revised on 3/20/24 showed the following:</p> <ul style="list-style-type: none"> -He/She was at risk for falls related to history of falls within the last six months prior to admission, medications, Alzheimer's Disease, history of wandering, incontinence, and requiring assistance with activities of daily living (ADLs); -He/She used a wheelchair for most locomotion and required assistance of one staff; -He/She was impulsive at times and would get out of his/her wheelchair without assistance; -Provide resident with proper, well-maintained footwear; -Resident had a fall on 11/8/23, intervention put into place after the fall included staff instruction to ensure resident had non-skid socks on when out of bed. <p>Observation of the resident on 3/19/24 at 12:43 P.M., showed the resident sat at the dining room table in his/her wheelchair eating lunch without shoes or socks with grippers. He/She wore white socks without grippers.</p> <p>Observation of the resident on 3/20/24 at 5:15 A.M., showed Nurse Aide (NA D) assisted the resident with dressing. NA D placed white socks without grippers on the resident's feet without shoes and pushed the resident to the dining room in his/her wheelchair without placing foot pedals on the wheelchair. The resident's socked feet brushed the carpeted floor as he/she was transported from his/her room to the activity room.</p> <p>During an interview on 3/20/24 at 6:13 A.M. NA D said he/she did not put foot pedals on the resident's chair because the resident was able to self-propel him/herself.</p> <p>Observation of the resident on 3/20/24 at 10:30 A.M., showed NA E transferred the resident from his/her wheelchair to the bed without proper footwear. The resident wore white socks without grippers and was not wearing any shoes during the transfer.</p> <p>During an interview on 3/20/24 at 7:00 A.M., NA E said the resident fell all of the time. The resident would stand up next to the rail or table and/or grab something not stable like a wheelchair. The resident could walk but would get tired, lower him/herself to the floor or fall. The resident wore normal socks and never wore shoes.</p> <p>Observation of the resident on 3/20/24 at 7:05 A.M. showed he/she attempted to stand at the end of the hall by the nurses station without proper footwear in place. He/She wore white socks without grippers.</p> <p>Observation of the resident on 3/20/24 at 11:12 A.M. showed he/she attempted to stand without proper footwear in place. He/She wore white socks without grippers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/24 at 11:08 A.M., Certified Nurse Assistant (CNA) Q said the resident had tennis shoes he/she supposed to wear.</p> <p>5. Review of Resident #19's undated face sheet showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> -Cellulitis (infection) of right lower limb; -Laceration without foreign body, right lower leg; -Fracture of unspecified part of neck of left femur, initial encounter for closed fracture; -Alzheimer's disease; -History of falling; -Dementia. <p>Review of the resident's quarterly MDS, dated [DATE] showed the following:</p> <ul style="list-style-type: none"> -Cognition was severely impaired; -His/Her mobility devices included wheelchair; -He/She was independent with wheeling at least 150 feet in the corridor or similar area; -He/She required partial to moderate assistance with putting on and taking off socks and shoes or other footwear that was appropriate for safe mobility; -He/She had two or more falls with no injury. <p>Review of the resident's care plan, last reviewed/ revised on 3/18/24, showed the following:</p> <ul style="list-style-type: none"> -He/She required limited assistance with wheelchair transfers; -He/She was independent with locomotion on/off unit in wheelchair; -Licensed nursing staff to determine his/her capabilities for transfers on a day to day basis using their judgment of his/her mood, physical ability at the time of care; re-evaluate for any change in safety/ability. <p>Observation of the resident on 3/20/24 at 5:05 A.M. showed the following:</p> <ul style="list-style-type: none"> -The resident sat at the dining room table with no foot pedals on his/her wheelchair; -The resident was not wearing any socks or shoes on his/her feet. <p>Observation on 3/20/24 at 6:05 A.M. showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident propelled himself/herself down the hallway and asked staff to give him/her a shove;</p> <p>-CMT I pushed the resident down the hall to the dining room with no foot pedals on the wheelchair.</p> <p>During an interview on 3/20/24 at 5:35 A.M., CNA T said the resident should not be pushed in a wheelchair without foot pedals.</p> <p>6. Review of Resident#4's undated CCD showed the following diagnoses:</p> <p>-Schizophrenia (a severe, lifelong brain disorder that causes people to interpret reality abnormally);</p> <p>-Dementia;</p> <p>-Abnormalities of gait and mobility;</p> <p>-Muscle weakness;</p> <p>-Unsteadiness on feet;</p> <p>-Need for assistance with personal care;</p> <p>-Dystonia (a movement disorder that causes the muscles to contract involuntarily).</p> <p>Review of the resident's progress notes dated 1/09/2024 at 1:33 P.M. showed the resident was observed on the floor next to his/her bed after he/she attempted to self-transfer and slid to the floor.</p> <p>Review of the resident's quarterly MDS dated [DATE] showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-He/She had one non-injury fall since the previous assessment.</p> <p>Review of the resident's care plan last reviewed/ revised on 3/20/24 directed staff to keep floor mat in place with bed in lowest/locked position.</p> <p>Observation of the resident on 3/20/24 at 5:00 A.M., showed he/she lay in his/her bed without a fall mat beside the bed. There was no fall mat located in the resident's room for use.</p> <p>Observation on 3/21/24 at 11:05 A.M. showed resident lay in his/her bed without fall mat next to the bed. There was no fall mat located in the resident's room for use.</p> <p>During an interview on 3/21/24 at 11:08 A.M., CNA Q said the resident did not use a fall mat. He/she followed the resident's care plan or asked the nurse for direction of care. He/She was unaware the resident was to use a fall mat when in bed.</p> <p>During an interview on 3/20/24 at 5:35 A.M., CNA T said the resident should not be pushed in a wheelchair without foot pedals.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. During an interview on 3/21/24 at 7:35 PM, the Director of Nursing said she expected staff to follow interventions as directed on the resident's care plan, including placement of proper footwear. She expected staff to place foot pedals on the resident's wheelchair before transporting them. Foot pedals should be readily available in a bag on the back of resident's wheelchairs for use when needed.</p> <p>32899</p> <p>45563</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45563</p> <p>Based on observation, interview, and record review, the facility failed to obtain an order for oxygen use and maintain equipment according to the facility policy for two residents (Residents #28 and #54), in a review of 23 sampled residents. The facility census was 95.</p> <p>Review of the undated facility policy, Physician Orders, showed the oxygen orders include the specific rate of flow, route, and rationale.</p> <p>Review of the undated facility policy, Cleaning Guidelines-Oxygen Equipment, showed tubing, masks, and cannulas used with oxygen therapy should be replaced monthly and PRN (as needed) and marked with date and initials.</p> <p>Review of the undated facility policy, Oxygen Administration, showed the following:</p> <ul style="list-style-type: none"> -Set the flow meter to the rate ordered by the physician, then place the oxygen cannula on the resident; -At regular intervals, check and clean oxygen equipment, masks, tubing and cannulas; -At regular intervals, check liter flow contents of oxygen cylinder and fluid level in humidifier. <p>1. Review of Resident #54's Continuity of Care Document (CCD), showed he/she had a diagnosis of systolic congestive heart failure (inability of the heart to contract effectively and distribute blood flow to meet the needs of the body).</p> <p>Review of the resident's nurse note, dated 11/7/23, showed the following:</p> <ul style="list-style-type: none"> -A certified nurse aide (CNA) notified the nurse the resident was not at baseline; -The resident's oxygen saturation was 78% (normal range is between 92% and 100%) on room air; -The nurse administered oxygen at 2 liters/minute, which increased the resident's oxygen saturation to 88%; -The nurse was unable to maintain the oxygen saturation level as it continued to decrease despite oxygen administration; -The physician's office was called and orders given to send the resident to the hospital emergency department. <p>Review of the resident's nurse notes, dated 11/17/23 at 7:56 P.M., showed the following:</p> <ul style="list-style-type: none"> -The resident returned from the hospital on oxygen at 3 liters/minute via nasal cannula; -He/She was supposed to have oxygen continuously. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility, dated 12/29/23, showed the following:</p> <ul style="list-style-type: none"> -The resident had severe cognitive impairment; -The MDS did not identify the resident received oxygen therapy or experienced shortness of breath. <p>Review of the resident's physician orders, dated March 2024, showed no orders for oxygen frequency, liter flow, indication or changing tubing/cannulas.</p> <p>Review of the resident's care plan, last updated 3/8/24, showed no documentation the resident received oxygen therapy or interventions regarding oxygen therapy.</p> <p>Review of the resident's nurse note, dated 3/14/24 at 7:56 P.M., showed the following:</p> <ul style="list-style-type: none"> -The nurse entered the resident's room to find the resident was not wearing the oxygen cannula; -The resident's oxygen saturation on room air was 82%, so the nurse put the oxygen cannula back on the resident; -The resident's oxygen saturation came back up to 92%, lung sounds were diminished, no cough, and no congestion found. <p>Observation on 03/20/24 at 8:01 A.M., showed the following:</p> <ul style="list-style-type: none"> -The resident had an oxygen cannula in his/her nose, but not around his/her ears to keep it in place; -The liter flow on the oxygen tank regulator on the back of the resident's wheelchair was set to 0 liters/minute; -Nurse Aide (NA) B walked by the resident, looked at the regulator, then walked down the hall to another staff member; -He/She asked the certified medication technician (CMT) about the liter flow and was told 2 liters/minute; -No staff members set the regulator to 2 liters per minute on the regulator; -The resident continued down the hallway to his/her room. Once in the room, the resident took off the cannula to the oxygen tank and put on the cannula to the oxygen concentrator that was set on 2 liters per minute/nasal cannula. <p>During an interview on 3/21/24 at 10:02 A.M., NA B said the following:</p> <ul style="list-style-type: none"> -He/She saw the liter flow was not set and didn't think he/she was allowed to set the liter flow; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She said something to the certified medication technician, but decided to look for the nurse instead;</p> <p>-After he/she found the nurse, the resident was in bed with the cannula on the oxygen concentrator.</p> <p>Observation on 03/21/24 at 10:45 A.M., showed the resident propelled in his/her wheelchair in the hallway towards the dining room. The resident had the nasal cannula in place in his/her nostrils. The nasal cannula was connected to the oxygen tank, secured to the back of his/her wheelchair, however the oxygen tank was empty.</p> <p>Observation in the dining room on 3/21/24 at 11:40 A.M., showed the resident sat at the dining room in his/her wheelchair with oxygen cannula in place. The oxygen tank regulator showed the tank was empty.</p> <p>Observation in the television common area on 3/21/24 at 1:20 P.M. and 1:50 P.M., showed the resident sat in his/her wheelchair with oxygen cannula in place and his/her eyes closed. The oxygen regulator showed the oxygen tank was empty.</p> <p>Observation in the television common area on 03/21/24 at 3:10 P.M., showed the following:</p> <p>-The resident sat in wheelchair performing purse lip breathing (technique that allows people to control their oxygenation and ventilation when they experience shortness of breath). The oxygen cannula was in his/her nose;</p> <p>-The oxygen regulator showed the oxygen tank was empty;</p> <p>-Licensed Practical Nurse (LPN) F asked the resident if he/she would go with him/her to get a new oxygen tank;</p> <p>-The nurse pushed the resident to the empty oxygen tank room, took the regulator off the empty tank, put it in the empty tank room, went to a separate room to obtain a new tank, connected the regulator, and set the liter flow to two liters/minute;</p> <p>-The nurse asked the CMT for a pulse oximeter. The CMT took one out of medication card and said it needed batteries, so the nurse had to go to another room to get batteries.</p> <p>During an interview on 3/21/24 at 3:25 P.M., LPN F said the following:</p> <p>-He/She had not checked the resident's oxygen saturation yet, because he/she had just come on shift and didn't have an oximeter;</p> <p>-Once batteries were in the device, the nurse checked the resident oxygen saturation, and it was 93%;</p> <p>-He/She was unaware the resident didn't have an order for oxygen.</p> <p>2. Review of Resident #28's quarterly MDS, dated [DATE], showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Cognition was moderately impaired;</p> <p>-He/She required oxygen therapy.</p> <p>Review of the resident's care plan, last reviewed/revised 3/20/24, showed the following:</p> <p>-He/She used an oxygen concentrator in his/her room and portable oxygen tanks when out of the room;</p> <p>-Administer oxygen and change tubing as ordered on physician order sheets;</p> <p>-Store oxygen tubing in bag when not in use.</p> <p>Review of the resident's February 2024 physician orders showed the following:</p> <p>-Oxygen 2 to 3 liters continuous to keep saturation (oxygen saturation; the amount of oxygen circulating in the blood) above 90 out of 100;</p> <p>-Change oxygen tubing weekly on Tuesday.</p> <p>Review of the resident's Medication Administration Record (MAR), dated February 2024, showed the following:</p> <p>-Change oxygen tubing weekly on Tuesday;</p> <p>-Staff documented changing the tubing on 2/27/24.</p> <p>Review of the resident's MAR, dated March 2024, showed the following:</p> <p>-Change oxygen tubing weekly on Tuesday;</p> <p>-Staff documented changing the tubing on 3/5/24 and 3/12/24.</p> <p>Observation on 3/18/24 at 1:05 P.M. showed the resident lay in bed awake with an oxygen nasal cannula in his/her nose. The oxygen tubing was dated 2/28.</p> <p>During an interview on 3/21/24 at 9:30 A.M., LPN A said the following:</p> <p>-Staff should change oxygen cannulas/tubing either weekly or monthly;</p> <p>-The changing schedule was on the electronic treatment administration section for the nurse to check off it was completed;</p> <p>-Staff could change cannulas/tubing as needed when dirty;</p> <p>-Staff should label the supplies with the date when changed.</p> <p>3. During an interview on 3/21/24 at 7:35 P.M., the Director of Nursing said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oxygen tubing should be labeled and stored in a bag; -Tubing was changed weekly and as needed; -She expected staff to get an order for oxygen. 46506

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on observation, interview, and record review, the facility failed to assess resident's need for bed rail use and obtain informed consent with description of the risks of bed rail use prior to installing and using bed rails for three residents (Residents #25, #58, and #62), in a review of 23 sampled residents. The facility census was 95.</p> <p>Review of the facility's undated policy, Bed Rails, showed the following:</p> <p>-Once the bed rail observation is completed, the facility will print the observation and review associated risks and benefits with the resident and/or resident representative;</p> <p>-After the review is complete, the resident and/or resident representative will sign the consent line and the nurse will sign as well;</p> <p>(The policy did not address the frequency of bed rail assessments.)</p> <p>1. Review of Resident #25's face sheet showed the following:</p> <p>-The resident had a responsible party;</p> <p>-Diagnoses included Alzheimer's disease (type of dementia that affects memory, thinking and behavior), falls, and weakness.</p> <p>Review of the resident's nurse note, dated 8/28/23 at 10:39 A.M., showed the following:</p> <p>-The staff completed an assessment of the resident's U-bar (assist bar/bed rail) use;</p> <p>-The resident's physical condition declined around Coronavirus disease 2019 (COVID-19)(highly contagious viral illness caused by severe acute respiratory syndrome Coronavirus 2) infection resulting in more staff physical assistance with mobility and the resident not using U-bar effectively during transfers/turns in bed;</p> <p>-The staff was supposed to remove the U-bar with a re-evaluation if the resident returned to previous physical health.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility, dated 1/15/24, showed the following:</p> <p>-The resident had moderately impaired cognition;</p> <p>-He/She was independent with rolling right and left in bed;</p> <p>-He/She required maximal assistance with lying to sitting on the side of bed;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Chair/bed-to-chair transfers was not attempted due to medical condition or safety concerns;</p> <p>-He/She had one fall without injury since last quarterly assessment.</p> <p>Review of the resident's care plan, last updated 2/14/24, showed the following:</p> <p>-The resident required assistance with activities of daily living (ADL) and mobility due to pain and weakness;</p> <p>-Assist with one staff with bed mobility and transfers;</p> <p>-Limited use of left side due to pain and weakness related to previous fall;</p> <p>-No documentation the resident used an assist bar or U-bar on the resident's bed.</p> <p>Observation on 3/19/24 at 9:23 A.M., showed the resident lay in bed with U-bars/assist bars on both sides of the bed.</p> <p>Observation on 3/20/24 at 7:00 A.M., showed the resident lay in bed with U-bars/assist bars on both sides of the bed.</p> <p>During an interview on 3/21/24 at 9:30 A.M., Licensed Practical Nurse (LPN) A said the following:</p> <p>-The resident used the U-bars/assist bar on his/her bed;</p> <p>-When staff repositioned/turned the resident in bed, the resident held onto the bar when staff cued him/her.</p> <p>During an interview on 3/21/24 at 10:02 A.M., Nurse Aide (NA) B said the resident used the U-bar to assist staff with moving in bed.</p> <p>Review of the resident's electronic medical record showed there was no documentation to show staff completed a bed rail assessment or obtained consent for use of the U-bars (assist bars/bed rail).</p> <p>2. Review of Resident #62's side rail assessment and consent, dated 8/5/22, showed the following:</p> <p>-Medical symptoms that required the use of side rails included generalized weakness, need for assistance with personal care, ataxic gait (difficulty walking in a straight line, lateral veering, poor balance, a widened base of support, inconsistent arm motion, and lack of repeatability), history of falls, and dementia;</p> <p>-He/She required the use of a U-bar side rail to assist with positioning and transfers.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <p>-Cognition was severely impaired;</p> <p>-He/She was independent with mobility, transfers, and positioning.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's physician's orders, dated March 2024, showed an order for placement of a U-bar to the left side of bed for increased bed mobility/leverage in position changes, and transfers related to chronic pain (start date was 5/5/23).</p> <p>Review of the resident's care plan, last reviewed/revise on 3/20/24, showed the following:</p> <ul style="list-style-type: none"> -He/She had a left sided U-bar placed on his/her bed for aid with transfers and positioning of which he/she continued to use effectively; -Complete assessments quarterly and with any change in condition. <p>Observation on 3/21/24 at 1:00 P.M. showed the presence of a U-Bar assist rail located on the left side of the bed.</p> <p>Review of the resident's electronic medical record showed there was no documentation to show staff completed a bed rail assessment since 8/5/22.</p> <p>3. Review of Resident #58's face sheet showed the following:</p> <ul style="list-style-type: none"> -Diagnoses included cerebral infarction (stroke), contracture, muscle weakness (generalized), reduced mobility and seizures; -The resident's responsible party was a family member. <p>Review of the resident's quarterly MDS dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Moderately impaired cognition; -Dependent on staff for bed mobility, rolling left to right, and transfers. <p>Review of the resident's care plan, last reviewed on 3/20/24, showed the following:</p> <ul style="list-style-type: none"> -He/She had self care deficits with ADLs with impairment of physical abilities; -Adapt environment to maximize resident's safety. <p>Observation on 3/18/24 at 1:40 P.M. showed the the resident lay in bed asleep with U-bar assist rails in the upright position on both sides of his/her bed.</p> <p>Observation on 3/20/24 at 5:00 A.M. showed the resident lay in bed awake with U-bar assist rails in the upright position on both sides of his/her bed.</p> <p>Review of the resident's medical record showed no evidence of a bed rail assessment or consent for use of the U-bar assist rails (bed rails).</p> <p>During an interview on 4/3/24 at 3:23 P.M., the resident's responsible party said the following:</p> <ul style="list-style-type: none"> -The facility did not have him/her sign a consent for the use of U-bar assist rails; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She was aware there were rails on the resident's bed;</p> <p>-He/She did not think the resident even uses the rails because he/she had no movement on the left side.</p> <p>4. During an interviews on 3/21/24 at 7:35 P.M. and on 4/2/24 at 3:32 P.M., the Director of Nursing (DON) said the following:</p> <p>-Management staff was to complete bed rail assessments quarterly;</p> <p>-The MDS Coordinator responsible for obtaining bed rail consents, although nurses could obtain consent as well. This should be completed prior to the placement of bed rails and quarterly.</p> <p>During an interview on 03/21/24 02:00 P.M., the Administrator said the DON and/or management staff was to complete assessments at least quarterly.</p> <p>45563</p> <p>46506</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>32530</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate amount of staff to provide care and protective oversight for residents on the special care unit (SCU). Residents on the unit had impaired cognition, were at risk for falls and behaviors including resident to resident altercations. The facility utilized nurse aides (NAs) on the unit with no certified nurse assistant (CNA) to work with the uncertified NA. The facility census was 95.</p> <p>Review of an electronic notification from the administrator on 3/26/24 at 7:22 A.M. showed she was unable to locate the facility's staffing policy.</p> <p>Observation of the SCU on 3/18/24 at 11:47 A.M. (day shift starts at 6:00 A.M.) showed the following:</p> <ul style="list-style-type: none"> -The census of the SCU was 15; -Two NAs and one activity aide were present on the unit. The unit was staffed with two NAs (NA E and NA L) and one activity aide. <p>Observation of the SCU on 3/19/24 from 7:00 A.M. until 3:00 P.M. showed the following:</p> <ul style="list-style-type: none"> -Two NA's (NA E and NA K) worked the unit; -There was no activity aide on the unit. -Residents were left unattended in the TV room while NA E and NA K provided care to other residents. <p>Observation on 3/19/24 at 1:35 P.M., showed Resident #82 became verbally aggressive, walked up to Resident #51 and yelled at him/her, These are my glasses! Resident #82 become upset and started to walk toward Resident #51. NA E and NA K were down the hall caring for another resident with the door closed. NA E heard the yelling with the door closed, and came down the hall to redirect Resident #82.</p> <p>During an interview on 3/19/24 at 1:40 P.M., NA E said Resident #82 and Resident #51 did not get along and had a history of altercations, staff have to monitor the residents. The residents should not be left unattended. There was usually an activity aide to assist with monitoring, but there was not one on the unit and he/she did not know why.</p> <p>Observation of the SCU on 3/20/24 at 4:50 A.M. (night shift) showed the following:</p> <ul style="list-style-type: none"> -The unit was staffed with one NA (NA D); -Resident #74 sat in the hallway outside of his/her room in his/her wheelchair. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/24 at 4:50 A.M., NA D said the following:</p> <ul style="list-style-type: none"> -This was the first time he/she had worked night shift on the unit; -Resident #74 woke up and rolled out of bed earlier that morning, and the charge nurse instructed him/her to leave the resident up in his/her chair; -Resident #74 required two staff assist with the use of a Hoyer lift. He/She had to ask another staff from another unit to assist with transferring the resident; -He/She could not watch over all the residents when he/she was in another resident's room with the door closed. <p>Observation of the SCU on 3/20/24 at 5:05 A.M. showed NA D asked Licensed Practical Nurse (LPN) F to come to the unit to watch over Resident #74 who was up in his/her wheelchair while he/she went to assist other residents with morning care. LPN F came to the unit.</p> <p>During an interview on 3/20/24 at 5:10 A.M. LPN F said the SCU was staffed with one or two staff on the night shift, but generally just one. There should be more than one staff on the SCU because residents wandered and staff were not able to appropriately monitor the residents. One staff could not see everyone who was up when the door was closed while caring for others.</p> <p>Observation of the SCU on 3/20/24 at 5:15 A.M. showed LPN F exited the unit while NA D was in Resident #82's room with the door closed. NA D came out and asked if the charge nurse left, because the charge nurse was going to stay on the unit and watch over Resident #74 while he/she got other residents up. Resident #74 remained at the end of the hallway in his/her wheelchair.</p> <p>Observation on 3/20/24 at 5:35 A.M. showed Resident #74 leaned over in his/her wheelchair to touch his/her feet and almost fell forward out of his/her chair. NA D was in another resident's room with the door closed. NA D came out of the room and assisted Resident #74 to the TV room, then returned to the room where he/she was previously assisting another resident.</p> <p>Observation on 3/20/24 at 5:45 A.M. showed Resident #74 sat in his/her wheelchair in the TV room with no staff present.</p> <p>Observation of the SCU on 3/20/24 from 6:00 A.M. until 3:00 P.M. showed the unit staffed with two NAs (NA E and NA K). There was no activity staff on the unit during this time frame. There were no activities conducted during this time. Staff left residents unattended to care for other residents.</p> <p>During an interview on 3/20/24 at 7:25 A.M., NA K said he/she normally worked on another hall with a CNA and not with another NA. He/She wasn't sure why they put him/her on the SCU with another NA.</p> <p>During an interview on 3/20/24 at 12:30 P.M., LPN H said there should be a CNA on the SCU working with the NAs. He/She did not realize that both staff working on the SCU were NAs. There was no certified staff on the SCU at this time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/24 at 1:43 P.M. the staffing coordinator said he/she scheduled two CNAs per hall except the 100 hall (this hall was not the SCU), and they had one. The staff on the SCU were responsible for giving the residents their showers. The SCU had two CNA/NAs during the day and evening shifts and one on the night shift because of the staff ratio requirements at night. Normally, the facility had a CNA on the SCU and tried not to staff NAs by themselves, but NA E had been on the SCU a while and was familiar with the residents. She normally did not put two NAs together. He/She felt this was sufficient staff, but care seemed to go smoother when activity staff was scheduled on the SCU to help monitor the residents. When activity staff was not on the SCU, the CNA/NA had to do activities along with care of the residents. There were a couple of residents on the SCU who required two staff to assist and night staff were encouraged to keep the room doors open and the curtains closed when providing care so they could still hear what was going on. She was not sure if staff could get to Resident #34, who was impulsive and frequently fell to prevent him/her from falling if staff was in a room with the curtain closed.</p> <p>During an interview on 3/20/24 at 3:51 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> -The staffing coordinator tried to staff a CNA with an NA and to keep consistent staff on the SCU, but NA E had worked on the unit and was familiar with the residents. The facility had several new NAs that were either ready to take their test to become certified and/or were currently enrolled in CNA classes; -Having only one staff on the SCU at night was normally not a problem after residents were in bed at night; -It would be better to have extra staff on the SCU to monitor residents if both staff were in a resident's room providing care and residents were unattended to prevent accidents/incidents. <p>During an interview on 3/21/24 at 11:50 A.M., the Administrator said ideally NAs should not be working alone and should be scheduled with a CNA . It did not depend on whether the NA had worked for an extended period and was familiar with the residents. Also, it was not ideal to have an NA working alone at night on the SCU. Generally, not much was going on on the SCU at night, but the facility should readjust the times to have staff come in early so residents were not left unattended when staff was assisting residents with morning care. Staff on the SCU have been told to ask the nurse to come the the SCU if needed. LPN F should not have left when an NA asked for him/her to be on the unit.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>32530</p> <p>Based on interview and record review, the facility failed to ensure three nurse aides (NA) completed a certified nurse aide (CNA) training program within four months of their employment. The facility census was 95.</p> <p>Review of an electronic mail communication on 3/22/24 at 7:22 A.M., the Administrator said she could not locate a policy on Nursing Assistant and Certified Nursing Assistant training program.</p> <p>1. Review of the facility provided list of employees hired since last annual survey showed NA E's date of hire was 7/5/21.</p> <p>Review of NA E's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date.</p> <p>Review of the staffing schedule dated March 2024 showed NA E was scheduled to work as an NA on 3/1/24, 3/2/24, 3/3, 3/4/24, 3/5/24, 3/6/24, 3/8/24, 3/11/24, 3/12/24, 3/13/24, 3/15/24, 3/16/24, 3/17/24, 3/17/24, and 3/19/24.</p> <p>During an interview on 3/18/24 at 11:47 A.M., NA E said she had been an NA since June of last year (2023) but had just finished classes. He/She was scheduled to take the knowledge portion of the certification test on 3/29/24 but will still have to schedule the skills test. He/She had not taken the test because he/she did not realize, he/she had to schedule it himself/herself.</p> <p>2. Review of the facility provided list of employees hired since last annual survey showed NA N's date of hire was 1/16/23.</p> <p>Review of NA N's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date.</p> <p>Review of the staffing schedule dated March 2024 showed NA N was scheduled to work as an NA on 3/1/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, 3/11/24, 3/12/24, 3/13/24, 3/14/24, 3/15/24, 3/18/24, 3/19/24, 3/20/24, and 3/21/24.</p> <p>3. Review of the facility provided list of employees hired since last annual survey showed NA O's date of hire was 2/13/23.</p> <p>Review of NA O's employee file showed no documentation he/she completed a CNA training program within four months of his/her hire date</p> <p>Review of the staffing schedule dated March 2024 showed NA O was scheduled to work as an NA on 3/1/24, 3/4/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, 3/11/24, 3/12/24, 3/13/24, 3/14/24, 3/15/24, 3/18/24, 3/19/24, 3/20/24, and 3/21/24.</p> <p>4. During an interview on 3/20/24 at 1:43 P.M., the staffing coordinator said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-NA E was hired on 7/5/21 and was scheduled to test on 3/29/24;</p> <p>-NA N was hired on 1/16/23. NA N failed his/her previous test and was waiting for a retest date;</p> <p>-NA O was hired on 2/13/23. NA N failed his/her previous test and was waiting for a retest date;</p> <p>-These staff should have been moved to another department after four months and until they could pass the test.</p> <p>During an interview on 3/21/24 at 11:50 A.M., the nurse educator/CNA instructor said per regulation NAs should be certified within four months. There had been some delay with testing because of scheduling from the testing site. NA E had not tested because he/she was scared to test, but was scheduled for the knowledge test on 3/29/24. NA O and NA N did not pass and needed to retest. Technically, the NAs should not be working until they pass the CNA test.</p> <p>During an interview on 3/21/24 at 12:00 P.M., the Administrator said NAs should be certified within four months and should not be working after four months if they had not tested and/or passed the certification test.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>32899</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #59), in a review of 23 sampled residents, was free of significant medication errors when staff failed to transcribe a new order to increase the resident's trazodone (a sedative/anti-depressant medication) and administered the incorrect dose for ten days. The facility census was 95.</p> <p>Review of the facility undated policy, Medication Administration Guidelines, showed residents are to receive their medications on a timely basis and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information.</p> <p>1. Review of Resident #59's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 2/26/24, showed the following:</p> <ul style="list-style-type: none"> -Severely impaired cognition; -Feeling down depressed or hopeless two to six days (of the 14 day look back period); -Verbal behaviors one to three days; -Rejection of care one to three days. <p>Review of the resident's Physician Order Sheet (POS), dated March 2024, showed the following:</p> <ul style="list-style-type: none"> -Diagnoses included depression and insomnia (difficulty sleeping); -Trazodone (sedative/anti-depressant) 50 milligrams (mg) by mouth. Special instructions to give one half tablet (original order dated 3/23/22). <p>Review of the resident's progress notes, dated 3/11/24 at 12:57 P.M., showed the nurse practitioner with psych saw the resident. New order to increase trazodone from 25 mg to 50 mg at bedtime for insomnia.</p> <p>Review of the resident's POS, dated March 2024, showed an new order dated 3/11/24 for trazodone 50 mg one tablet at bedtime.</p> <p>Review of the resident's Electronic Medication Administration Record (EMAR) for March 2024 showed the following:</p> <ul style="list-style-type: none"> -Trazodone 50 mg (special instructions: give 1/2 tab to equal 25 mg) at bedtime; -Documentation showed staff administered trazodone 50 mg (1/2 tab) from 3/11/24 to 3/20/24. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(The resident received the incorrect dose for ten days.)</p> <p>Observation on 3/21/24 at 2:30 P.M. of the resident's trazodone bubble pack, store in the medication cart, showed it was filled on 2/20/24 and read trazodone 50 mg, give one half tab by mouth at bedtime. The individual bubble packs were packed with one half tab (25 mg).</p> <p>Observation on 3/21/24 at 2:45 P.M., showed Certified Medication Technician (CMT) CC pulled the card of trazodone 50 mg (1/2 tab) from the medication cart. CMT CC said he/she passed medications in the evening to the resident, and he/she had been administering trazodone 50 mg 1/2 tab.</p> <p>Observation on 3/21/24 at 2:47 P.M., showed Licensed Practical Nurse (LPN) H pulled the trazodone 50 mg (1/2 tab) card from the medication cart and placed a new card of trazodone 50 mg whole tablets in the medication cart for the resident.</p> <p>During an interview on 3/21/24 at 2:48 P.M., LPN H said the following:</p> <ul style="list-style-type: none"> -The new card of trazodone should have been placed in the medication cart and the old card removed when the order was changed (on 3/11/24); -Nurses get the new order, enter it into the computer and send the order to the pharmacy, either by fax or computer; -Medications were delivered nightly between 6:30 P.M. and 8:00 P.M. Either a CMT or nurse receive the medications and place them in the medication room; -The CMT assigned to that cart should go to the medication room and place the new card in the cart and remove the old one; -The night nurse goes through and does chart checks and should have caught that there was a new order. <p>During an interview on 3/21/24 at 4:20 P.M., the resident said he/she still had trouble sleeping and hoped it would get better.</p> <p>During an interview on 3/21/24 at 4:03 P.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> -He/She transcribed the trazodone order received on 3/11/24 (on 3/11/24), but missed removing the special instruction section on the computer which read to give 1/2 tab; -He/She corrected the order today and ensured the new card with the correct dose was in the medication cart. <p>During an interview on 4/9/24 at 11:00 A.M. the Nurse Practitioner said he/she would have expected the new dosage to begin within two days of the new order.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>34536</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents on a pureed diet received food in the proper form in accordance with their physician's orders. The facility census was 95.</p> <p>Review of the facility policy, Types of Diets, dated May 2015, showed the following:</p> <ul style="list-style-type: none"> -Pureed Diet: This diet is for the edentulous resident and residents with swallowing difficulties; -Foods are blended to mashed potato consistency or altered to meet the needs of the resident, using as little liquid as possible. <p>Review of the facility's Order Report by Category from 2/18/24 through 3/18/24, printed by staff on 3/18/24, showed two residents had a physician-ordered pureed diet.</p> <p>Review of the Diet Spreadsheet menu for the lunch meal on 3/18/24 showed staff were to serve residents on a pureed diet the following items:</p> <ul style="list-style-type: none"> -Pureed roasted new potatoes; -Pureed corn O'Brien; -Smooth thick gravy. <p>Observation on 3/18/24 at 10:55 A.M. showed Dietary Cook G began to puree the corn. He/She placed an unmeasured amount of corn into the food processor. He/She obtained an unmeasured amount of hot water from the hot water dispenser on the coffee pot into a plastic pitcher and poured it into the food processor. He/She started the food processor and let it run for several minutes. Dietary Cook G stirred the mixture and restarted the food processor and let it run for another minute. The texture of the mixture was chunky and not smooth. He/She removed the mixture from the food processor and placed it in a steam table pan, covered it with foil and put it in the oven.</p> <p>Observation on 3/18/24 between 11:44 A.M. and 1:27 P.M. during the lunch meal service, showed the Dietary Manager served pureed corn with visible chunks and pureed potatoes with visible red chunks to residents on a pureed diet. The Dietary Manager did not prepare or serve gray with any of the pureed items.</p> <p>Observation on 3/18/24 at 1:31 P.M. of the sample test tray showed the following:</p> <ul style="list-style-type: none"> -The pureed corn had visible chunks of corn and the mixture was chunky and not smooth; -The pureed roasted potatoes had large visible red chunks and the mixture was not smooth; -No gravy was served with any pureed food item. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 3:38 P.M., the Dietary Manager said the following: -A pureed food item should be pudding thick and should be smooth; -Staff should follow the menu and use the diet spreadsheet to ensure all food items are prepared.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34536</p> <p>Based on observation, interview, and record review, the facility failed to ensure scoops were not stored inside bulk containers with food items, failed to ensure food items were sealed when not in use, failed to maintain the exhaust vent over the dish machine to be free of a buildup of debris, failed to ensure two microwaves were easily cleanable and free of a buildup of debris, and failed to ensure the light bulb in the walk-in freezer was shielded. The facility census was 95.</p> <p>1. Review of the facility policy, Receiving and Storage of Food, dated May 2015, showed the following:</p> <ul style="list-style-type: none"> -The dining services manager is responsible for receiving and storing food and nonfood items; -Keep all foods in clean, undamaged wrappers or packages. Reseal open boxes effectively. <p>Observation on 3/18/24 at 10:41 A.M. showed a large clear plastic storage tub with a green lid contained what appeared to be sugar (fine white crystals). The tub was not labeled. A blue measuring cup was stored inside the tub.</p> <p>Observation on 3/18/24 at 10:50 A.M. showed a metal scoop stored inside a bulk container of oats. The lid sat loosely on top of the container and was not secure.</p> <p>Observation on 3/18/24 at 10:53 A.M. showed a metal measuring cup stored inside a large plastic container of breadcrumbs stored over the recipe books.</p> <p>Observation on 3/18/24 at 11:10 A.M. showed an 18-ounce container of ground white pepper and a 28-ounce container of lemon and pepper seasoning salt sat on the shelf with the lids open and unsealed.</p> <p>2. Review of the facility policy, Work Spaces and Storage, dated May 2015, showed the following:</p> <ul style="list-style-type: none"> -Walls, doors, vents and ceiling must be washed thoroughly at least twice a year. Heavily soiled surfaces must be cleaned more frequently; -The type of surface will determine the type of detergent and cleaning method. Ceramic tile, stainless steel, and other surfaces must be cleaned according to the manufacturer's instructions. <p>Observation on 3/18/24 at 2:50 P.M. showed a heavy buildup of dark fuzzy debris inside the metal exhaust vent over the dish machine in the kitchen.</p> <p>3. Review of the facility policy, Stoves, Ovens and Microwaves, dated May 2015, showed the following guidelines for cleaning the microwave:</p> <ul style="list-style-type: none"> -Wash out spills and splatters as they occur, using a detergent solution; -Sanitize with appropriate strength solution. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 3/18/24 at 2:52 P.M. showed a microwave sat on a metal preparation counter in the kitchen. The interior of the microwave, along the bottom and sides, had a buildup of what appeared to be melted, burnt and peeling of the black coating of the microwave door. Areas of brownish rusty debris was visible where the black coating was missing.</p> <p>Observation on 3/19/24 at 9:35 A.M. showed a microwave sat inside a storage room (inside the nurse's station area) on the 400 hall. The interior of the microwave had a heavy buildup of food debris on the door and on the glass plate inside.</p> <p>During an interview on 3/19/24 at 4:54 P.M., Nurse Aide (NA) L said nursing staff or maintenance staff was supposed to clean the microwave on the 400 hall. He/She was unsure how often the unit should be cleaned.</p> <p>4. Observation on 3/19/24 at 12:51 P.M. showed a light bulb, located above the walk-in freezer door on the inside of the unit, was not shielded or protected from breakage.</p> <p>5. During an interview on 3/19/24 at 3:38 P.M., the Dietary Manager said the following:</p> <ul style="list-style-type: none"> -Food scoops should not be stored inside food containers. Scoops should be stored outside the food item in a clean container or in a drawer; -Lids on spices should be sealed after being used; -Maintenance staff was supposed to clean the vent over the dish machine monthly; -The damage to the microwave in the kitchen had been present for the last three years. She was unsure how the damage occurred. The microwave was not easy to clean with the damage to the door. Staff should clean the microwave daily. The microwave needed to be replaced; -Nursing unit aides should clean the microwave on the 400 hall daily. Dietary staff was not responsible for cleaning this particular microwave; -The walk-in freezer light bulb shield had been missing for three years and needed to be replaced. <p>During an interview on 3/20/24 at 10:10 A.M., the Maintenance Supervisor said the following:</p> <ul style="list-style-type: none"> -Maintenance or housekeeping staff should clean the vent above the dish machine monthly; -He was unaware the glass globe that should cover the light bulb in the freezer was missing; -He was unaware of the damage to the microwave in the kitchen. The microwave needed to be replaced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on observation, interview and record review, the facility failed to ensure proper infection control techniques were followed for five residents (Resident #27, #29, #59, #501, #502 and #503) in a sample of 23 residents. The facility failed to follow infection control practices while performing blood glucose monitoring (a procedure where a drop of blood is obtained to test the amount of sugar in the blood) for Resident #27 and #29 when staff failed to appropriately sanitize the glucometer machine (machine that tests a drop of blood for the amount of sugar it contains) after use. Review showed Resident #29 had Hepatitis C (a virus that attacks the liver and leads to inflammation and is spread by contact with contaminated blood). Staff documented performing an accucheck on one resident, Resident #59, with the same glucometer that was not properly disinfected, after using it on Resident #29. The facility identified staff utilized this multi-resident use glucometer for five residents who resided on the 300 hall. Additionally, staff failed to use appropriate infection control procedures for hand hygiene and changing gloves, to prevent the spread of bacteria or other infection causing contaminants, and when indicated by professional standards of practice, during incontinence care for two residents (Resident #12 and #27). The facility census was 95.</p> <p>The administrator was notified on 04/04/24 at 2:55 P.M. of an Immediate Jeopardy (IJ) which began on 03/20/24. The IJ was removed on 4/5/24 as confirmed by surveyor on-site verification.</p> <p>Review of the facility's policy for Standard and Transmission Based Precautions from the Nursing Guidelines Manual dated 2007 showed the following:</p> <ul style="list-style-type: none"> -Standard precautions would be used in the care of all residents regardless of their diagnoses or suspected and/or confirmed infection status. Standard precautions presume all blood, body fluids, secretions, and excretions, non-intact skin, and mucous membranes that may contain transmissible infectious agents; -Hand hygiene referred to handwashing with soap or using alcohol-based hand rubs that do not require access to water; -Hands should be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom; -In the absence of visible soiling of hands, alcohol-based hand rubs were preferred for hand hygiene; -Wash hands after removal of gloves; -Wear gloves when you anticipate direct contact with blood, body fluids, mucous membranes non-intact skin, and other potentially infected materials; -Wear gloves when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-Change gloves as necessary during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one);</p> <p>-Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments.</p> <p>Review of the facility's undated policy, Blood Glucometer Disinfecting, showed the following:</p> <p>-Purpose: to prevent the spread of infection;</p> <p>-Equipment: approved wipes with 10% bleach or comparable product;</p> <p>-Wash hands and put on gloves;</p> <p>-Provide a clean field in which to place the glucose meter (a paper towel worked well);</p> <p>-Clean the blood glucose meter prior to using with approved wipes with 10% bleach or comparable product, place on clean field and let air dry according to the manufacturer's directions. Do not touch the clean field with gloves including the test port. Glucometer may be wrapped in another wipe and stored;</p> <p>-Remove gloves and wash hands.</p> <p>Review of the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS) recommendations, dated August 2010, showed the following:</p> <p>-Blood contamination is often evident on glucometers even if one cannot see it;</p> <p>-Facilities must use an EPA-registered disinfectant to clean glucometers;</p> <p>-Rubbing alcohol is not an effective disinfectant against Hepatitis B and should not be used;</p> <p>-It is important to use a glucose monitoring device designed for institutional use that can be disinfected frequently;</p> <p>-The manufacturer's instructions should say which cleaning solution a device can withstand;</p> <p>-If the manufacturer's instructions do not specify steps for cleaning and disinfecting between uses of glucose monitoring devices, the devices generally should not be shared among residents according to CMS;</p> <p>-Environmental surfaces such as glucometers should be decontaminated regularly and anytime contamination with blood or body fluids occurs or is suspected;</p> <p>-Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the Evencare G3 blood glucose monitoring guidelines from medline.com showed the following:</p> <p>-Cleaning and Disinfecting Procedures:</p> <p>-The meter should be cleaned and disinfected between each patient;</p> <p>-The following products have been approved for cleaning and disinfecting the meter: Dispatch(R) Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8), Medline Micro-Kill+ (Trademark) Disinfecting, Deodorizing, Cleaning Wipes with Alcohol (EPA Registration Number: 59894-10), Clorox Healthcare(R) Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12), Medline Micro-Kill (Trademark) Bleach Germicidal Bleach Wipes (EPA Registration Number: 37549-1);</p> <p>-Steps to cleaning/disinfecting a meter:</p> <p>-Step 1. Wash hands with soap and water;</p> <p>-Step 2. Put on single-use medical protective gloves;</p> <p>-Step 3. Inspect for blood, debris, dust, or lint anywhere on the meter. Blood and bodily fluids must be thoroughly cleaned from the surface of the meter;</p> <p>-Step 4. To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter including both the front and back surfaces until visibly clean. Avoid wetting the meter test strip port;</p> <p>-Step 5. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use;</p> <p>-Caring for the meter:</p> <p>-Wipe all external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test strip port. Wipe meter dry, or allow to air dry;</p> <p>-Step 6. Remove gloves.</p> <p>Review of the EvenCare G3 (glucometer) manufacturer guidelines from medline.com, testing a resident's glucose, showed the following:</p> <p>-Users need to adhere to standard precautions when handling or using this device;</p> <p>-All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals.</p> <p>Review of a resident list, provided by the facility, showing which residents used the multi-resident use glucometer for the 300 hall, showed the list included Resident #29, #59, #501, #502, and #503.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Review of Resident #29's face sheet showed the following:</p> <p>-He/She resided on the 300 hall;</p> <p>-His/her diagnoses included Type 2 diabetes mellitus with hyperglycemia (elevated blood sugar (the amount of sugar in the blood)), and chronic viral Hepatitis C.</p> <p>Review of the resident's physician orders, dated March 2024, showed an order for accuchecks (finger stick procedure where a droplet of blood is obtained for sampling to determine the amount of sugar in the blood) two times a day and as needed (PRN).</p> <p>Observation on 3/20/24 at 7:03 A.M. showed the following:</p> <p>-Licensed Practical Nurse (LPN) H removed a universal (multi-resident shared) blood glucose monitoring machine from the locked 300 hall medication/treatment cart and cleaned it with an alcohol wipe;</p> <p>-LPN H washed his/her hands and applied gloves;</p> <p>-LPH N placed a glucose test strip into the glucometer;</p> <p>-LPN H cleaned the resident's finger with an alcohol wipe and used a lancet to stick the resident's finger to obtain a blood droplet;</p> <p>-LPN H wiped the first drop of blood from the resident's finger and then obtained another drop of blood from the resident's finger and drew it up into the glucometer test strip to check the resident's blood sugar;</p> <p>-LPN H removed his/her gloves and washed his/her hands;</p> <p>-With his/her bare hands, LPN H cleaned the glucometer with an alcohol wipe and laid the glucometer on a tissue on top of the medication/treatment cart to dry.</p> <p>-LPN H did not disinfect the multi-resident shared blood glucose monitor with the proper disinfectant wipes.</p> <p>During an interview on 3/20/24 at 7:03 A.M. and 7:30 A.M. and 4/4/24 at 2:30 P.M., LPN H said the following:</p> <p>-He/She was taught to clean the multi-resident use glucometers with alcohol wipes;</p> <p>-He/She used this glucometer on all residents requiring blood glucose checks assigned to that cart (300 hall);</p> <p>-The way he/she cleaned the glucometer was how the facility instructed him/her to do so;</p> <p>-He/She was taught years ago to clean with alcohol wipes and that's the way he/she has always done it;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-He/She could have found bleach wipes to use and didn't;</p> <p>-The bleach wipes were available for use;</p> <p>-He/She was aware Resident #29 had Hepatitis C.</p> <p>2. Review of Resident #59's face sheet showed the following:</p> <p>-He/She resided on the 300 hall;</p> <p>-His/Her diagnoses included diabetes mellitus.</p> <p>Review of the resident's physician orders, dated March 2024, showed an order for accuchecks three times daily with meals.</p> <p>Review of the resident's electronic medical record, specifically vital sign results, showed LPN H documented he/she obtained the resident's accucheck on 3/20/24 at 7:30 A.M.</p> <p>3. Review of Resident #501's face sheet showed the following:</p> <p>-He/She resided on the 300 hall;</p> <p>-His/Her diagnoses included diabetes mellitus.</p> <p>Review of the resident's physician orders, dated March 2024, showed an order for accuchecks twice daily, before breakfast and at bedtime.</p> <p>4. Review of Resident #502's face sheet showed the following:</p> <p>-He/She resided on the 300 hall;</p> <p>-His/Her diagnoses included diabetes mellitus.</p> <p>Review of the resident's physician orders, dated March 2024, showed an order for daily accuchecks.</p> <p>5. Review of Resident #503's face sheet showed the following:</p> <p>-He/She resided on the 300 hall;</p> <p>-His/Her diagnoses included diabetes mellitus.</p> <p>Review of the resident's physician orders, dated March 2024, showed an order for accuchecks twice daily with meals.</p> <p>6. Review of Resident #27's undated continuity of care document (CCD) showed his/her diagnoses included diabetes (elevated blood sugars), dementia, and urinary tract infections (UTI). He/She resided on the 400 hall.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 2/20/24, showed the following:</p> <ul style="list-style-type: none"> -Cognition was severely impaired; -He/She was always incontinent of bowel and bladder; -He/She was dependent on staff for toileting hygiene. <p>Review of the resident's physician's orders, dated March 2024, showed an order for accuchecks three times a day.</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the following:</p> <ul style="list-style-type: none"> -He/She required assistance with toileting and personal hygiene; -Provide incontinence care after each incontinent episode. <p>Observation on 3/20/24 at 6:30 A.M. showed the Nurse Aide (NA) A and NA E entered the resident's room to assist the resident with morning cares. Without performing hand hygiene, NA D and NA E put on gloves and walked over to the resident. The resident was incontinent of bladder. NA D cleaned the resident's perineal area, assisted the resident onto his/her left side and NA E cleaned the resident's buttocks. Without changing gloves and performing hand hygiene after providing incontinence care, NA E placed a clean bed pan under the resident, rolled the resident to his/her right side and NA D removed the soiled linens from under the resident, pulled the clean bed pad under the resident, removed the resident's soiled gown, obtained a clean shirt from the resident's closet, and placed it on the resident. Without removing his/her gloves and performing hand hygiene after providing incontinence care, NA E opened the door and exited the room to discard the soiled linens to the dirty utility room. NA E returned to the resident's room with a new package of incontinence briefs. NA E did not wear gloves when he/she returned to the room.</p> <p>During an interview on 3/20/24 at 7:10 A.M., NA E said he/she was to wash and/or sanitize his/her hands between gloves changes, when entering a room, before exiting a room, and anytime gloves became contaminated. He/She should not touch anything clean with contaminated gloves and/or hands.</p> <p>Observation on 3/20/24 at 7:30 A.M. showed LPN H removed the glucometer from the treatment cart, cleaned it with an alcohol wipe, obtained the blood sample from the resident and then placed it on the strip in the glucometer, returned to the treatment cart, placed hand sanitizer on a tissue and wiped the glucometer with the tissue, removed his/her gloves, sanitized his/her hands, and finished cleaning the glucometer with an alcohol wipe.</p> <p>7. Review of Resident #12's MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Dependent for personal hygiene; -Always incontinent of bladder and bowel. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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)
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the resident's progress notes, dated 3/14/24 at 3:38 P.M., showed the resident had a new order to insert a 16 French/10 cubic centimeter (cc) urinary catheter due to wound on the coccyx (tailbone).</p> <p>Review of the resident's care plan, last revised 3/20/24 showed the following:</p> <ul style="list-style-type: none"> -Poor mobility and incontinence; -Provide incontinence care after each incontinent episode. <p>Observation on 3/20/24 at 8:30 A.M. showed the following:</p> <ul style="list-style-type: none"> -The resident lay on his/her back in the bed; -Certified Nurse Assistant (CNA) W entered the room, donned gloves, emptied the resident's urinary drainage bag into a urinal and emptied it into the toilet; -Without removing his/her gloves, CNA W pulled the bed linens down from the resident and assisted the resident to turn onto his/her right side, touching the linens and the resident's hip with contaminated gloves; -Using a wet washcloth, he/she removed formed feces from between the resident's buttocks, threw this in the trash can nearby, and used a clean cloth to clean the resident's buttocks. He/She removed his/her gloves, and without performing hand hygiene, put on new gloves; -He/She tucked the soiled pad under the resident, placed a clean, cloth pad under the soiled pad and rolled the resident onto his/her left side; -He/She pulled the soiled linens out from under the resident, placed them in a plastic bag on the bed and pulled the clean linens through and beneath the resident; -Without removing his/her gloves, CNA W used a wet, clean cloth and wiped the large urinary catheter drainage tubing and then used the same area of the cloth to wipe the resident's groin area. With the same cloth, he/she wiped from the urinary catheter insertion site outward three times with the same area of the cloth. <p>8. During an interview on 3/21/24 at 7:35 A.M., 4/4/24 at 11:27 A.M., the Director of Nurses (DON) said the following:</p> <ul style="list-style-type: none"> -Staff were to clean the glucometer with bleach wipes because they were a better disinfectant. Alcohol wipes were not good enough; -She would expect staff to clean the glucose monitor after each use with bleach wipes; -She was unaware of any resident having Hepatitis C or any bloodborne virus that received routine accuchecks; -The facility has one glucose monitor for each hall, so one at each nurse's station/cart; <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-There are approximately five to ten residents that received accuchecks on each hall;</p> <p>-Staff identify that a resident has a bloodborne virus by it being listed on their diagnoses list with ICD-10 codes;</p> <p>-She would expect the following measures to be in place if a resident has a bloodborne virus and is receiving accuchecks: gloves/proper PPE, handwashing and ideally, they would have their own glucose monitor;</p> <p>-Staff were to wash their hands and change their gloves when they become contaminated;</p> <p>-Staff were to wash hands when entering a resident's room, exiting a resident's room, and in between dirty to clean surfaces. Staff should not touch clean surfaces with contaminated gloves and/or hands;</p> <p>-Staff were to remove soiled gloves and wash hands after emptying a urinary drainage bag and before beginning perineal/catheter care.</p> <p>During an interview on 4/4/24 at 11:37 A.M., the Administrator said the following:</p> <p>-There were five glucose monitors in the building;</p> <p>-There are five residents on the 300 hall that receive accuchecks from the same multi-resident use glucose monitor (Residents #29, #59, #501, #502, and #503);</p> <p>-She expected the DON and nurse managers to do walking rounds to ensure staff are cleaning the glucose monitors properly;</p> <p>-The infection preventionist can pull a report with those residents having a diagnosis of any bloodborne virus;</p> <p>-She would expect staff to manage a resident with Hepatitis C and accuchecks with proper PPE including gloves and to clean the blood glucose monitor properly with bleach wipes and according to manufacturer's guidelines;</p> <p>-She was not aware the resident had Hepatitis C and received routine accuchecks.</p> <p>NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level K. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the E level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).</p> <p>32899</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530</p> <p>Based on observation, interview, and record review, the facility failed to complete inspections of bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for three residents (Resident #25, #58, and #62), in a review of 23 sampled residents who used bed rails/assist bars. The facility census was 95.</p> <p>Review of the facility's undated Bed Rails policy, showed the following:</p> <p>-Overview of FDA potential zones of entrapment with FDA dimension recommendations;</p> <p>1. Zone 1: Within the rail;</p> <p>a. Any open space between the perimeters of the rail can present a risk of head entrapment;</p> <p>b. FDA recommended space: less than 4 3/4 inches;</p> <p>2. Zone 2: Under the rail, between the rail supports or next to a single rail support</p> <p>a. The gap under the rail between the mattress, may allow for dangerous head entrapment;</p> <p>b. FDA recommended space: less than 4 3/4 inches;</p> <p>3. Zone 3: Between the rail and the mattress;</p> <p>a. This area is the space between the inside surface of the bed rail and the mattress and if too big it can cause a risk of head entrapment;</p> <p>b. FDA recommended space: less than 4 3/4 inches;</p> <p>4. Zone 4: Under the rail at the ends of the rail</p> <p>a. A gap between the mattress and the lowermost portion of the rail poses a risk of neck entrapment;</p> <p>b. FDA recommended space is less than 2 3/8 inches;</p> <p>5. Zones 5-7: The FDA has not provided dimension recommendations for Zones 5-7. These zones should be assessed for entrapment risk. The facility should refer to manufacturer guidelines for the bed rails, mattresses, and beds;</p> <p>6. Zone 5: Between split bed rails;</p> <p>a. When partial length head and split rails are used on the same side of the bed, the space between the rails may present a risk of either neck or chest entrapment;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Zone 6: Between the end of the rail and side edge of the head or foot board;</p> <p>a. A gap between the end of the bed rail and the side edge of the headboard or footboard can present the risk of resident entrapment;</p> <p>8. Zone 7: Between the head or foot board and the end of the mattress;</p> <p>a. When there is too large of a space between the inside surface of the headboard or footboard and the end of the mattress, the risk of head entrapment increases;</p> <p>-Staff will conduct regular inspections of all bedframes, mattresses, and bed rails, to identify areas of possible entrapment.</p> <p>1. Review of Resident #25's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility, dated 1/15/24, showed the following:</p> <p>-The resident had moderately impaired cognition;</p> <p>-He/She was independent with rolling right and left in bed;</p> <p>-He/She required maximal assistance with lying to sitting on the side of bed.</p> <p>Review of the resident's care plan, last updated 2/14/24, showed the following:</p> <p>-Assist with one staff member with bed mobility and transfers;</p> <p>-Limited use of left side due to pain and weakness related to previous fall.</p> <p>Observation on 3/19/24 at 9:23 A.M., showed the resident lay in bed with assist bars on both sides of the bed.</p> <p>Observation on 3/20/24 at 7:00 A.M., showed the resident lay in bed with assist bars on both sides of the bed.</p> <p>Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress, or assist bars to identify areas of possible entrapment.</p> <p>2. Review of Resident #62's side rail assessment and consent, dated 8/5/22, showed the following:</p> <p>-Medical symptoms that required the use of side rails included generalized weakness, need for assistance with personal care, ataxic gait (difficulty walking in a straight line, lateral veering, poor balance, a widened base of support, inconsistent arm motion, and lack of repeatability), history of falls, and dementia;</p> <p>-He/She required the use of a U-bar side rail to assist with positioning and transfers;</p> <p>-Entrapment zones were measured with this assessment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	
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)		
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Cognition was severely impaired; -He/She was independent with mobility, transfers, and positioning. <p>Review of the resident's physician's orders, dated March 2024, showed an order for placement of a U-bar to left side of bed for increased bed mobility/leverage in position changes, and transfers related to chronic pain (start date was 5/5/23).</p> <p>Review of the resident's care plan, last reviewed/ revised on 3/20/24, showed the following:</p> <ul style="list-style-type: none"> -He/She had a left sided U-bar placed on his/her bed for aid with transfers and positioning of which he/she continued to use effectively; -Complete assessments quarterly and with any change in condition. <p>Observation on 3/21/24 at 1:00 P.M. showed a U-bar assist rail was attached to the left side of the resident's bed.</p> <p>Review of the resident's electronic medical record showed no documentation bed rail assessments, including entrapment zone measurements, had been completed since 8/5/22.</p> <p>3. Review of Resident #58's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Moderately impaired cognition; -Dependent on staff for bed mobility, rolling left to right, and transfers. <p>Review of the resident's care plan, last reviewed on 3/20/24, showed the following:</p> <ul style="list-style-type: none"> -He/She had self care deficits with activities of daily living with impairment of physical abilities; -Adapt environment to maximize resident's safety. <p>Observations on 3/18/24 at 1:40 P.M. and on 3/20/24 at 5:00 A.M., showed the resident lay in bed with assist rails in the upright position on both sides of his/her bed.</p> <p>Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress, or assist bars to identify areas of possible entrapment.</p> <p>4. During an interview on 03/21/24 at 2:00 P.M., the Administrator said the Director of Nursing and/or the management team were to complete the bed rail assessments, including entrapment zone measurements, at least quarterly.</p> <p>32899</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Troy Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Thompson Drive Troy, MO 63379	

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45563 46506