STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265705	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Community Care and Rehabilitation	200 West 12th Street Lockwood, MO 65682

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for all residents that included measurable objectives and timeframes to meet a resident's medical and nursing needs as identified in the comprehensive assessment when staff did not care plan one resident's (Resident #11) use of an anticoagulant medication and did not care plan one resident's (Resident #46) oxygen usage. A sample of 19 residents was reviewed in a facility with a census of 62. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised December 2016, showed the comprehensive person-centered care plan will incorporate identified problem areas; incorporate risk factors associated with identified problems; and reflect currently recognized standards of practice for problem areas and conditions. 1. Review of the facility policy titled, Anticoagulant-Clinical Protocol, revised September 2012, showed the following: -The staff will identify and address potential complications in individuals receiving anticoagulation; -The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems; -If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in the urine), hemoptysis (blood in the sputum), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. Review of Resident #11 's face sheet showed: -admitted [DATE]; -Diagnoses included dementia, heart failure, chronic kidney disease, and low back pain. Review of the resident's March 2023 Physician Order Sheet (POS) showed the following: (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A current order for Eliquis (blood thinner/anticoagulant) 2.50 milligrams (mg), staff to administer one tablet by mouth two times daily for a diagnosis of atrial fibrillation (an abnormal heart rhythm). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 02/21/24, showed resident taking anticoagulants. Review of the resident's current care plan showed staff did not care plan related to the resident's use of an anticoagulant medications. During an interview on 03/28/24, at 10:12 A.M., Certified Nurse Assistant (CNA) R said the following: -He/she does restorative therapy with the residents; -The CNA was not aware which residents were taking blood thinners, unless the resident told the CNA about the blood thinner; -The CNA said it was important to know who was on blood thinners, so that he/she could watch for any signs of bruising or bleeding and notify the nurse. During an interview on 03/28/24, at 10:26 A.M., CNA S said the following: -The CNA currently worked as the shower aide; -The CNA did not know which residents were taking blood thinners; -The CNA should know which residents were on blood thinners, in case they sustained a cut or skin tear; -The CNA said the nurse would have to tell him/her which residents were on blood thinner or he/she could look in the resident care plans. During an interview on 03/28/24, at 10:48 A.M., Registered Nurse (RN) M said the following: -He/she was unsure if the aides were informed of which residents were on blood thinners, but they could ask the nurse; -In a way, it would be important for staff to know in case the resident started bleeding, but anytime a resident started bleeding the aide should tell the nurse anyway. During an interview on 04/01/24, at 3:27 P.M., RN T said staff could look at the care plan to find out if a resident took blood thinners. During an interview on 03/29/24, at 9:39 A.M., RN L said the following: -He/she worked as the MDS and Care Plan Coordinator for the entire facility since August 2022; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident was on an anticoagulant, that information should be on the resident's care plan; -He/she recently became aware that he/she had missed some of the care plans. During an interview on 03/28/24, at 2:38 P.M., the Director of Nursing (DON) said the following: -Resident care plans should include information about blood thinners and precautions; -The nurse aides should know which residents are on blood thinners so they can watch for potential for more injury or bruising/bleeding. During an interview on 04/01/24, at 12:11 P.M., the Administrator said nursing should include a resident's use of anticoagulants on the care plan. 49585 2. Review of the Resident #46's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included congestive heart failure (a long-term condition in which the heart can't pump blood well enough to meet the body's needs), dependence on supplemental oxygen, dyspnea (difficult or labored breathing), and severe persistent asthma. Review of the resident's physician order, dated 12/26/23, showed an order for oxygen at two to three liters/minute/nasal cannula (NC). Review of the resident's admission MDS, dated [DATE], showed the resident had continuous oxygen therapy. Review of the resident's care plan, revised on 01/15/24, showed resident had oxygen tubing that he/she does not keep off the floor. (Staff did not address when and how much oxygen was used or what to monitor related to the use of oxygen.) Observation on 03/26/24, at 11:07 A.M., showed the resident in his/her room sitting in wheelchair with oxygen in place via nasal cannula putting a puzzle together. Observation on 03/27/24, at 1:27 P.M., showed resident in room with oxygen in place via nasal cannula. Observation on 03/28/24, at 3:02 P.M., showed resident sitting in recliner in room with oxygen in place via nasal cannula. During an interview on 03/29/24, at 10:49 A.M., RN O said he/she communicates with aides about resident changes. The MDS Coordinator completes care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/29/24, at 11:01 A.M., Nurse Assistant (NA) F said he/she uses the care plan or will ask the nurse to find resident information on resident oxygen use. During an interview on 03/29/24, at 12:19 P.M., CNA P said the care plan gives information regarding resident care. Nurse assistants also give report to each other at shift changes. During an interview on 04/01/24, at 3:27 P.M., RN T said staff could look at the care plan to determine if a resident required oxygen therapy. During an interview on 03/29/24, at 1:20 P.M., the MDS Coordinator said oxygen use should be updated in the care plan. No specific information regarding oxygen use was included in the resident's care plan. During an interview on 04/01/24, at 12:11 P.M., the Administrator said nursing should include a resident's use of oxygen on the care plan. 3. During an interview on 04/01/24, at 3:27 P.M., RN T said any nurse can update a resident care plan with changes, but typically RN L (the Care Plan Coordinator) updated the resident care plans with changes/new interventions. 4. During an interview on 03/29/24, at 1:20 P.M., the MDS Coordinator said the following: -Care plan information is obtained using information found in chart, MDS, staff interviews and observations; -Nurses leave a note in his/her box for resident changes or declines; -Care plan is updated quarterly or for any changes; -All updates should occur when change happens or as soon as possible. 5. During an interview on 04/01/24, at 12:11 P.M. the Administrator said the nurses or the Care Plan Coordinator should update the care plan with changes in the resident's status. 36974

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on interview, and record review, the facility failed to ensure the revision of comprehensive care plans to include measurable objectives and timeframes to meet the medical and nursing needs for two residents (Resident #11, and Resident #313) who sustained falls with injuries, for one resident (Resident #10) who declined requiring the use of a wheelchair, and for one resident (Resident #14) who required significant additional nutritional assistance out of 19 sampled residents. The facility census was 62. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised December 2016, showed the following: -The comprehensive person-centered care plan will incorporate identified problem areas; incorporate risk factors associated with identified problems; and reflect currently recognized standards of practice for problem areas and conditions; -Assessment of residents is ongoing and care plans are revised as resident information or condition changes; -The Interdisciplinary Team (IDT) must update the care plan when there is a significant change, the desired outcome is not met, after a hospital stay, and quarterly. 1. Review of the facility policy titled, Falls and Fall Risk, Managing, revised December 2007, showed the following: -Based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; -The staff will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions; -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicated why the current approach remains relevant; -If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until calling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable; -Falls committee will review all falls to identify and implement relevant interventions to try to minimize serious consequences of falling. 2. Review of Resident #11 's face sheet showed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted [DATE]; -Diagnoses of dementia, heart failure, chronic kidney disease, and low back pain. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 02/21/24, showed the following: -Severe cognitive impairment; -Functional limitation in range of motion to both lower extremities; -Dependent on staff (staff does all effort) wheelchair mobility, transfers, toileting, and personal hygiene; -One (non-injury) fall since admission. Review of the resident's care plan, updated 02/27/24, showed the following: -Resident will require assistance for activities of daily living (ADL) completion related to weakness and diagnosis of dementia and history of fracture of lower extremity; -Resident is alert and able to communicate her needs. He/she is non-weight bearing on lower extremity. And uses a Hoyer (mechanical lift) for transfers. He/she requires assistance for toileting, transfers, feeding, dressing, grooming, and ambulation. His/her ability to assist will decrease throughout the day as he/she fatigues; -Keep area free of clutter/obstacles; -Resident will require one to two assist for bed mobility, toileting, and hygiene needs; -Resident is a risk for falls related to weakness, impulsivity due to dementia, history of falling, and history of leg fracture that did not heal properly; -Resident uses a Hoyer lift for transfers and resident is dependent for ambulation. Review of the resident's fall risk evaluation, dated 02/28/24, completed by facility staff, showed staff assessed the resident as a fall risk. Review of the facility's fall scene investigation report, dated 03/10/24, showed the following: -At 8:10 A.M., the resident slipped out of the wheelchair in the activity room; -A drawn picture showed a wheelchair and a ramp with a stick figure lying at the end of the ramp; -Aide started coming up the ramp after breakfast; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Re-creation of events before fall: The resident was gotten up and taken down for breakfast. After breakfast geri-chair (a reclining wheelchair with a foot rest that can be elevated by staff), not in reclined mode, was pushed by staff. When staff started to go up ramp, they push the chair forward and the resident fell out; -What appears to be the initial root cause of the fall: Not understanding how geri-chairs work and need to be reclined to push resident around; -Describe initial interventions to prevent future falls: More education to staff on geri-chair and why need to be reclined to push up ramp; -Falls team meeting notes conclusion: Resident leaned forward and fell out chair was at normal height for feeding; -Additional care plan/nurse aide assignment updates: Fall education provided to all nursing staff. Review of the resident's nurse's note, dated 03/11/24, showed at 5:15 A.M., the resident returned from the hospital emergency room in an ambulance with a knee immobilizer in place. Social services to contact an orthopedic surgeon for a follow up appointment due to fracture. Review of the resident's care plan showed staff did not update the care plan with the most recent fall, the fracture, or new interventions following the resident's fall/fracture on 03/10/24. During an interview on 03/29/24, at 9:39 A.M., Registered Nurse (RN) L said the following: -He/she worked as the MDS and Care Plan Coordinator for the entire facility since August 2022; -If the resident had a fall, the care plan should be updated to reflect the new fall intervention; -He/she recently became aware that he/she had missed some of the care plans; -The resident should have had a fall care plan update after his/her fall on 03/10/24 with new intervention. 49585 2. Review of Resident #313's face sheet showed the following: -admitted [DATE]; -Diagnoses included inflammatory polyarthropathy (arthritis affecting multiple joints), muscle weakness, and repeated falls. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Impairment in range of motion to upper and lower extremities; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Partial to moderate assistance with bed mobility, walking, and transfers; -Uses walker for mobility. Review of the resident's care plan, dated 01/15/24, showed the following: -Resident required assistance of one staff for transfers, ambulation, toileting, dressing, and hygiene; -Alert with confusion at times; -At risk for falls related to weakness and a history of falling; -Resident had a fall on 01/27/24, 03/20/24, and 03/26/24. (Staff did not care plan implementation new interventions after the resident's falls on 01/27/24, 03/20/24, or 03/26/24.) 3. Review of Resident #10's face showed the following: -admitted [DATE]; -Diagnoses included dementia (impaired ability to remember, think, or make decisions), repeated falls, muscle weakness, abnormalities of gait and mobility, and osteoarthritis. Review of the resident's Physical Therapy Discharge Summary, dated 08/10/23, showed resident upon discharge was substantial to maximal assistance for transfers. Resident can stand without gait tolerance and required partial to moderate assistance with wheelchair mobility. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Impairment in range of motion to lower extremities; -Requires substantial to maximal assistance with transfers; -Dependent for wheelchair for mobility. Review of the resident's care plan, dated 01/31/24, showed the following: -Requires assistance of one staff for activities of daily living (ADL); -Uses a roller walker; -Requires supervision for transfers and ambulation; -Alert with confusion at times; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Risk for falls related to weakness. (Staff did not update the care plan to show the resident's need to use a wheelchair.) During an interview on 03/29/24, at 9:57 A.M., RN O said the resident used a wheelchair for ambulation. During an interview on 03/29/24, at 11:01 A.M., Nurse Assistant (NA) F said he/she used the care plan or will ask the nurse to find resident information. During an interview on 03/29/24, at 12:19 P.M., Certified Nurse Assistant (CNA) P said the following: -The care plan gives information regarding resident care; -Nurse assistants also give report to each other at shift changes. During an interview on 03/29/24, at 1:20 P.M., RN L (Care Plan Coordinator) said the following: -Care plan information is obtained using information found in chart, MDS, staff interviews and observations; -Nurses leave a note in his/her box for resident changes or declines; -Care plan is updated quarterly or for any changes; -Fall interventions should be updated after a resident fall; -Changes in mobility or a change in mobility device should be updated in care plan; -All updates should occur when change happens or as soon as possible; 36974 4. Review of Resident #14's face sheet showed the following: -admitted [DATE]; -Diagnoses included Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), history of stroke, right-side paralysis following a stroke, and heart failure. Record review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -He/she resident had severe impairment on one side of his/her body; -He/she required oversight or instruction while eating; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she required some staff assistance to sit up in bed from a lying position; -He/she had complaints of difficulty swallowing. Review of the resident's March 2024 physician's orders showed the following: -An order, dated 01/31/24, to offer the resident a protein shake twice a day; -An order, dated 02/01/24, to weigh the resident once a week; -An order, dated 02/16/24, for staff to measure fluid intake once a week and for staff assist resident to sit up in bed or chair due to concerns of aspiration pneumonia (when food or liquid is breathed into the airways or lungs, instead of being swallowed). Review of the resident's current care plan, last updated 01/24/24, showed the following: -The resident has a pureed diet with thickened liquids; -Resident had difficulty swallowing following a stroke; -Resident able to communicate preferences most of the time; -Resident required assistance with feeding; (Staff did not address the nutritional needs of giving the resident a nutritional shake, to weigh the resident once a week, to measure fluid intake once a week, or for staff to assist resident to sit up in bed or chair due to concerns or aspiration pneumonia on the care plan.) 5. During an interview on 04/01/24, at 3:10 P.M., CNA AA said he/she would look at care plans for information on resident care . The care plans are available at nurses' stations and are updated on regular basis. If staff have are concerns for care plans, he/she would go to nurse. 6. During an interview on 03/29/24, at 11:01 A.M., NA F said he/she used the care plan or will ask the nurse to find resident information. 7. During an interview on 03/29/24, at 12:19 P.M., CNA P said the following: -The care plan gives information regarding resident care; -Nurse assistants also give report to each other at shift changes. 8. During an interview on 04/01/24, at 3:27 P.M., RN T said the following: -Any nurse can update a resident care plan with changes, but typically RN L (Care Plan Coordinator) updated the residents' care plans with changes/new interventions; -After a resident fell , staff try a new intervention and that interventions should end up on the care plan; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurse aides could look in the resident's care plan or ask a nurse to find out how much staff assistance a resident required for transfers, if the resident required a wheelchair for mobility, or if the resident had specific fall interventions. 9. During an interview on 03/29/24, at 1:20 P.M., RN L (the Care Plan Coordinator) said the following: -Care plan information is obtained using information found in chart, MDS, staff interviews and observations; -Nurses leave a note in his/her box for resident changes or declines; -Care plan is updated quarterly or for any changes; -Fall interventions should be updated after a resident fall; -Changes in mobility or a change in mobility device should be updated in care plan; -All updates should occur when change happens or as soon as possible. 10. During an interview on 04/01/24, at 12:11 P.M., the Administrator said the following: -The nurses or the Care Plan Coordinator should update the care plan with changes in the resident's status: -Nursing should update the resident's care plan after each fall with a new interventions and date the intervention; -If a resident previously used a walker, but later required a wheelchair for mobility, nursing should ensure the care plan was up to date with that information.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on interview and record review, the facility failed to ensure a system in place that clearly and consistently represented each resident's choice of code status (if they wished to receive cardiopulmonary resuscitation (CPR - lifesaving technique that's useful in many emergencies in which someone's breathing or heartbeat has stopped) if their heart and/or breathing stopped) when staff failed to have the physician sign one resident's (Resident #46) Outside the Hospital Do Not Resuscitate Form (DNR - do not attempt CPR) and when staff failed to ensure one resident's (Resident #20) code status was consistent throughout the medical record. The facility census was 62. Review of the facility's policy titled, Advanced Directive, revised [DATE], showed the following: -The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive; -The interdisciplinary team will review annually with the resident his or her advanced directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument; -Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment and care plan; -The Director of Nursing (DON) or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. 1. Review of the Resident #46's face sheet (a document that gives a resident's information at a quick glance) showed the following: -An admitted [DATE]; -Diagnoses included congestive heart failure (a long-term condition in which the heart can't pump blood well enough to meet the body's needs), dyspnea (difficult or labored breathing), and severe persistent asthma; -Code status of DNR. Review of resident's Outside the Hospital Do Not Resuscitate Order (OHDNR), dated [DATE], showed the form signed by the resident. A physician had not signed the form. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated [DATE], showed the resident had moderate cognitive impairment. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised on [DATE], showed a code status of DNR. Review of the resident's Physician Order Sheet (POS), dated [DATE], showed code status as DNR. During an interview on [DATE], at 3:02 P.M., the resident said he/she spoke with a social worker and physician about a DNR order this week and confirmed he/she does not want chest compressions. 50155 2. Review of Resident #20's face sheet, undated, showed the following -admitted [DATE]; -Diagnoses included depression (a common mental disorder causing depressed mood or loss of pleasure or interest in activities); -Full code status (wished to receive CPR). Review of the resident's POS, dated [DATE], showed the resident as a DNR code status. Review of the resident's Annual Social Service Care Plan Note, dated [DATE], showed resident wished to remain full code status. Review of the resident's Annual Review Code Status Form, dated [DATE], showed a code status of full code. Review of the resident's care plan, revised [DATE], showed a resident as a DNR code status. Review of the resident's POS, dated February 2024 and [DATE], showed the resident as a DNR code status. During an interview on [DATE], at 3:15 P.M., the resident said the staff have asked many times about what he/she wants his/her code status to be. He/she just recently changed it to full code. 3. During an interview on [DATE], at 1:40 P.M., Licensed Practical Nurse (LPN) BB said if the resident's code status changes the social worker will change the dots by the resident's names outside their door. A red dot for DNR and green for CPR. He/She said if the information was different on the POS for that resident it should be caught by the DON who is responsible for doing the change out/monthly medication administration record (MAR) review. 4. During an interview on [DATE], at 2:30 P.M., LPN CC said if the code status changes the social worker will change the dots by the resident's names outside their door. Red for DNR and green for CPR. He/She said if the information was different on the POS for that resident, it would be by the DON who is responsible for change out/monthly MAR review to catch the error. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During an interview on [DATE], at 12:15 P.M., the MDS Nurse said if the code status changes that Social Services notifies him/her and that it won't take long to change the status on the MDS/Care Plan. If one had not been changed, he/she would go in and change it as soon as it was brought to his/her attention. 6. During an interview on [DATE], at 12:35 P.M., the Social Services Coordinator said if the code status changes, he/she would change the paper in front of chart the dot outside the resident's door. He/she would also change it in the electronic medical record. He/she would also notify the family/guardian to get them to sign if resident was not the responsible party and then send the new form to physician for signature. 7. During an interview on [DATE], at 1:55 A.M., the DON said social workers are directed to have the resident and/or representative to complete a form with the resident's code status wishes and it would be signed off by the physician. She said the information should be the same in each area of the resident's medical records. She checks the Physician Order Summary monthly to verify orders are correct in the resident's medical chart. The MDS Coordinator was responsible to verify the care plan reflected the information in the resident's medical chart. 8. During an interview on [DATE], at 3:25 P.M., the Administrator said she would expect the resident's code status to be documented in the resident's charts as soon as the order changes. The information should be the same and if not, it would be caught in monthly change over the next month. 33187

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on observation, interview, and record review, the facility failed to ensure an environment as free of accident hazards as possible when staff failed to use equipment improperly resulting a fall with injury, when staff did not update the care plan with new interventions after the fall, and when staff did not document a timely and complete assessment of the resident after the fall for one resident (Resident #11). The facility failed to ensure residents were transferred safely when staff failed to transfer one resident properly with a Hoyer lift (mechanical devised used for lifting residents) resulting in bruising to the resident's face and failed to document a full and timely assessment of the bruise received for one resident (Resident #21). The facility failed to ensure an effective system was in place to monitor all residents ability to smoke and monitor smoking supplies when staff were unclear if one resident (Resident #32) could smoke independently safely and could keep his/her smoking supplies on his/her person. A sample of 19 residents was reviewed in the a home with a census of 62. 1. Review of the facility policy titled, Falls and Fall Risk, Managing, revised December 2007, showed the following: -Based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; -The staff will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions; -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicated why the current approach remains relevant; -If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until calling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable; -Falls committee will review all falls to identify and implement relevant interventions to try to minimize serious consequences of falling. Review of Resident #11's face sheet showed the following: -admitted [DATE]; -Resident on hospice services; -Diagnoses included of dementia, heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs), chronic kidney disease (characterized by progressive damage and loss of function in the kidneys), and low back pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 02/21/24, showed the following: -Severe cognitive impairment; -Functional limitation in range of motion to both lower extremities; -Used a wheelchair for mobility device; -Dependent on staff (staff does all effort) for wheelchair mobility, transfers, toileting, and personal hygiene; -Required partial/moderate assistance of staff with eating; -One (non-injury) fall since admission. Review of the resident's care plan, dated 02/27/24, showed the following: -Resident will require assistance for activities of daily living (ADL) completion related to weakness and diagnosis of dementia and history of fracture of lower extremity; -Resident is alert and able to communicate her needs; -Resident is non-weight bearing on lower extremity and uses a Hoyer (mechanical lift) for transfers; -Resident requires assistance for toileting, transfers, feeding, dressing, grooming, and ambulation; -Resident's ability to assist will decrease throughout the day as he/she fatigues; -Keep area free of clutter/obstacles; -Resident will require one to two assist for bed mobility, toileting, and hygiene needs; -Resident will require set up assistance for meals; -Resident is a risk for falls related to weakness, impulsivity due to dementia, history of falling, and history of leg fracture that did not heal properly; -Resident uses a Hoyer lift for transfers and resident is dependent for ambulation. Review of the resident's Fall Risk Evaluation, completed by facility staff, dated 02/28/24, showed a total score of 14 (a resident who scores a 10 or higher is at risk for falls). Review of the facility's Fall Scene Investigation Report, dated 03/10/24, showed the following: -At 8:10 A.M., the resident slipped out of his/her wheelchair in the activity room; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A drawn picture showed a wheelchair and a ramp with a stick figure lying at the end of the ramp; -Re-creation of events before fall: Staff had gotten the resident up and taken him/her down for breakfast. After breakfast, the resident's geri-chair (a high back cushioned wheel that reclines preventing rising) was not in reclined mode. Staff was pushing and started to go up the ramp and pushed chair forward. The resident fell out; -What appears to be the initial root cause of the fall: Not understanding how geri-chairs work and need to be reclined to push resident around; -Describe initial interventions to prevent future falls: More education to staff on geri-chair and why need to be reclined to push up ramp; -Falls team meeting notes conclusion: When speaking with nurse aide immediately after resident leaning forward. When resident leaned forward and fell out chair was at normal height for meal assistance; -Additional care plan/nurse aide assignment updates: Fall education provided to all nursing staff. Review of the resident's nurses' notes, dated 03/10/24, showed the following: -Staff did not document regarding the resident's fall on the day of the fall; -At 10:00 A.M., a nurse called the resident's physician to report a deformity of the resident's right knee and leg. New physician's order received for an X-ray of the resident's knee and tibia (shin bone)/fibula (calf bone). The nurse contacted the mobile X-ray company and scheduled the X-ray STAT (immediately); -An untimed note, nurse received results from X-ray. The nurse notified the physician and received an order to send the resident to the emergency room for evaluation. The resident's next of kin notified and requested a particular hospital. The nurse notified the paramedics and sent the resident out via ambulance at 6:10 P.M.; -An untimed note, the nurse placed a call to the physician regarding deformity of the resident's knee. The physician ordered an x-ray and then sent the resident to the emergency room . The resident returned to the facility with a knee immobilizer. Review of the resident's March 2024 physician orders showed an order, dated 03/10/24, for an X-ray of the resident's right knee. Review of the resident's nurse's note dated 03/11/24, at 5:15 A.M., showed the resident returned from the hospital emergency room in an ambulance with a knee immobilizer in place. Social services to contact an orthopedic surgeon for a follow up appointment. Review of the resident's care plan showed staff did not update the care plan with the most recent fall, the fracture, or new interventions following the resident's fall/fracture on 03/10/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's March 2024 physician orders showed an order, dated 03/20/24, for staff to send the resident to the emergency room for evaluation of his/her right leg. Review of the resident's physician progress note, dated 03/20/24, showed the following: -Resident admitted to the facility due to distal tibia/fibula (lower leg bones) fractures that required an open reduction-internal fixation (ORIF - a surgery used to stabilize and heal broken bones). A few weeks later, the resident fell and broke his/her distal femur just proximal to (above) the knee. The resident is now wearing a knee immobilizer. During an interview on 03/29/24, at 9:39 A.M., Registered Nurse (RN) L said the following: -He/she worked as the MDS and Care Plan Coordinator for the entire facility since August 2022; -If the resident had a fall, the care plan should be updated to reflect the new fall intervention; -He/she recently became aware that he/she had missed some of the care plans; -The resident should have had a fall care plan update after his/her fall on 03/10/24 with new intervention. During an interview on 03/27/24, at 1:57 P.M., Nurse Assistant (NA) V said the following: -On the day of the resident's fall, he/she propelled the resident out of the dining room after the meal; -He/she planned to recline the resident's back in his/her wheelchair and raise the resident's legs while in the dining room, but there were other residents close by and the NA was afraid of bumping into another resident; He/she decided to recline the resident back in his/her wheelchair approximately two inches from the beginning of the ramp while propelling the resident forward. The resident leaned forward and fell out of the chair onto the ramp; -The resident landed on the carpet on his/her right side and his/her right leg was twisted; -He/she left the resident and went and found Registered Nurse (RN) O and told the nurse about the fall; -The nurse came and assessed the resident; -The NA then said he/she did not notice the resident was leaning forward, because the aide was trying to elevate the resident's feet and recline the chair using hand controls at the back of the chair, but he/she did not get the footrest up and the front of the resident's wheelchair footrest ran into the ramp and the resident fell forward and out of the wheelchair. -Sometimes, other NAs or nurses helped the NA to lean the resident's chair back, when he/she had difficulties reclining the chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/24, at 2:17 P.M., NA U said the following: -On the day of the resident's fall on the ramp, RN O said NA V were pushing the resident up the ramp, but forgot to lean him/her chair back and the resident fell ; -The nurse asked NA U for help getting the resident up out of the floor. During an interview on 03/27/24, at 2:25 P.M., NA G said the following: -Staff asked him/her to assist getting the resident up out of the floor; -When he/she arrived on the ramp, the resident lay on his/her side on the ramp in front of the reclining wheelchair; -The wheelchair was the type that reclines and tilts with a footrest. The chair had two handles at the back, staff can squeeze one to tilt the chair and one to recline and elevate the footrest; -He/she helped the nurse assess the resident, the resident's legs were bent, but the resident did not complain of pain; -Staff assisted the resident up and back to his/her room and onto the bed; -An hour or two later, he/she noticed the resident's inner leg below the knee looked swollen and the resident complained of a little pain; -He/she reported the change to the nurse, RN O, who then assessed the resident's leg; -The physician ordered an X-Ray. During an interview on 03/27/24, at 2:50 P.M., the Director of Nursing (DON) said he/she could not locate a nurse's note related to the resident's fall on 03/10/24, but the nurse did complete a fall investigative report. During an interview on 03/28/24, at 10:26 A.M., Certified Nurse Assistant (CNA) S said the following: -The resident was a high fall risk; -He/she leaned the resident back in the reclining wheelchair anytime the resident was not eating or drinking, due the resident being a high fall risk. During an interview on 03/28/24, at 10:48 A.M., RN M said the following: -The resident fell out of his/her wheelchair onto the ramp and fractured his/her leg because a nurse aide (NA V) forgot to elevate the resident's wheelchair footrest and he/she ran the footrest into the ramp floor (carpeted). The resident sustained a fracture to his/her femur; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she had an issue, prior to the resident's fall with the resident's reclining wheelchair catching on the ramp carpet; -He/she tried to educate staff to elevate the resident's leg rest on the reclining wheelchair before staff attempted to propel the resident's chair up the ramp, but NA V was not working the day the nurse provided the education; -After the resident's fall on the ramp, the facility moved the resident to another part of the facility where staff did not have to push the resident up the ramp; -Staff should have leaned the resident back in a reclined position, if the resident was not eating or drinking; -The nurse said he/she did not think that any of the residents had specific orders or were care planned to be leaned back, but the nurse said he/she thought it was more of a common sense/nursing judgement to lean the residents back, because they sit up very straight in that style of chair and can topple over easily. During an interview on 03/28/24, at 11:45 A.M., NA H said during meals, staff sat the resident up straight in his/her reclining wheelchair, but any other time, staff should lay the resident back, so the resident's footrest did not bump into the ramp and the resident did not fall out of his/her chair. During an interview on 04/01/24, at 3:27 P.M., Registered Nurse (RN) T said the following: -Staff needed to ensure the resident was positioned safely and reclined back in the chair when going up the ramp, so the resident did not lean forward and fall out of the chair. During an interview on 03/28/24, at 2:38 P.M., the Director of Nursing (DON) said the following: -The resident admitted to the facility with a leg fracture, so the facility placed the resident in a reclining wheelchair for comfort; -While eating, staff placed the resident straight up in his/her wheelchair, but if not eating or drinking staff positioned the resident back for comfort, and decreased fall risk. The resident was at a high risk for falls; -He/she expected staff to assist the residents with mobility while on the ramp and staff should position the residents for safety in the wheelchairs; -From what he/she understood, NA V had to get enough momentum going to get up the ramp when propelling a resident up; -On the day of the resident's fall on the ramp, the resident leaned forward, just as the NA got to the ramp and he/she fell forward; -The DON said he/she was not aware the resident's reclining wheelchair footrest hit the ramp; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DON said the NA should have had the resident positioned properly in his/her wheelchair. During an interview on 04/01/24, at 2:34 P.M., the resident's physician, Physician Y, said the following: -Nurses should assess residents with a change in condition and document the assessments in the resident's medical record; -The facility staff should properly operate a reclining wheelchair ensuring the resident's safety; -The facility staff should have elevated the resident's footrest prior to going up the ramp high enough that the resident's footrest did not hit the ramp; -Improper use of the wheelchair could increase the risk of accidents occurring. 2. Review of the facility policy titled, Using a Mechanical Lifting Machine, revised July 2017, showed, the following: -The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device; -At least two nursing assistants are needed to safely move a resident with a mechanical lift; -When the transfer destination is reached, slowly lower the resident to the receiving surface; -Once the resident's weight is released, stop the lowering, and ensure that the sling bar does not hit the resident; -Detach the sling from the lift; -Carefully remove the sling from under the resident. Be mindful of the resident's position and balance, and skin. Review of Resident #21's face sheet showed the following: -Readmitted [DATE]; -Diagnoses of osteoarthritis (a common form of arthritis) of both hands, dependence on wheelchair, congestive heart failure (heart failure), and muscle weakness. Review of the resident's care plan, revised on 07/05/23, showed the following: -Resident required assistance for ADL completion related to weakness; -Resident used a wheelchair for mobility; -Resident will require assistance of one to two staff for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognitive ability; -Dependent (helper does all the effort) on staff for mobility, transfers; -Used wheelchair for mobility device. Review of a note, hand-written by Certified Nurse Assistant (CNA) P showed on 3/22/24, he/she accidentally hit the resident with the Hoyer lift above the resident's eye and informed the nurse. Observation of the resident on 03/25/24, at 10:41 A.M., showed the following: -The resident sat up in a wheelchair in his/her room; -The resident sat on a Hoyer lift pad; -The resident had a dark, purplish-red, skin discoloration, approximately two centimeters (cm) in diameter, to his/her right, outer eye brow area. Review of the resident's nurse notes showed staff did not document in the nurses' notes from 03/22/24 to 03/25/24. Review of the resident's Skin Monitoring: Comprehensive CNA Shower review form, dated 03/26/24, showed resident had bruising to his/her right eye area. Review of the resident's nurse's note, dated 03/26/24 (untimed), showed the following: -Per CNA report, a bruise to the resident's right eye was from a Hoyer hook when moving the Hoyer lift out of the way on 03/22/24. The DON and the MDS Coordinator were made aware. Review of an accident report, dated 03/27/24, showed a nurse documented the following: -On 03/22/24, while transferring a resident with a Hoyer lift, resident sustained a bruise to his/her eye; -Staff education provided on proper Hoyer lift use and keeping hand on the bar for resident protection. During an interview on 03/28/24, at 10:26 A.M., CNA S said the following: -He/she worked as the shower aide; -On Monday, 03/25/24, he/she noticed a bruise by the resident's right eye; -He/she filled out a shower skin sheet (a form with a body diagram and list of skin issues, indicating the resident's bruise and location) and told the nurse about the bruise by the resident's s right eyebrow; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/24, at 11:55 A.M., RN L said the following: -On Friday 03/22/24, he/she worked as the charge nurse for a couple of hours and then RN X came in and took over as the charge nurse; -Sometime on Friday, 03/22/24, CNA P informed RN L he/she bumped the resident with a Hoyer lift bar during a transfer, but said there were no apparent injuries to the resident. RN L instructed CNA P to notify RN X because he/she needed to complete an incident report. Later that same day, CNA P said the resident's right outer brow was starting to bruise. At that time, RN L assessed the resident and he/she had light bruising to the right outer brow. The bruise was approximately 1.5 centimeters (cm) in size, with a reddish-purple color. -The resident denied pain to the area, denied a headache. -The nurse said he/she did not document incident/ injury, did not notify the resident's physician or next of kin, and did not follow up with the charge nurse, RN X, but he/she should have done so; -Staff should keep one hand on the lift bar, at all times, to avoid hitting a resident with the swinging bar; -CNA P said he/she knew to hold onto the bar, but CNA P was not mindful of how close the bar was to the resident's head. During a phone interview on 03/28/24, at 1:37 P.M., RN X said the following: -On Friday, 03/22/24, he/she arrived at the facility at 10:00 A.M., and received report from RN L; -RN L relayed that CNA P reported, he/she accidentally bumped the resident on the head with a Hoyer sling bar, but no apparent injuries; -Later in the shift, (unsure of time) CNA P came to RN X and said the resident had developed a bruise; -RN X went to the resident and observed the resident had an approximate half-dime size bruise to his/her right outer eyebrow area; -The resident did not answer when the nurse asked the resident if he/she was in pain; -The nurse said she checked the resident's pupils and they looked normal and equal; -The nurse did not chart anything about the incident or injury; -The nurse should have documented an assessment, neurological checks, and VS in the nurse's notes, but he/she failed to do so; -The nurse said he/she did not notify the resident's physician or responsible party because he/she assumed RN L had made the notifications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/24, at 2:38 P.M., the DON said the following: -Staff should stabilize the Hoyer bar to keep the bar from swinging into a resident; -The nurses should have assessed the resident and documented the assessment in the resident's nurse notes; -The nurses should have notified the resident's physician and responsible party and documented the notifications in the nurse notes; -If the nurse did not document, then it was not done. 3. Review of the facility policy titled, Smoking Policy and Procedure, undated, showed the following: -This facility shall establish and maintain safe resident smoking practices; -To identify factors that may put resident at risk for smoking independently and so provide appropriate supervision/approaches for safety; -Prior to, or upon admission, resident shall be informed about any limitation on smoking, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences; for example, in making room assignments; -All residents who smoke tobacco products shall have a Smoking Assessment completed upon admission, quarterly, and as needed; -Risk factors identified through the assessment process shall be used in the development of the plan of care; -Each individual facility shall develop a Smoking Policy based on the facility environment and staffing capabilities; -All residents/responsible party shall receive a copy of the facility Smoking Policy; -All residents, visitors, and associated shall smoke in designated smoking areas only; -Smoking restrictions shall be strictly enforced in all non-smoking areas. Smoking is prohibited inside the facility; -The facility shall establish designated times to provide smoking opportunities to residents requiring assistance and/or supervision; -The smoking assessment shall be filed in the assessment portion of the medical record; -All smoking products (cigarettes, lighters, etc.) in the locked medication room; -Residents who smoke independently, will not be assigned a smoking schedule; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Independent smokers will be allowed to smoke without associate supervision. Residents will notify the charge nurse when they would like to smoke and their whereabouts while smoking (designated smoking area). Residents will be responsible to return all smoking products/materials back to the charge nurse after smoking. Review of Resident # 32's face sheet showed the following: -Readmitted [DATE]; -Diagnoses of need for continuous supervision, stroke, hemiplegia (paralysis of one side of the body) and hemiparesis (loss of motor skills of one side of the body) affecting non-dominant side, chronic kidney disease, peripheral vascular disease (a circulatory condition is which narrowed blood vessels reduce blood flow to the limbs), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), dementia, generalized anxiety disorder, and major depression. Review of the resident's care plan, revised on 05/26/23, showed the resident enjoyed smoking and has supervised cigarette breaks. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Used wheelchair independently for mobility device; -Functional limitation in range of motion (ROM) lower extremity impairment on one side; -Independent with eating, oral hygiene, toileting hygiene, upper body dressing, and personal hygiene; -Required substantial/maximum assistance (helper does greater than half of the effort) with showering, sitting to standing and chair/bed transfers; -Required partial/moderate assistance (helper does less than half of the effort) with lower body dressing. Review of the resident's smoking safety evaluation, completed on 02/21/24, showed the resident had demonstrated ability to safely smoke without supervision. Review of the resident's care plan showed staff did not update the care plan regarding the resident's need to be supervised or not for smoking. Review of the resident's March 2024 physician orders showed activity level as up ad lib (as often as desired/necessary). Observation and interview of the resident on 03/25/24, at 10:52 A.M., showed the following: -The resident sat in a wheelchair in his/her room; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident said he/she was preparing to go outside to smoke and had misplaced his/her cigarettes; -The resident began looking through clothing located in a laundry basket for cigarettes and a lighter; -The resident said he/she kept a lighter and cigarettes in his/her room and could go outside to smoke any time. Observation on 03/26/24, at 2:50 P.M., showed the following: -The resident sat in his/her wheelchair, in the outside courtyard, smoking a cigarette; -The resident was completely alone, with no other residents or staff visible outside. During an interview on 03/26/24, at 3:07 P.M., RN M said the following: -At the time of hire, other staff members told the nurse which residents were independent with smoking; -Three residents were independent with smoking, including the resident; -The resident was allowed to keep his/her cigarettes and lighter in his/her room. During an interview on 03/27/24, at 10:19 A.M., CNA R said the following: -The resident smokes outside by him/herself. The CNA said when the resident starts sleeping a lot, the CNA stayed outside with the resident; -The resident keeps cigarettes and possibly a lighter in his/her room; -Some of the residents kept their cigarettes and lighters at the nurse's desk; -He/she assumed the resident was supposed to leave his/her cigarettes and lighter at the desk. During an interview on 03/28/24, at 10:26 A.M., CNA S said the following: -The resident fell asleep frequently while smoking; -Staff allow the resident to go outside by him/herself, but he/she was not supposed to be allowed to smoke without supervision; -He/she was not aware of the resident ever burning him/herself, but the resident does not have burn holes in his/her clothing. During an interview on 03/28/24, at 10:48 A.M., RN M said the following: -Prior to this week, the resident was going outside and smoking independently; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the early part of January 2024, the resident would get drowsy and fall asleep in the hallway, more recently he/she usually makes it to his/her room before falling asleep; -The nurse said he/she was unsure if the resident fell asleep outside while smoking; -The nurse he/she did not think any of the residents should go outside and smoke by themselves because it was not safe; -When he/she first started working at the facility, he/she asked other nurses about the resident smoking by him/herself, and other staff told the nurse the resident was independent with smoking and the resident had always been allowed to keep his/her own cigarettes and lighter in his/her room or on his/her person. During an interview on 03/28/24, at 11:45 A.M., NA H said the following: -Prior to this week, the resident went outside independently to smoke anytime, but the facility now had scheduled resident smoke times, and someone had to be with the resident outside, beginning this week; -Prior to this week, the resident was allowed to keep his/her cigarettes and lighter in his/her room, now he/she was supposed to keep those at the nurses' desk. During an interview on 03/28/24, at 2:38 P.M., the DON said the following: -The DON was unsure who was responsible for completing the resident smoking assessments, but the nurses should complete the assessments; -Social services kept the resident smoking assessments in their office; -The facility's smoking policy prohibits residents from keeping cigarettes or lighters in their rooms; -The DON and staff encouraged the resident to leave his/her lighter and cigarettes at the desk, but the resident did not always comply; -A staff member should be outside with the resident when he/she smoked and normally there was someone outside with the resident; -Several of the staff members smoke and can take the resident outside with them; -The resident frequently falls asleep, which is why he/she should not be alone outside while smoking. During an interview on 03/28/24, at 3:57 P.M., the Admission Coordinator said the following: -Social Services (SS) completed all the resident smoking safety assessments on a quarterly basis (every 3 months) and kept the assessments in a folder in the SS office; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was pretty safe with smoking, but he/she did have a habit of falling asleep; -Staff did not allow the resident to keep his/her lighter or cigarettes in his/her room, but staff had an issue at times, with the resident not turning in his/her lighter and cigarettes at the nurses' desk; -Prior to this week, facility staff allowed the resident to go outside by him/herself to smoke. During an interview on 03/29/24, at 9:39 A.M., RN L said the following: -He/she was responsib [TRUNCATED]

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 33187 Based on interview and record review, the facility failed to have a system in placed to ensure nurse aides (NA) completed their training, competencies, and testing in a timely manner when seven NAs (NA D, NA E, NA F, NA G, NA H, NA I, and NA J) failed to complete a state approved certified nursing assistant (CNA) training program, competency evaluation, and certification test timely and continued to work providing direct care to residents. The facility's census was 62. Review of the facility policy titled, Nurse Aide Qualifications & Training Requirements, revised October 2017, the facility will not employ any individual as a nurse aide for more than four months full-time, temporary, per diem or otherwise unless: -That individual is competent to provide nursing care and nursing related services, and -That the individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state, or; -That individual has been deemed competent as provided in 483.150 (a) and (b) of the requirements of participation. 1. Review of the facility's Staff Position Report, dated 03/27/24, showed the following: -NA I was hired as an NA on 11/16/22; -NA E was hired as an NA on 05/30/23; -NA J was hired as an NA on 06/14/23; -NA F was hired as an NA on 07/18/23; -NA D was hired as an NA on 08/17/23; -NA H was hired as an NA on 08/25/23; -NA G was hired as an NA on 10/13/23. Review of facility and personnel records for NA I, NA E, NA J, NA F, NA D, NA H, and NA G showed the facility did not have documentation of the NA's completing a state approved CNA testing program within four months of hire. During an interview on 03/27/24, at 1:57 P.M., NA V said the following: -He/she worked at the facility as an NA for approximately 2 years; -He/she completed the NA training class, but still needed to take the test to become certified; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility had not told NA V when he/she would be taking the CNA test. During an interview on 04/01/24, at 11:00 A.M., NA G said the following: -He/she had been employed at the facility as an NA since October of 2023; -He/she completed the NA classes the end of January 2024, but he cannot afford to take the test yet due to the testing site being three hours away. The facility has not indicated they will pay for testing cost upon inquiry; -Has not taken his NA competency test; -Received a emailed letter from the facility indicating he/she had until February 2025 to test; -Worked his/her entire time at the facility as a NA. During an interview on 04/01/24, at 11:45 A.M., NA H said the following: -He/she has worked at the facility since August of 2023 as an NA. -Completed the classes to become a CNA by the end of December 2023; -He/she waited to schedule for his/her test in February 2024; -He/she just completed his/her competency evaluation on 03/29/24 at a testing site three hours away and was awaiting test results; -Worked his/her entire time at the facility as a NA. During an interview on 03/29/24, at 12:15 P.M., Registered Nurse (RN) K said the following: -He/she teaches the NA classes at the facility; -Students complete the free course work and skills training at the facility; -Class hours are usually around 100 hours and the course will take longer with absences; -The students complete training within four months of hire, but they take the course test elsewhere; -The NA students must register online for an outside testing site once the class is completed at the facility; -He/she was not aware of the length of time they can continue employment as a NA after they complete the classroom portion of the course; -Aware that students have to wait a long period of time before they test and has brought these concerns to administration; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NA's are allowed to work the floor after they complete the program and wait for testing to be finished. During an interview on 04/01/24, at 12:15 P.M., RN L said the following: -Notified this week during the current inspection process of NA's not completing their CNA classes in four months; -Previous testing practices allowed the staff to test at the facility increasing compliance with completing the course; -Since using the online testing service the students are not testing or scheduling for their test less than four months; -Students are allowed to take up to a year to complete the course. During an interview on 04/01/24, at 1:55 P.M. the Director of Nursing (DON) said the following; -NA's should complete 16 hours of basic skills training and then complete 75 hours of additional competency training before they can test for their certified nurse aide test; -NA's should complete the training within 4 months or be allowed to work in a non-nursing care area if they have not completed the training within 4 months; -Students schedule their own test online, but have difficulties with getting this done; -Recently asked to pay for a NA's test, but is hesitant to do this due to fear of the staff member not completing the testing or leaving employment after completion; -He/She is aware of NA's not completing their CNA classes and testing within the required four months; -Not aware of how many NA's they have working past four months. During an interview on 04/01/24, at 3:25 P.M., the Administrator said the following: -The facility uses an online testing company for their certified nurse aide program. He/she is aware of current NA staff taking longer than four months to complete the course. An NA should be terminated, restart the program or be reassigned as a non-nurse domestic aide or a dietary aide until they are fully certified. The facility will help the NA pay for the testing if needed and was not made aware this was a reason staff were not scheduling their testing until the current inspection inquiry. The NA should be reassigned to a non-nursing related service until they complete the program. 34906 50155

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33187 Based on observation, interview, and record review, the facility failed to establish a system of records to ensure all controlled drugs were routinely and consistently reconciled and that discontinued or expired controlled medications and disposed of in a timely manner. The facility's census was 62. Review of the facility's Storage of Medications Policy, dated April 2007, showed the following: -The facility shall store all drugs and biological's in a safe, secure and orderly manner; -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others; -Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems; -Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of missing medications of several residents; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location; -Medications must be stored separately and labeled accordingly. Review of the facility's Discarding and Destroying Medications Policy, dated October 2014, showed the following: -Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances; -All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of; -Schedule II, III and IV (non-hazardous controlled substances) will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non hazardous controlled medications; -Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below: removal of the medication from its original containers and mix medication, either liquid or solid, with an undesirable substance. Undesirable substances include, sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage; -Dispose with the solid waste in the presence of two witnesses; -Document the disposal of the medication disposition record and keep on file for at least two years; -For emergency kit controlled substances disposal, complete the appropriate portions of the controlled medication accountability form. Review of the facility's Controlled Substances Policy, dated December 2012, showed the following: -Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises; -The Director of Nursing (DON) will identify staff members who are authorized to handle controlled substances; -Controlled substances must be counted upon delivery by the nurse receiving the medication, along with the person delivering the medication together. Both individuals must sign the designated controlled substance record; -Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medication. This container must remain locked at all times, except when it is accessed to obtain medications for residents; -The charge nurse on duty will maintain the keys to controlled substance containers. The DON will maintain a set of back-up keys for all medication storage areas including keys to controlled substance containers; -Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON; -The DON shall investigate any discrepancies in narcotic reconciliation to determine the cause and identify any reasonable parties, and shall give the Administrator a written report of such findings. 1. Review of the facility's Narcotic Overflow Log, dated 03/13/24, for the facility's emergency kit (E-Kit) showed the red tag (lockout tag - 02426005) was placed on the counted locked cabinet. The staff did not document that a count was performed, only with the change of a red tag. Review of the facility's Current Narcotic Overflow Medication Count Inventory Sheet, showed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/08/23, staff added two cards of thirty tablets (total of 60 tablets) of tramadol (a controlled pain medication) to the cabinet; -On 12/08/23, staff added one bottle of ninety tablets of Ativan (a controlled antianxiety medication) 0.5 milligram (mg) to the cabinet; -Staff did not document medication counts for overflow narcotics from 12/09/23 to 03/07/24; -On 03/07/24, staff added a medication card containing three tablets of Fentanyl (a controlled pain medication), a medication card containing twelve tablets of morphine (a controlled pain medication), a medication card containing six tablets of Lyrica 50 mg (a controlled anticonvulsant medication), and two vials of Narcan (a medication to reverse narcotic overdose) 0.4 mg/ml to the cabinet. Two nurses signed off on the current count; -Staff did not document medication counts for overflow narcotics from 03/08/24 to 03/12/24; -On 3/13/24, staff removed three tablets of Fentanyl, a medication card containing twelve tablets of morphine, a medication card containing six tablets of Lyrica 50 mg, and two vials of Narcan 0.4 mg/ml from the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for overflow narcotics from 03/14/24 to 03/27/24. Observation on 03/29/24, at 11:40 A.M., of the current narcotic inventory count with Registered Nurse (RN) L and RN Z of the facility's lower medication room's current narcotic overflow medication count Inventory showed the following: -Two cards of thirty tablets (total of 60 tablets) of tramadol; -One bottle of ninety tablets of Ativan 0.5 mg. Review of the facility's Current Discontinued Narcotic Log, last dated 03/21/24, showed the red tag (02725976) was placed on the locked medication discontinued narcotic overflow cabinet. The staff made no documentation that a count was performed, only with the change of a red tag. Review of the facility's Current Discontinued Narcotic Log Sheet showed the following: -On 11/16/23, staff documented the cabinet was empty and did not have any discontinued narcotics; -On 11/16/23, untimed, staff added a bottle of 25.25 ml of Roxanol (narcotic pain medication) 20 mg/ml, three unopened 30 ml bottle of Roxanol 20 mg/ml, twenty-eight tablets of Ativan 0.5 mg, twenty-nine tablets of Norco (a narcotic pain medication) 7.5 mg/325 mg, twenty tablets of oxycodone (a narcotic pain medication) 5 mg, twelve tablets of clonazepam (a controlled anticonvulsant medication) 0.5 mg, eighteen tablets of pregabalin (Lyrica) 50 mg, and thirty tablets of pregabalin 50 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 11/17/23 to 11/21/23; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/22/23, untimed, staff added a bottle of 20.75 ml of morphine sulfate 20 mg/ml, twenty-six tablets of lorazepam (Ativan) 0.5 mg, twenty-one tablets of lorazepam 0.5 mg, and thirteen tablets of hydrocodone 5 mg/325 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for the discontinued narcotics from 11/23/23 to 11/25/23; -On 11/26/23, untimed, staff added thirty tablets of tramadol (an controlled pain medication) 50 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 11/27/23 to 12/05/23; -On 12/06/23, untimed, staff added 14 tablets of phenobarbital (an anitseizure medication) 30 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics during from 12/07/23 to 12/29/23; -On 12/30/23, untimed, staff added a bottle of 29.5 ml of morphine sulfate 20 mg/ml and a 29.5 ml bottle of lorazepam 2 mg/ml to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 01/31/23 to 01/25/24; -On 01/26/24, untimed, staff added thirty tablets of tramadol 50 mg, six tablets of tramadol 50 mg, nineteen tablets of alprazolam (a controlled antianxiety medication) 0.25 mg, and thirty tablets of alprazolam 0.25 mg to the cabinet. Two staff signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics on 01/27/24; -On 01/28/24, untimed, staff added ten tablets of hydrocodone 5 mg/325 mg, eight tables of lorazepam 1 mg, one 60 ml bottle of lorazepam 2 mg/ml, one 27.5 ml bottle of morphine sulfate 20 mg/ml, and twenty-eight tablets of phenobarbital 32.4 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 01/29/24 to 02/04/24; -On 02/05/24, untimed, staff added ten tablets of tramadol 50 mg, one 29.5 ml bottle of lorazepam intensol 2 mg/ml, and one 28.25 ml bottle of lorazepam intensol 2 mg/ml to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 02/06/24 to 02/07/24; -On 02/08/24, untimed, staff added thirty tablets of oxycodone 7.5 mg/325 mg and ten tablets of hydrocodone 7.5 mg/325 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 02/09/24 to 02/22/24; -On 02/23/24, untimed, staff added one 28.35 ml bottle of lorazepam 2 mg/ml and one 29.5 ml bottle of morphine sulfate 20 mg/ml to the cabinet. Two nurses signed off on the current cabinet count; (continued on next page)

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	265705	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Community Care and Rehabilitation	200 West 12th Street Lockwood, MO 65682

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 02/24/24, untimed, staff added twenty-one tablets of Ativan 0.5 mg, and eight tablets of Norco 7.5 mg/325 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics 02/25/24 to 02/29/24; -On 03/01/24, untimed, staff added one 27.5 milliliters (ml) bottle of lorazepam 2 mg/ml, fifteen tablets of lorazepam 0.5 mg, a 19 ml bottle of morphine sulfate 20 mg/ml, and sixteen tablets of lorazepam 0.5 mg to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics during from 03/02/24 to 03/14/24; -On 03/15/24, untimed, staff added twenty six tablets of tramadol, eight tablets of tramadol, and twenty-eight tablets of Xanax (a controlled antianxiety medication) to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 03/16/24 to 03/20/24; -On 3/21/24 untimed, staff added twenty tablets of tramadol, twenty-four ml of liquid Ativan 2 mg/ml, and seven ml of Roxanol 20 mg/ml to the cabinet. Two nurses signed off on the current cabinet count; -Staff did not document medication counts for discontinued narcotics from 03/21/24 to 03/27/24. During an observation 03/27/24, at 10:40 A.M. of the lower medication room on showed the following: -A red tag (02725976) on a locked cabinet labeled, Medication Discontinued Narcotic Overflow Cabinet; -A red tag (02426005) on a locked cabinet labeled, Active Overflow Narcotic Substances. During an observation and interview on 03/27/24, at 11:00 A.M., RN L accessed the facility's medication dispensing system. Observations were made of RN L performing a count on a current supply of medication kept in the facility E-kit. RN L said the count has to be correct or the dispensing machine will not allow the staff to continue with withdraw from the machine. The staff are not provided a number of the medication on hand prior to the staff entering the count. Staff only count the controlled medication if they accessed a locked supply of controlled medications with a red tag. The RN was aware staff are expected to count controlled medication per shift with the oncoming nurse. The RN was not aware of anyone checking the red tags routinely to see if they are broken. During an observation on 03/29/24, at 11:04 A.M., of the narcotic inventory count with RN L and RN Z, of the facility's lower medication room's discontinued narcotic storage cabinet showed the following: -A bottle of 25.25 ml of Roxanol 20 mg/ml; -Three unopened, 30 ml bottle of Roxanol 20 mg/ml; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Twenty-eight tablets of Ativan 0.5 mg; -Twenty-nine tablets of Norco 7.5 mg/325 mg; -Twenty tablets of oxycodone 5 mg; -Twelve tablets of clonazepam 0.5 mg; -Eighteen tablets of Pregabalin 50 mg; -Thirty tablets of Pregabalin 50 mg; -A bottle of 20.75 ml of morphine sulfate 20 mg/ml; -Twenty-six tablets of lorazepam 0.5 mg; -Twenty-one tablets of lorazepam 0.5 mg; -Thirteen tablets of hydrocodone 5 mg/325 mg; -Thirty tablets of tramadol 50 mg; -Fourteen tablets of phenobarbital 30 mg; -A bottle of 29.5 ml of morphine sulfate 20 mg/ml; -A 29.5 ml bottle of lorazepam 2/g/ml; -Thirty tablets of tramadol 50 mg; -Six tablets of tramadol 50 mg; -Nineteen tablets of alprazolam 0.25 mg; -Thirty tablets of alprazolam 0.25 mg; -Ten tablets of hydrocodone 5 mg/325 mg; -Eight tables of lorazepam 1 mg; -One, 60 ml bottle of lorazepam 2 mg/ml; -One, 27.5 ml bottle of morphine sulfate 20 mg/ml; -Twenty-eight tablets of phenobarbital 32.4 mg; -Ten tablets of tramadol 50 mg (a pain medication); (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One, 29.5 ml bottle of lorazepam intensol 2 mg/ml; -One, 28.25 ml bottle of lorazepam Intensol 2 mg/ml; -Thirty tablets of oxycodone 7.5 mg/325 mg; -Ten tablets of hydrocodone 7.5 mg/325 mg; -One, 28.35 ml bottle of lorazepam 2 mg/ml; -One, 29.5 ml bottle of morphine sulfate 20 mg/ml; -Twenty-one tablets of Ativan 0.5 mg; -Eight tablets of Norco 7.5 mg/325 mg; -One, 27.5 milliliters (ml) bottle of lorazepam 2 mg/ml; -Fifteen tablets of lorazepam 0.5 mg; -A 19 ml bottle of morphine sulfate 20 mg/ml; -Sixteen tablets of lorazepam 0.5 mg; -Twenty six tablets of tramadol; -Eight tablets of tramadol; Twenty-eight tablets of Xanax; -Twenty tablets of tramadol; -Twenty-four ml of liquid Ativan 2 mg/ml; -Seven ml of Roxanol 20 mg/ml. During an interview on 03/27/24, at 1:13 P.M., the Director of Nursing (DON) said the staff are required to do a reconciliation of medications on the facility's automatic dispensing system when the medication box is counted. The staff only do counts if the red tag is broken or if a medication is used. She tries to destroy medication when she has time. She has not had time to destroy any medications recently, but did not realize it has been five months since any expired medication destruction has occurred. During an interview on 03/28/24, at 10:48 A.M., RN M said the following: -He/she worked as a charge nurse on the day shift; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurses locked the overflow or discontinued controlled medications in a locked cabinet in the medication room; -Nurses have not been checking the red plastic tag locks on medication room controlled medication cabinet at the beginning and end of each shift. During an interview on 03/28/24 at 1:37 P.M., RN X said the following: -He/she worked as a charge nurse on the night shift; -He/she counted the controlled medications stored in the medication and treatment carts at the beginning an end of each shift with the oncoming and off going nurse or CMT; -He/she did not count the controlled medications stored in the medication cabinet at the beginning and end of each shift; -The nurses counted the controlled medications stored in the medication room cabinet when accessing the cabinet to remove or add a medication, but otherwise did not count these medications. During an interview on 04/01/24, at 11:30 A.M., RN Q said the oncoming nurses should count with the previous shift for any controlled substances. He/she has not recently signed out any overflow narcotics or destroyed any discontinued medications recently. The staff count only when the red tag is removed or changed on the locked narcotics. During an interview on 04/01/24, at 12:50 P.M. RN N said staff are expected to count every shift the narcotic count tag and check the storage cabinets are locked. This is a new practice discovered this week and staff have not started implementing it. The staff realized the this was not being done and should have been checked every shift. During an interview on 04/01/24, at 2:30 P.M. the DON said all expired medications showed be destroyed timely. He/she is working on establishing a set time to destroy medications at least quarterly. He/she is encouraging certified medication technicians (CMT's) to destroy medications with the charge nurse to keep from large amounts of medications to accumulate. The red tags were being checked at least weekly before, but the nurses should check them at least every shift. During an interview on 04/01/24, at 3:25 P.M., the Administrator said the nursing staff should count narcotics at the beginning of their shift. The staff should utilize counts and a tag system to assist with securing medication every shift. 34906

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33187 Based on observation, interview, and record review, the facility failed to ensure all controlled medications were stored per standards of practice when a controlled substance was not stored in a locked box. The facility's census was 62. Review of the facility's Storage of Medications Policy, dated April 2007, showed the following: -The facility shall store all drugs and biological's in a safe, secure, and orderly manner; -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others; -Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately and labeled accordingly. Review of 19 Code of State Regulation (CSR) 30-1.034 showed controlled substances shall be stored in a securely locked, substantially constructed cabinet. 1. Observation on 03/27/24, at 10:35 A.M., of the facility's lower nurse medication room showed the following; -The medication room refrigerator emergency kit (E-Kit) storage box was unlocked. The box contained six vials of Ativan Intensol (antianxiety medication/controlled substance) 2 milligram/milliliter (mg/ml). -Registered Nurse (RN M) immediately locked the cabinet and returned the box to the refrigerator. During an interview on 03/27/24, at 10:37 A.M., RN M said the controlled substances kept in the facility's locked refrigerator for the emergency kit should be double locked at all times. The Ativan vials were unopened and the count was correct at the beginning of the shift. During an interview on 04/01/24, at 2:30 P.M. the Director of Nursing (DON) said staff are expected to secure all medication. During an interview on 04/01/24, at 3:25 P.M., the Administrator said staff are expected to store controlled medication in a double locked cabinet or refrigerator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in a manner to protect the food from possible contamination when staff failed to store food in sealed containers; failed to discard expired and freezer burnt food; failed to ensure vents, windows, and fans were free of dirt and lint; failed to ensure the dishwasher washed and rinsed the dishes at the recommended temperature; and failed to ensure the dishwasher chemicals tested at recommended level. This had the potential to affect all residents who consumed food from the facility kitchen. The facility had a census of 62 residents. 1. Review of the 2013 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location and where it is not exposed to splash, dust, or other contamination. Review of the facility policy titled, Food Receiving and Storage, revised [DATE], showed the following: -Food services, or other designated staff, will maintain clean food storage areas at all times; -Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such foods will be rotated using a first in and first out system; -All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). Observations on [DATE], beginning at 10:14 A.M., showed the standing refrigerator in the kitchen area contained the following: -An opened container of Greek yogurt with an expiration date of [DATE] with a hand written date of , d+[DATE]; -An unopened container of sauce with a best buy date of [DATE]; -A bag of opened whipped topping in sealed bag with no label/date; -An unsealed bag flour tortillas with the package opened to air with no label/date; -A plastic container with aluminum foil cover with a four to five inch slit, open to air, with potato salad written in marker with no date; -Sealed bag of romaine lettuce sealed no label/date; -Large rectangular plastic container with lettuce and onion and no label/date. Observations on [DATE], beginning at 10:14 A.M., of the food storage area showed he following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two 57 ounce open containers of instant mashed potatoes with no label/date. The containers were unsealed and open to air. Observations on [DATE], beginning at 10:14 A.M., of the standing freezers showed the following: -A bag of tater tots sealed with no label/date. There were visible ice crystals on the tater tots; -A bag of sliced peaches inside sealed bag with no label/date; -Sealed bag with label pumpkin ,d+[DATE] written in marker with visible ice crystals on the pumpkin; -One bag of opened self-rising flour inside an unsealed plastic grocery bag; -One bag of opened bread flour inside an unsealed plastic grocery bag. During an interview on [DATE], at 2:20 P.M., Dietary Cook A said the following: -Staff should put open food products in a sealed plastic container or sealed plastic bag and label with the date opened and three days after that date; -Expired foods should be immediately discarded; -The facility does not have a schedule for performing spot checks for expired foods; -He/she does not know of steps staff should take to avoid foods becoming freezer burnt and assumed freezer burnt food should be immediately thrown out. During an interview on [DATE], at 3:19 P.M., the Dietary Manager (DM) said the following: -Staff should store opened food in a sealed plastic container or plastic bag with a label including name of the product, date opened and three days after the open date (throw away date); -Expired food should be discarded immediately; -The facility does not have a system in place for checking for expired foods; -Staff should double wrap food and put in plastic bags to avoid freezer burn; -Staff should dispose of any freezer burnt foods immediately. During an interview on [DATE], at 3:19 P.M., the Administrator said staff should store opened food in a sealed container with a date, and stored food should not be expired. 2. Review of the 2013 Missouri Food Code showed the following: -Food shall be protected from contamination by storing the food in a clean, dry location and where it is not exposed to splash, dust, or other contamination; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues; -The physical facilities shall be cleaned as often as necessary to keep them clean. Observation on [DATE], at 10:14 A.M., showed the ceiling vent near food preparation table contained visible dirt and lint that could fall into food being prepared. Observation on [DATE], at 11:16 A.M., showed the following: -Large long vents above the window in dishwashing preparation area contained visible dirt and lint which could fall and contaminate clean dishes; -The screen windows and window cranks in the dishwasher and microwave area were visibly dirty with lint particles, dirt and grime; -The windowsill had a large number of pieces of dirt and lint. The window sill was located directly over the area where the clean dishes come out of the dishwasher and are stored for drying; -A fan attached to the wall directly facing the area where dishes come out of the dishwasher had dangling lint particles and was running; -A metal box unit and metal spindles on top of the range hood had visible dirt, grime, and lint and located in the area where food is prepared and served; -Ceiling vent near food preparation table contained visible dirt and lint. During an interview on [DATE], at 2:20 P.M., Dietary Cook A said the following: -The facility has a cleaning schedule including the day of the week and what tasks should be completed; -Maintenance staff are responsible for cleaning the vents and windows, and he/she is unsure of the schedule. During an interview on [DATE], at 2:32 P.M., Dishwasher B said the following: -He/she has performed some of the cleaning tasks, but is not sure if there is a cleaning list; -He/she only cleans what he/she has been told to clean. During an interview on [DATE], at 3:05 P.M., Dietary Aide C said the following: -The facility has a weekly cleaning schedule; -He/she looks at the schedule on a daily basis and checks off tasks as completed; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Maintenance is responsible for cleaning vents requiring a ladder and any other tasks requiring use of a ladder. During an interview on [DATE], at 3:19 P.M., the DM said the following: -There is a weekly cleaning check list; -Staff use a pole to clean the vents above once a month; -The screen window is not on the cleaning list, and she cleaned it the last time it was cleaned; -Dishwashing staff should wipe down the fan above the dishwasher daily; -The cleaning list does not specify wiping down the fan, but does specify the dishwasher should clean the dishwasher area daily. -Maintenance cleans the range hood and anything above it, including the spindles and the box on top of the hood. During an interview on [DATE], at 11:01 A.M., the Maintenance Supervisor said the following; -Maintenance has a monthly checklist for kitchen duties such as inspecting the filters and drip pans in the fridges and freezers, inspect the sprinklers, and clean the entire range hood; -The spindles on top of the range hood and the box on top are not on the monthly checklist to clean, and staff complete visual spot checks; -He is not sure when it was last cleaned and will add it as a duty on the monthly checklist; -There should not be visible dust and grime on the box or the spindles. During an interview on [DATE], at 3:19 P.M., the Administrator said there should be a monthly cleaning schedule for the entire kitchen. The dietician also inspects the monthly cleaning schedule. The dietary supervisor is in charge of making sure it is completed. Dietary aides are assigned to monthly cleaning. There is an extra aide who just cleans some items such as surfaces and areas behind the refrigerator. 3. Review of the facility policy titled, Good [NAME] Nursing Home Protocol Dish Washing, undated, showed the following: -The dishes shall be cleaned, dry, and sanitary for next use; -The dishwasher shall visually inspect chemicals of the dish machine and replace any that are empty; -The chemical tests should be completed after the first two racks of dishes to ensure sanitation; -The results of the chemical tests shall be recorded on the sanitation log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE], at 11:46 A.M. showed the following: -The dishwasher had displayed the manufacturer recommendations for the wash and rinse cycles at a minimum of 120 degrees Fahrenheit (F), and the sanitizer should test at a minimum of 50 parts per million (pmm) chlorine sanitizer. Review of the facility's Low Temperature Chemical Sanitation Log, for March of 2024, showed 54 out of 82 temperature were documented to be below 120 degrees F for the wash cycle in the month of [DATE]. Observation on [DATE], beginning at 11:46 A.M. showed the following: -Dishwasher temperatures during three cycles were 105.5 degrees F, 115.6 degrees F, and 116.8 degrees F; -The sanitizer test strip did not read 50 pmm or above during two separate tests. During an interview on [DATE], at 2:20 P.M., Dietary Cook A said the following: -He/she runs the dishwasher on a rare occasion, and it should run at 120 degrees F, but he/she is not sure if that is for the wash and rinse cycle; -He/she is aware of the sanitizer test strips, but not sure of details; -There is a log for staff to keep track of the temperatures and test strips results. During an interview on [DATE], at 2:32 P.M., Dishwasher B said the following: -He/she thinks the dishwasher should run at 185 degrees at wash and 200 degrees at rinse; -He/she documents the dishwasher temperatures and sanitizer test strip per meal service on the log; -He/she believes the sanitizer test strip should show 200 pmm; -Dishwasher temperatures have not been running hot enough, and he/she has notified the DM; -He/she notified the DM when the sanitizer test strip did not test where they should. During an interview on [DATE], at 3:05 P.M., Dietary Aide (DA) C said the following: -Dishwasher temperatures should not run below 100 degrees F for the wash or rinse cycle; -Staff should notify the cook, DM, or maintenance if the dishwasher temperatures fall below 100 degrees F; -Staff should take dishwasher cycle temperatures at the beginning of every shift and document; -The sanitizer test strips should be testing at 200 pmm; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she had documented temperatures lower than 120 degrees F during the month of [DATE], but did not notify management because they were not below 100 degrees F. During an interview on [DATE], at 3:19 P.M., the DM said the following: -Dishwasher washer and rinse cycles should be over 120 degrees F; -Sanitizer test strips should show 200 pmm per the dietician; -Staff should obtain and document the temperatures and sanitation testing at the beginning of every shift; -Staff should contact the DM or maintenance if the temperatures are not high enough or sanitizer is not testing out appropriately. During an interview on [DATE], at 3:19 P.M., the Administrator said dishwasher temperatures should be 120 degrees F or above. Staff document every shift (twice daily) for temperatures and test strips. If the test-strip levels is out of range the staff should stop using the dishwasher, notify the supervisor, then go to procedure of three-compartment sink.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265705	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Community Care and Rehabilitation	200 West 12th Street Lockwood, MO 65682

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 49585 Based on interview, and record review, the facility failed ensure medical records were maintained and accurate in accordance of standards of practice when staff failed to timely document an assessment and notification of the physician for one resident (Resident #313), who fell and sustained a foot fracture. A sample of 19 residents was reviewed in a facility with a census of 62. Review of the facility policy titled, Changes in a Resident's Condition or Status, revised December 2016, showed the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition change or status. Review of the facility policy titled, Charting and Documentation, revised July 2017, showed the following: -All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. -The following information is to be documented in the resident's medical record: objective observations; medications administered; treatments or services performed; changes in the resident's condition; events, incidents, or accidents involving the resident; and progress toward or changes in the care plan goals and objectives. 1. Review of Resident #313's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included of inflammatory polyarthropathy (painful inflammation and stiffness of multiple joints), muscle weakness, repeated falls, and lack of coordination. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/10/23, showed the following: -Severe cognitive impairment; -Impairment in range of motion to upper and lower extremities; -Partial to moderate assistance with bed mobility, walking, and transfers; -Uses walker for mobility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Fall Risk Evaluation, dated 12/29/23, showed staff assessed the resident as a fall risk. Review of the resident's care plan, revised on 01/15/24, showed the following: -Required assistance of one staff for transfers, ambulation, toileting, dressing, and hygiene; -Resident was occasionally incontinent of urine and continent of bowel; -Resident was alert with confusion at times; -At risk for falls related to weakness and a history of falling; -Resident had falls on 01/27/24, 03/20/24, and 03/26/24; -Controlled Ankle Movement (CAM) boot; -Check skin every shift. Review of facility Fall Scene Investigation Report, dated 03/20/24, showed the following: -Staff found the resident on the floor near his/her bed after staff heard a crash coming from the room; -Contributing factors leading to fall noted as medical status, physical condition, diagnosis, and mood or mental status. Review of the resident's nursing progress note dated 03/20/24, at 6:30 A.M., showed the following: -The resident stated he/she poured buckets of pee on the floor, but floor appeared dry; -The resident ambulated to restroom with two staff after fall; -The resident was unsteady and crying with no tears; -Resident went to dining room for breakfast. Review of transfer record dated 03/20/24, at 12:00 P.M., showed the following: -The resident transferred to an acute care hospital due to a possible fracture of his/her left foot; -The resident was able to ambulate short distance, then complained of pain with weight bearing; -Staff noted a knot to the resident's left lateral foot. Review of hospital after visit summary dated 03/20/24, at 2:49 P.M. showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a fracture at the base of the fifth metatarsal (bone in the foot); -The resident should wear walking boot and may bear weight as tolerated. Review of the resident's nursing progress note dated 03/20/24, at 3:40 P.M., showed the following: -The resident returned to the facility from the emergency room with family; -The resident reported to staff he/she has a fracture of foot and was wearing a walking boot; -No orders or instructions were given to facility. Review of nursing notes showed staff did not document an assessment, assessment findings, or notification to physician after the fall. During an interview on 03/28/24, at 2:03 P.M., Registered Nurse (RN) N said the following: -He/she conducted a head-to-toe assessment of resident after fall and found no abnormal findings; -He/she would not document range of motion or skin assessment after a fall unless abnormal findings noted; -Resident had a flesh colored almond sized bump on outside of foot noted on the way to dining room for lunch; -Nurse contacted physician after resident complaint of pain and a bump discovered; -Resident sent out to hospital around lunch time; -He/she forgot to document physician order for transfer and assessment in chart. During an interview on 03/29/24, at 11:08 A.M., RN O said the following: -If a resident has a fall, he/she would document an assessment, obtain vital signs, complete fall paperwork, and notify the physician. During an interview on 04/01/24, at 3:27 P.M., RN T said the following: -The nurse should document the fall assessment and notifications in the nurse notes and complete an incident report and conduct neurological checks per the facility policy, if the resident sustained a head injury of the fall was not witnessed; -The nurse should assess the resident for any injuries for three days following the fall, and document in the resident's nurse notes. During an interview on 03/28/24, at 3:18 P.M., the Medical Director said he/she would expect nurses to document an assessment after a resident fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/24, at 2:38 P.M., the Director of Nursing (DON) said the nurse should document the fall, assessment, and notifications in the nurses' notes. During an interview on 04/01/24, at 12:11 P.M., the Administrator said the following: -Nurses should chart when a resident has an accident or injury at the time of the occurrence in the nurse notes; -The nurse should assess a resident for injury and notify the resident's physician, next of kin, and document in the resident's nurse notes; -The nurse should assess the resident again later if the resident develops latent signs/symptoms of injury; -Nurses should chart for 72 hours on any resident fall on the fall monitoring sheet and daily for three days in the nurse notes