STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll House	307 Grand Carrollton, MO 64633

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observation interview and record review, the facility failed to provide a dignified existence for three residents (Resident #2, #11 and #24) when the facility allowed multiple residents to remain in common areas with bare skin exposed with no staff intervention. This affected 3 out of 20 sampled residents. The facility census was 53. Review of the facility's undated Resident Rights Policy showed in part: -The resident shall be treated with consideration and respect and full recognition of their dignity and individuality. 1. Observation on 5/27/24 at 12:22 P.M. showed: -Multiple younger residents moving from table to table; -Multiple residents with their abdomen showing and upper buttocks showing; - Multiple residents yelling back an forth at each other and yelling at the kitchen; -The geriatric residents are staying seated while the younger residents are going up to the meal window yelling at the kitchen staff. 2. Review of Resident #2's Significant Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/3/24 showed: -Severe cognative impairment; -No mood behavior issues; -Maximum assist for Activities of Daily Living (ADL's -an individual's daily self-care activities such as eating, bathing, walking and transfers); -Incontinent of bowel and bladder; -Receives Hospice services; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included Alzheimer's Disease (a disease that affects the brain causing memory problems), arthritis, and high blood pressure. Review of the Resident's care plan dated 3/21/24, showed: -The resident requires the assistance of two staff for ADL's and transfers; -The resident has behaviors; -Avoid over stimulation; -Maintain a calm environment. During an interview on 05/28/2, at 04:24 P.M., the Resident's responsible party said: -It is very loud and busy at the facilty now and he/she is not sure the resident will be comfortable with the new residents; -Several of the residents are not dressed appropriately for this age group; -He/She had very little notice of the room change and that a group of younger, behavioral health residents would be moving into the facilty; -He/She has concerns that the new residents came so quickly and he/she is afraid that the younger residents will not interact the resident appropriately; -He/She has concerns that the new staff would not know how to take care of the resident; -He/She does not feel the resident would be as safe as he/she was in the past; -He/She is considering moving the resident because of this. 3. Review of Resident #11's Quarterly MDS, dated [DATE] showed: -Moderate cognative impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included heart failure, high blood pressure and high cholesterol. -Review of the resident's care plan dated 4/28/24, showed: -Provide the resident with support with ADL's; -The resident has anxiety; (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident is a Do Not Resuscitate (DNR - medical order that instructs the health care provider to not no live resuscitative measures if a persons heart stops) code status. During an interview on 05/28/24 at 03:32 P.M., the resident said: -He/She has a lot of anxiety since the new younger residents moved in to the facilty; -He/She hates to go to the dining room now because the new residents are loud and yelling at each other; -The new residents need to pull their pants up and their shirts down; -He/She does not like to see all the exposed body parts when he/she goes to the dining room; -He/She used to keep the door to his/her room open but knows it is noisy and he/she doesn't feel safe; -The staff know he/she is concerned but nothing gets done. 4. Review of Resident #24's Quarterly MDS, dated [DATE] showed: -Moderate cognative impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included diabetes mellitus (too much sugar in the blood), high blood pressure and high cholesterol. -Review of the resident's care plan dated 12/28/23, showed: -Provide the resident support with ADL's; -The resident has pain; -The resident is a DNR code status. During an interview on 05/28/2, at 03:39 P.M., the resident said: -The new residents walk around with their bottoms and stomachs showing and he/she does not like that because it is disrespectful; -The staff tell them to pull their pants up but they fall back down again; -There was a fight in the dining room at supper last night:; -He/She feels like this is not his/her home anymore; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She sets next to a resident that talks all the time and it is upsetting and the staff will not move the resident; -He/She is nervous about leaving his/her door open because of the new residents. During an interview on 05/30/24 at 04:10 P.M., the Administrator said: -He/She expects that residents in the common areas and the dining room should be dressed appropriately; -All residents should treat each other with respect; -There should be no exposed skin. MO236514

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, interview, and record review the facility failed to follow their policy when the facility did not provide four residents a written notice regarding a room change, including the reason for the room change, before the facility moved the resident to another room (Resident # 3, Resident #2, Resident #11 and Resident #24), of the 14 sampled residents . These residents did not want to be moved and were emotionally upset about the room changes. The facility's census was 53. Review of the facility policy, Room Change, dated 2017 showed: -It is the policy of this facility to promote a resident's right to make choices and to promptly receive written notice of a room change or change in an assigned roommate. The facility supports the resident's right to refuse a room change made solely for the staff's convenience. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of the facility staff, the resident, family and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate and ask questions about the move. The room change or roommate assignment change notice will be issued as much as in advance as possible upon knowledge of the need for change. Documentation of the notice and response will be included in the medical record. The notice contains the reason for the room or change, the effective date of the change and the location to which the resident will be moved. 1. Review of Resident #3 Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/18/24 showed: -Brief Interview of Mental Status (BIMS) of 15, Indicated no cognitive deficit. -No behaviors -Moderate to dependence of staff for activities of daily living (ADL's: tasks completed in a day to care for oneself such as bathing, toileting, personal hygiene) -Diagnoses of Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration.), diabetes mellitus(a group of diseases that result in too much sugar in the blood) , anxiety disorder (a feeling of fear, dread, and uneasiness), and obstructive sleep apnea (occurs when the throat muscles relax and block the airway while sleeping). Review of the resident's medical record showed: -Nurse progress notes on 5/03/2024 at 1:16 P.M. resident's daughter and resident were notified of move/room change next week by Assistant Director of Nursing (ADON). His/her family mentioned possibly changing to a private pay room. -There was no written notice of room moves. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/24 at 9:40 A.M. Resident #3 said: - He/She had to move out of his/her room so multiple new residents could move in. -He/She was previously on the 400 hall. -He/She was not given written notice. -He/She was not given a choice about moving rooms. -He/She was told one day and moved rooms 2 days later. -This had all been very distressing for him/her. 46706 2. Review of Resident #2's Significant Change MDS dated [DATE], showed: -Severe cognative impairment; -No mood behavior issues; -Maximum assist for ADL's; -Incontinent of bowel and bladder; -Receives Hospice services; -Diagnoses included Alzheimer's Disease, arthritis, and high blood pressure. Review of the resident's care plan dated 3/21/24, showed: -The resident requires the assistance of two staff for ADL's and transfers; -The resident has behaviors; -Avoid over stimulation; -Maintain a calm environment. Review of the resident's medical record showed: -Nurses note dated 5/3/24 showed the resident's responsible party was notified by phone of the room move; -No written notice of the room move was found. During an interview on 05/28/24 at 04:24 P.M., the resident's responsible party said: (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility called on 5/3/24 and said they where moving the resident to another hall so they could keep the new residents on the same hall; -The facilty did not give the resident a choice of rooms or to move; -He/she did not receive a written notice; He/she would have liked some time to talk this over more with the facilty. 3. Review of Resident #11's Quarterly MDS, dated [DATE] showed: -Moderate cognative impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included heart failure, high blood pressure and high cholesterol. -Review of the resident's care plan dated 4/28/24, showed: -Provide the resident with support with ADL's; -The resident has anxiety; -The resident is a Do Not Resuscitate (DNR - medical order that instructs the health care provider to not no live resuscitative measures if a persons heart stops) code status. Review of the resident's medical record showed: -Nurses note dated 5/3/24 showed he resident's family was notified by phone of the room move; -No written notice of the room move was found. During an interview on 05/28/24 at 03:32 P.M., the resident said: -The Assistant Director of Nursing (ADON) called on a Friday and the facilty moved him/her to another room on a Monday; -The facilty provided the resident with no written notice; -His/her family was called but nothing in written was provided to either of them; -He/she was not given a choice of a room or the choice to move; -The facilty just said his/her new room would be a certain number; -He/she would have like more notice before the room change. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #24's Quarterly MDS, dated [DATE] showed: -Moderate cognative impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included diabetes mellitus (too much sugar in the blood), high blood pressure and high cholesterol. -Review of the resident's care plan dated 12/28/23, showed: -Provide the resident with support with ADL's; -The resident has pain; -The resident is a DNR code status. Review of the resident's medical record showed: -Nurses note dated 5/3/24 showed he resident's responsible party was notified by phone of the room move; -No written notice of the room move was found. During an interview on 05/28/24 at 03:39 P.M., the resident said: -The staff told him/her to get ready to move to another room and only gave us a few days notice; -The staff did not let him/her choose a room the facilty told him/her the room he/she would be in; -He/she did not receive a written notice of the room move; During an interview on 05/30/24 at 02:25 P.M., the resident's family member said: - He/she did not receive a written notice of the facilty was going to move the resident; - He/she was verbally notified of the room move while at the facilty; - The facilty did not give the resident a choice of a room or the choice to move at all, the facilty said they were moving the resident; - He/she would have liked advanced notice in writing. During an interview on 05/30/24 at 04:10 P.M., the Administrator said: (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The notification of the room moves are documented in the nurses notes of the residents that were here prior to the new residents admitting; -Residents should be provided a a written notice regarding a room change, including the reason for the room change, before the facility moved the resident to another room.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on interview and record review, the facility failed to clarify the status of the Resident #11's Do Not Resuscitate Order (DNR, medical order that instructs the health care provider not to do resuscitative measures if a person's heart stops) when the resident's responsible party signed the revocation provision of the DNR, with out changing the order on the resident's Physician's Order Sheet (POS) to Full Code Status. This affected one resident (Resident #11). The facilty census was 53. Review of the facilty's Advanced Directive Policy, dated March 2015, showed: -The social services designee will inquire of the resident and/or his/her family members about the existence of any written advanced directives information; -Advanced directive shall be displayed prominently in the medical record under the advanced directive tab. 1. Review of the resident's DNR showed: - 10/16/23, The resident's responsible party signed the revocation provision, revoking the resident's DNR code status. Review of Resident #11's Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 4/28/24 showed: -Moderate cognative impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included heart failure, high blood pressure and high cholesterol. -Review of the resident's care plan dated 4/28/24, showed: -admitted [DATE]; -Provide the resident with support with ADL's; -The resident has anxiety; -The resident is a DNR. Review of the residents POS dated 5/1/24 showed: -Order Start date 10/16/23: Code Status - DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 09:55 A.M., Administrator said: -Social Services usually takes care of this and he/she is not here today; -If the resident is a DNR there should be an order on the POS that states the resident is a DNR; -If the revocation provision is signed that means the resident is no longer a DNR but is a full code and live saving measures would be given; -He/She expects the Social Service Director to ensure any discrepancy on the DNR is clarified; -He/She expects the DNR form to be filled out correctly.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 The facility failed to provide a comfortable and home -like environment for four of 20 sampled residents (Resident #2, #11, #22 and #24) when they failed to ensure sound levels were not loud and uncomfortable in the dining room, when a resident was yelling and staff failed to intervene, and when the facility failed to ensure the door to the smoking area did not slam shut when residents went in and out and caused distress for one resident (resident #24). The facilty census was 53. Review of the facility's undated Resident Rights Policy showed: -The resident shall be treated with consideration and respect and full recognition of their dignity and individual preferences. The facility did not provide the requested policy regarding a comfortable and homelike environment. 1. Observation on 5/27/24 at 12:22 P.M. showed: -Multiple younger residents moving from table to table; - Multiple residents yelling back an forth at each other and yelling at the kitchen staff; -The geriatric residents stay seated while the younger residents are going up to the meal window yelling at the kitchen staff. 2. Review of Resident #2's Significant Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 4/3/24 showed: -Severe cognitive impairment; -No mood behavior issues; -Maximum assist for Activities of Daily Living (ADL's, an individual's daily self-care activities such as eating, bathing, walking and transfers); -Incontinent of bowel and bladder; -Receives Hospice services; -Diagnoses included Alzheimer's Disease (a disease of the brain that affects memory and reasoning), arthritis, and high blood pressure. Review of the Resident's care plan dated 3/21/24, showed: -The resident required the assistance of two staff for ADL's and transfers; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had behaviors; -Avoid over stimulation; -Maintain a calm environment. During an interview on 05/28/24 at 04:24 P.M., the Resident's responsible party said: -It is very loud and very busy at the facilty now. - He/She has concerns that the new residents came so quickly and he/she was afraid the younger residents will not interact with the resident appropriately; - He/She said he/she talked to an employee and a lot of their staff are being replaced by the staff from another facilty and do not know how to take care of mental health residents; -He/She said he/she had concerns that the people would not know how to take care of the resident; -The resident has the right to a home like environment. 3. Review of Resident #11's Quarterly MDS, dated [DATE] showed: -Moderate cognitive impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included heart failure, high blood pressure and high cholesterol. -Review of the Resident's care plan dated 4/28/24, showed: -Provide the resident with support with ADL's; -The resident has anxiety; -The resident is a Do Not Resuscitate (DNR - medical order that instructs the health care provider to not no live resuscitative measures if a persons heart stops) code status. During an interview on 05/28/24 at 03:32 P.M., the Resident said: -He/She has a lot of anxiety since the new residents moved in; -Meals are late he/she hates to go to the dining room because he/she has to set by those people; -He/She needs help at meals and the old staff would take the time to help him/her but the new staff said they do not have time; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She used to keep the door to his/her room open but does not feel like it is safe to do so anymore; -The door to the smoke area keeps slamming shut and he/she can hear it even with his/her door shut; -His/Her family is going to move him/her out of the facility because he/she just can't take it. 4. Review of Resident #22's Annual MDS, dated [DATE] showed: -Moderate cognative impairment; -No mood or behavior issues; -Maximum assist for ADL's; -Diagnoses included Cerebral palsy (disorder of movement, muscle tone or posture) high blood pressure and anxiety. Observation of the dining room on 5/28/24 at 1:15 P.M., showed: -Resident #179 was pacing on 200 hall and was talking on the phone, yelling loudly and cursing; -Residents are sitting in the dining room nearby and were looking at the resident pacing and yelling on 200 hall; -Staff are sitting at the dining room tables assisting residents with eating; -The staff did nothing to intervene and no staff responded to resident #179 that was yelling on 200 hall; -Resident #22 asked to be removed from the dining room because of the noise and told staff it increased his/her anxiety and he/she did not eat. During an interview on 5/29/24 at 11:17 A.M., Certified Nurses Aide (CNA) A said: -He/She had no education about dealing with mental health residents; -He/She was setting at a table when Resident #179 got upset and was yelling and he/she didn't do anything because he/she didn't know what to do; -He/She was afraid to say anything incase Resident #179 flipped out on him/her; -It really overstimulated Resident #22 and he/she was crying and acting out then he/she yelled because he/she was so upset with the other residents yelling; - A lot of our geriatric residents have left because of the new residents. During an interview on 5/30/24 at 11:31 A.M., CNA B said: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was here when Resident #179 got upset and he/she did not know what to; -He/She received no training; 5. Review of Resident #24's Quarterly MDS, dated [DATE] showed: -Moderate cognative impairment; -Supervision for ADL's; -Occasionally incontinent of urine; -Diagnoses included diabetes mellitus (too much sugar in the blood), high blood pressure and high cholesterol. -Review of the resident's care plan dated 12/28/23, showed: -Provide the resident with support with ADL's; -The resident has pain; -The resident is a DNR code status. Observation of 300 hall on 5/28/24, from 1:35 P.M. to 1:46 P.M., showed: -Resident #24 is in his/her room setting in a chair; -Multiple residents standing in the hall near the resident's room by the smoke room door; -Multiple residents walk out into the smoking area and the door loudly slams shut behind them; -1:39 P.M., a resident comes back inside from the smoke area and the door loudly slams shut; -1:41 P.M., a resident comes back inside from the smoke area and the door loudly slams shut; -1:42 P.M., a resident comes back inside from the smoke area and the door loudly slams shut; -1:45 P.M., a resident comes back inside from the smoke area and the door loudly slams shut; -1:46 P.M., a resident comes back inside from the smoke area and the door loudly slams shut. During an interview on 05/28/24 at 03:39 P.M., the resident said: -The resident that sets next to him/her at meals talk all the time and it upsets him/her and the staff will not move him/her. -The big problem is out side his/hers room is the door to their smoking area and the door slams hard every time someone goes in and out; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She goes to bed around 7:00 P.M. and the door is still slamming; -The slamming door makes him/her nervous; -He/She has told the staff about his/her concerns but nothing has been done so far. During an interview on 05/30/24 at 10:40 A.M., the resident said: -He/She is hearing the door close to the smoke area; -He/She has told the staff again but doesn't not remember who; -He/She liked things the way they were at the facility before the new residents came. During an interview on 5/30/24 at 11:31 A.M., CNA B said: -Some of the residents choose to stay in their rooms because of the noise and too much going on around them; -It gets pretty loud sometimes and he/she does not know how to make it any quieter or any better. During an interview on 05/30/24 at 04:10 P.M., the Administrator said: -He/She expects to have peaceful quiet areas in the facilty; -If the noise level is loud the staff ask the residents to turn down the noise level; -We try to keep the loud residents together and we cannot tell them they can't yell; -No one should be that uncomfortable in their own home.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44993 Based on observation, interview and record review, the facility failed to assure resident Minimum Data Set assessments were completed accurately and timely for three of 14 sampled residents (Residents #177, #78 and #80). The facility census was 53. Review of the facility provided Minimum Data Set and Care Planning Guidelines, dated 10/1/2015 included; It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, any published Interim RAI manual errata documents and applicable federal guidelines as the authoritative guide for completion of the MDS, CAAs and resident care planning. 1. Review of Resident #177's face sheet showed: - The resident admitted to the facility on [DATE]; - Diagnoses included: Schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), falls, pain in the right wrist, shortness of breath, generalized abdominal pain, nausea, diarrhea, pain, depressive episodes, low back pain, cough, bipolar disorder, migraine headaches, chronic obstructive pulmonary disease (a group of diseases that affect the lungs), diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), and anxiety. Review of the resident's medical record showed: -No completed MDS in the resident chart. -No care plan in his/her chart. 44395 2. Review of Resident #78 Face sheet showed: -He/she admitted to the facility 5/7/24 -Diagnoses of Schizoaffective Disorder, Edema (swelling) , Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), Morbid Obesity (more than 80 to 100 pounds above their ideal body weight), Paranoid Personality Disorder (a mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason to be suspicious) , Pervasive Developmental disorder (characterized by delays in the development of social and communication skills) , Insulin dependent Diabetes Mellitus, Anxiety, Schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed: -No completed MDS in the resident chart. -No care plan in his/her chart. 3. Review of Resident #80 Face sheet showed: -He/she admitted to the facility on [DATE] Diagnoses of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions.), difficulty walking, Cognitive Communication Deficit (difficulty understanding what is said, or inability to respond in a timely fashion), Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), seizures (a sudden, uncontrolled burst of electrical activity in the brain), dermatitis (a common condition that causes swelling and irritation of the skin) , Kidney failure (a condition in which one or both of your kidneys no longer work on their own), Schizoaffective Bipolar type (a mental disorder characterized by episodes of mania (extreme highs) and sometimes major depression (severe lows)). Review of the resident's medical record showed: -Entry tracking record completed 5/8/24 -No completed MDS in the resident chart. -No care plan in his/her chart. 4. During an interview on 05/30/24 at 10:00 A.M. the MDS Coordinator said: -Admission MDS Assessments should be completed within 14 days and submitted within 21 days. -If the MDS was started it would show in progress in the medical record. During an interview on 05/30/24 at 4:10 P.M. with the Director of Nursing and the Administrator : -The DON said admission MDS should be completed in 14 days. Residents who admitted on [DATE]th, 8th, or 9th should have had a completed MDS. -The administrator said residents should have had a MDS completed within 14 days of admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44395 Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents, for three of 14 sampled residents (Residents #8, #78 and #80). The census was 53. Review of the facility provided Minimum Data Set and Care Planning Guidelines, dated 10/1/2015 showed: It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, any published Interim RAI manual errata documents and applicable federal guidelines as the authoritative guide for completion of the MDS, CAAs and resident care planning. 1. Review of Resident #8 Admission MDS 5/1/24 showed: -admitted [DATE]; -Brief Interview of Mental Status (BIMS) of 14, indicated No cognitive deficits. -Vision was severely impaired , he/she wore corrective lenses; -Assist of 1-2 staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); -Continent of bowel and bladder; -Diabetic foot ulcers (wounds that are caused by the diabetes disease process); -Pressure reduction devices for the bed and chair; -Diagnoses of Unspecified fracture of right acetabulum (broken hip), fracture of the great toe, repeated falls, Constipation, Anxiety disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities), chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe.), hemiplegia (muscle weakness or partial paralysis on one side of the body) and hemiparesis (inability to move on one side of the body) following cerebral infarction (stroke), hypertension, Diabetes Mellitus (A group of diseases that result in too much sugar in the blood) with diabetic neuropathy (nerve damage that can occur if you have diabetes), chronic kidney disease(CKD: gradual loss of kidney function.), atrial fibrillation (a rapid and irregular heart beat), and peripheral vascular diseases (condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the medical record showed no comprehensive care plan for Resident #8. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #78 Face sheet showed: -He/She admitted to the facility 5/7/24; -Diagnoses of Schizoaffective Disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), edema (swelling) , Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), morbid obesity (more than 80 to 100 pounds above their ideal body weight), paranoid personality disorder (a mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason to be suspicious) , pervasive developmental disorder (characterized by delays in the development of social and communication skills), insulin dependent Diabetes Mellitus lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels). anxiety, schizophrenia (A disorder that affects a person's ability to think, feel, and behave clearly). Review of the resident's medical record showed: -No completed MDS in the resident chart. -No care plan in his/her chart. 3. Review of Resident #80 Face sheet showed: -He/she admitted to the facility on [DATE]; Diagnoses of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions.), difficulty walking, cognitive communication deficit (difficulty understanding what is said, or inability to respond in a timely fashion), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye), Parkinson's Disease, seizures (a sudden, uncontrolled burst of electrical activity in the brain), dermatitis (a common condition that causes swelling and irritation of the skin) , kidney failure (a condition in which one or both of your kidneys no longer work on their own), and schizoaffective bipolar type (a mental disorder characterized by episodes of mania (extreme highs) and sometimes major depression (severe lows)). Review of the resident's medical record showed: -Entry tracking record completed 5/8/24 -No completed MDS in the resident chart. -No care plan in his/her chart. During an interview on 05/30/24 at 10:00 A.M. the MDS Coordinator said: -Admission MDS Assessments should be completed within 14 days and submitted within 21 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If the MDS was started it would show in progress in the medical record. -Care Plans are completed after the MDS, within 7 days. During an interview on 05/30/24 at 4:10 P.M. with the Director of Nursing and the Administrator: -The DON said admission MDS should be completed in 14 days. Care plans are completed 7 days after the MDS is completed. -The administrator said residents should have had a MDS completed within 14 days of admission and a care plan within another 7 days. The process is 21 days total.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44395 Based on observation, interview, and record review the facility failed to train staff to adequately care for one resident (Resident #179) with behavioral health care needs, causing Resident #22 to feel unsafe within the facility. The facility census was 53. The facility did not provide a policy on education and competency. Review of education records for Certified Nurse Aide (CNA) A and B for August 2023-May 2024 showed no education on psychiatric illness and interventions. 1. Review of Resident #179 medical record showed: -admitted on [DATE]; -Diagnoses of: Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Post Traumatic Stress Disorder (a mental health condition that's triggered by a terrifying event - either experiencing it or witnessing it), Autism (developmental disorder that affects how people interact with others, communicate, learn, and behave); -No base line care plan, no comprehensive care plan, no Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff). 2. Review of Resident #22 Annual MDS dated [DATE] showed: -Brief Interview of Mental Status (BIMS) of 12, indicated slight cognitive loss; -No behaviors; -Maximum assistance to dependence on staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself); -Diagnoses of Cerebral Palsy (a group of conditions that affect movement and posture; caused by damage that occurs to the developing brain, most often before birth), Anxiety (a feeling of fear, dread and uneasiness), Hypertension (high blood pressure) and spastic quadriplegia (a permanent nerve and muscle disorder causing limitations with severe involvement of the legs and arms and floppiness of the neck.); 3. Observation on 05/28/24 at 1:15 P.M. showed -Resident #179 was pacing the 200 hall; -He/She was yelling loudly, and cursing into the telephone; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Multiple residents were sitting in the dining room, completing the noon meal, and watching resident #179; -CNA A was sitting at a dining table assisting residents to eat and observed resident #179 multiple times, and did not respond; -CNA B was sitting at a dining table assisting residents to eat and observed resident #179 multiple times and did not respond; -Resident #22 asked CNA B if he/she could assist him/her to his/her room. -CNA B assisted Resident #22 to his/her room and returned to the table. He/She did not respond to resident #179 pacing, cursing and yelling. During an interview on 5/29/24 at 9:34 A. M . Resident #22 said: -He/She had to be taken from the dining room because it was too loud and upsetting. During an interview on 5/29/24 at 11:04 A.M. CNA C said: -He/She transferred to this facility from another facility; -He/She had a quick reminder of how to use gloves and infection control prior to moving to the facility; - He/She did not get any further training. During an interview on 5/29/24 at 11:17 A.M. CNA A said: -He/She has been working at the facility for the last 8 to 9 months; -He/She was not provided any education on care of residents with psychiatric conditions; -He/She was sitting at the middle table when Resident #179 got upset and was yelling; -He/She did not do anything because he/she did not know what to do; -He/She was afraid to say anything to Resident #179 in case he/she flipped out; -It was really over stimulating. Resident #22 was crying and had to be taken to his/her room and did not finish his/her meal. During an interview on 5/30/24 at 11:31 A.M. CNA B said: -He/She was at a dining room table when resident #179 was pacing, yelling and cursing on the phone; -He/She did not know what to do to intervene; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had no training for behavior management and psychiatric conditions. During an interview on 5/30/24 at 4:10 P.M. with the Administrator and the Director of Nursing (DON): The Administrator said: - Staff absolutely need training how to deal with agitated residents and psychiatric disorders; -He/She is unsure what education staff have completed; - Registered Nurse A completes all education; -He/She and the DON will track all training; -He/She expects competency to be completed at least every 12 months, or quarterly as needed for issues. The DON said: He/She did not know what education had been completed prior to his/her arrival last week; -Competency should be completed annually. MO236514

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46706 Based on observation, interview, and record review, the facility failed to ensure staff stored food in a sanitary manner and failed to maintain the kitchen in a sanitary manner when floors, and vents were covered in dirt and debris, and when equipment in the kitchen was covered in dust and when the dry storage contained outdated food and hazardous chemicals and when the facilty failed to ensure the dishwasher sanitizer was checked before meal service. This could potentially impact all residents by dirt or debris coming in contact with food and food preparation areas and food being served on contaminated dishes. Additionally outdated food can be potentially hazardous due to spoilage. The facility census was 53. Review of the facility's Safe Food Handling Policy, dated 5/20/15, showed: -All food items should be stored and tightly sealed with an identifying label and date. Review of the facilty's Storage of Dry Food and Supplies Policy, dated 5/20/15, showed: -The store room must be neat and orderly; -Store chemicals in an area separate from food storage. Review of the facilty's Dish Wash Policy, dated 5/20/15, showed: -Check chemical dispensers for adequate supply of chemical three times a day. The facilty did not provide the requested policy on cleaning of the vents in the kitchen. 1. Observation on 05/29/24 at 10:44 A.M., showed: - An open package of noodles dated 2024; -Vent by the plastic storage container with the cleaning rags was covered with dust and debris; -Trash can between the refrigerators was open and overflowing with food particles running down the sides; -Two empty card board boxes, a fan covered with dirt and debris, a bucket containing a black liquid with a mop standing in it next to a food storage rack; -A vacuum cleaner and scattered papers on the floor in front of the storage rack that contained [NAME] crackers coffee and cocoa; -A step ladder covered with dust setting next to the refrigerator; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The dishwasher sanitation log had no entries on 4/7/24, 4/24/24, 4/25/24. 4/31/24 and 5/9/24 through 5/29/24. -The floor in the dry storage room was dirty and sticky; -The trash can in the dry storage room was overflowing: -There was a can of unopened bleach powder and three gallons of germicidal bleach setting on a rack in the dry storage where other foods were stored; - Storage bin with sugar dated 3/15/22 and a storage bin containing flour dated 2/22/22; -Open package of rice with no date. During an interview on 5/29/24 at 1:22 P.M., the Dietary Manager (DM) said: - Maintenance is responsible for cleaning the vents in the kitchen; -He/She puts a maintenance order either in the binder or by word of mouth and that is how it is reported; -The vents should be cleaned at least every two or three months. He/She cleaned the vents the last time they were cleaned but could not remember when; -There should be no sticky substances on the floors in the kitchen; -Chemicals shouldn't be stored with food in the dry storage room; -The trash can should not be overflowing in the kitchen or in the dry storage room and the lid to the trash can should be closed. The trash cans should be clean free of food debris and dripping debris; -The stepladder should not be in the kitchen and if it is it should be clean; -The vacuum, the box fan covered in dust, the brooms and debris on the floor by where the [NAME] crackers were stored shouldn't be in the kitchen; -The sanitizer for the dishwasher should be checked three times a day before meal service; -The bins with the sugar and the flour in the dry storage should not be dated older than one year. During an interview on 5/29/24 at 1:50 P.M., the Registered Dietitian (RD) said: -He/She expected the kitchen to be clean and free of dirt and debris; -He/She expected the vents to be clean and free of debris and chemicals should not be stored in the dry storage room with food; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The trash should be emptied before it becomes overflowing the trash can lid should not stand open; -The dates on the sugar and flour should not be later than one year; -He/She expected the sanitizer concentration in the dishwasher to be recorded before every meal service; -The unnecessary clutter of the fan, the empty boxes and the brooms should be removed from the kitchen; -He/She expected the kitchen to be clean and sanitary. During an interview on 5/29/24 at 2:14 P.M., the maintence department said: -He/She was not sure how often the vents should to be cleaned in the kitchen; -The kitchen staff takes care of cleaning the vents in the kitchen; -Any work orders for maintence are put in a book but generally are given by word of mouth; -No work orders for cleaning the vents in the kitchen have been received. During an interview on 5/29/24 at 4:10 P.M., the Administrator said: -He/She expected the kitchen staff to keep the kitchen clean and sanitary; -He/She expected the kitchen staff to make sure the food is stored properly; -He/She expected the sanitizer in the dishwasher to be checked before meals; -The kitchen staff were responsible for reporting any repairs to maintenance.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46706 Based on record review and interview, the facility failed to review and update their facility-wide assessment to determine what resources are necessary to care for their residents competently during day to day operations and emergencies. The facility census was 53. The facility did not provide the requested policy regarding maintaining a facility assessment. 1. Review of the facility's 802/Matrix (a tool used by facilty staff to identify pertinent care areas for residents living in the facilty), dated 5/27/24 showed: -32 residents with behavior health needs; -The facilty census was 53. Review of the facility assessment, provided by the facility, showed: -The name of the administrator was incorrect; -Assessment review date with the Quality Assurance and Assessment/ Quality Assurance and Performance Improvement (QAA/QAPI) committee was 12/14/22; -Annual review date was 2/2/23; -The average daily census was 20; -Three residents with behavior health needs; -The information provided was incorrect. During an interview on 5/30/2024 at 4:10 P.M., the Administrator said: - The facility assessment has not been updated to reflect recent changes at the facility, including change of administrator; -The facility assessment should be completed within seven to fourteen days after a change; - It is the Administrator's responsibility to ensure the facility assessment is reviewed regularly and updated as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265706	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll House	307 Grand Carrollton, MO 64633

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44993 Based on observation and interviews the facility failed to maintain infection control when two of 14 sampled resident's (Resident #177 and #178), nebulizer machines (a machine that turns liquid medication into a mist and is inhaled) and tubing were resting on the floor without a barrier. Additionally Resident #178's continuous positive airway pressure (CPAP) mask was observed resting on the floor and not on a barrier. The facility census was 53. The facility did not provide a policy regarding placement of nebulizer machines and CPAP mask's. 1. Review of Resident #177 record showed the following: -The resident was admitted to the facility on [DATE]; - Diagnoses included: Chronic obstructive pulmonary disease (COPD, a group of diseases that affects breathing), cough, and anxiety; - No Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff) or care plan had been completed; - A physicians order dated 5/21/24 for ipratropium- albuterol (a medication used to help make breathing easier and administered with a nebulizer machine) solution for nebulization 0.5 milligram (mg) -3 mg per vial. Administer 1 vial with the nebulizer machine every 6 hours as needed. Observation on 5/28/24 at 9:43 A.M. showed the resident's nebulizer machine sitting directly on the floor. The tubing and mouthpiece were lying on the floor. There was no barrier. During and interview and observation on 5/29/24 at 7:57 A.M. showed: - The resident's nebulizer machine on the floor with the tubing and mouth piece on the floor; - The resident said the nebulizer on the floor was the most convenient place for him/her because he/she did not have a table to set the nebulizer machine on; - If he/she had a table, he/she would store it on the table. 2. Review of Resident #178's record showed the following: - The resident was admitted to the facility on [DATE]; - Diagnoses included: Shortness of breath, cough and anxiety; - The resident's baseline care plan showed the resident used a CPAP machine; - No MDS or comprehensive care plan; (continued on next page)

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	265706	A. Building B. Wing	05/30/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Physician's order dated 5/26/24 for ipratropium-albuterol 0.5 mg-3 mg per vial. Give 1 vial with a nebulizer machine every 6 hours as needed; - Physician's order dated 5/16/24 to clean the CPAP weekly on Sundays, including the head gear and tubing, filter, and distilled water chamber. Observation on 5/28/24 at 9:08 A.M. showed: - The resident's nebulizer machine, tubing and mouth piece on the floor with no barrier; - The resident's CPAP mask was lying on the floor with no barrier. Observation on 5/29/24 at 10:22 A.M. showed: - The resident's CPAP mask on the floor without a barrier; - The resident's nebulizer machine and tubing was lying on the floor with no barrier. During an interview on 5/29/24 at 11:00 A.M. the resident said he/she stored the nebulizer machine and his/her CPAP mask on the floor because he/she did not have a table to store them on. 3. During an interview on 5/30/24 at 9:3.1. the Infection Preventionist said: - He/She expected all nebulizer machines with their tubing and CPAP masks to be off of the floor; - There should be an elevated surface available for the resident to store those items; - Nebulizer tubing, mouth pieces and CPAP masks should not touch the floor and should be wrapped in a disposable bag. During an interview on 5/30/24 at 4:10 P.M., the administrator and Director of Nursing (DON) said nebulizer machine, tubing and CPAP masks should be in a bag and not on the floor.

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	265706	A. Building B. Wing	05/30/2024

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 44395 Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year, failed to provide nurse aide's annual individual performance review or evaluation and competency,and failed to implement a tracking system for monitoring training hours. This effected two of two sampled nurse aides (Certified Nurse Aide; (CNA) D and CNA E) and had the potential to effect all staff and residents. The facility's census was 53. The facility did not provide a policy on education and competency. 1. Record review of the in-service records for CNA D showed: - A hire date of 6/15/2021; -Had less than twelve hours of in-service education per year; -No annual competency for 2023. 2. Record review of the in-service records for CNA E showed: -A hire date of 11/3/2023 with a previous hire date of 4/10/2014; -Had less than twelve hours of in-service education; -No annual competency. During an interview on 05/30/24 at 4:10 P.M. with the Director of Nursing and the Administrator said: -The Administrator said she started work at this facility a week ago; -Staff absolutely need training, particularly on how to deal with psychiatric illness and behaviors; -Registered Nurse (RN) A puts out booklets for education he/she wants the staff to have; -The DON and she will track training; -Competency should be completed annually or quarterly if there was an issue; -The DON said she began working at the facility a week ago; -She was not sure what education had been provided previously; -There was no tracking system for individual staff; (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Competency should be completed at least yearly or as needed.