STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265730	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Manor Care Center	1622 East 28th Street Trenton, MO 64683

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44939 Based on interview and record review, the facility failed to notify the responsible party or physician of a change in condition for four residents (Residents #1, #3, #4, and #5). The facility census was 84. Review of the facility Notification of Changes policy, dated 2023, showed: -The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification. -The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member/legal representative when there is a change requiring notification, such as: --Accidents resulting in injury or have the potential to require physician intervention; --Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status; --Circumstances that require a need to alter treatment, including new treatments or discontinuation of current treatment. 1. Review of Resident #1's Annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 9/22/24, showed: -Diagnoses of bradycardia (excessively low heart rate), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), repeated falls, weakness and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). -He/she scored 4 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). A score of 4 indicates severely impaired cognitive abilities. -He/she had no impairment to arms or legs and uses a manual wheelchair for ambulation. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she required partial to extensive assistance with activities of daily living, including bathing, toileting, dressing and personal hygiene. -He/she had two or more falls since admitting to the facility. -He/she had falls prior to admission to the facility and two or more falls at the facility since admission. Review of the resident's electronic progress note, dated 10/15/24, showed a fall assist was called to resident's room. Upon entering the room resident noted to be laying prone on the floor. Assistant Director of Nursing (ADON) and Wound Nurse (WN) rolled resident and noticed blood. Resident assessed for injuries after blood noted. Resident noted to be bleeding from forehead, left hand, and bilateral elbows. Resident's vitals taken. WN called EMS for resident to be sent to the local hospital for evaluation and treatment. Director of Nursing (DON), Administrator, Primary Care Physician (PCP) notified of fall. During an interview on 10/23/24 at 11:44 A.M., the resident's PCP said: -He/she was not notified of the fall on 10/15/24. -He/she was not aware the resident had fallen until he/she read it in the emergency room records. -It is his/her expectation that he/she be notified of any falls and injuries a resident sustains at the facility. During an interview on 10/22/24 at 3:45 P.M., the WN said: -He/she was charge nurse the morning of 10/15/24. -Although he/she documented in the resident's progress notes on 10/15/24 the PCP was notified of fall, he/she did not notify the PCP. He/she forgot because he/she was concerned about getting the resident to the hospital. 2. Review of Resident #3's admission Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 8/9/2024, showed: -He/she has adequate hearing, clear speech. He/she was able to make self understood and understand others. -He/she scored 11 on the BIMS. A score of 11 indicates moderately impaired cognitive skills. Review of the resident's electronic medical record showed: -The resident had a legal guardian. - The resident tested positive for COVID (a respiratory infection) on 10/1/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no documentation noting the resident's legal guardian was notified the resident tested positive. During an interview on 10/21/24 at 12:15 P.M., Resident #3's legal guardian said he/she was not notified the resident had tested positive for COVID. 3. Review of Resident #4's quarterly MDS, dated [DATE], showed: -He/she had clear speech, adequate hearing. He/she is able to make self understood and understand others. -He/she scored 11 on the BIMS. A score of 11 indicates moderately impaired cognitive skills. Review of Resident #4's electronic medical record showed: -The resident had a legal guardian. -He/she tested positive for COVID on 10/14/24. -There was no documentation noting the resident's legal guardian was notified the resident tested positive. During an interview on 10/21/24 at 12:21 P.M., Resident #4's legal guardian said he/she was not notified the resident had tested positive for COVID. 4. Review of Resident #5's quarterly MDS, dated [DATE], showed: -He/she had adequate hearing, clear speech. He/she was able to make self understood and understand others. -He/she scored 15 on the BIMS. A score of 15 indicates no cognitive impairment. Review of Resident #5's electronic medical record showed: -The resident had a legal guardian. -The resident tested positive for COVID on 10/1/24. -There was no documentation noting the resident's legal guardian was was notified the resident tested positive for COVID. During an interview on 10/21/24 at 10:40 A.M., Resident #5's legal guardian said he/she was not notified the resident tested positive for COVID. 5. During an interview on 10/31/24, the Interim DON said it was his/her expectation that anytime a resident has a change in condition, the resident's family and physician are to be notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/24, the Administrator said it is his/her expectation that when a resident has a change in care, change in treatment or decline, the staff are to notify the resident's family/responsible party and physician. MO242987

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44939 Based on interview and record review, the facility staff failed to follow policy and report an injury of unknown origin to the administrator or state survey agency when Licensed Practical Nurse (LPN) A discovered one resident (Resident #1) to have multiple bruises of unknown origin on or about 10/13/2024 on the resident's sides and lower breasts. The facility census was 84. Review of the facility's Abuse and Neglect policy, dated 9/17/2024, showed: -It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timelines. -Injuries of an unknown source includes circumstances when both the following conditions are met: --The source of the injury was not observed by any person or could not be explained by the resident. --The injury is suspicious because of the extent of the injury, location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. -Guidelines: --The facility will develop and operationalize policies and procedures for screening and training employees, protection or residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure the the facility is doing all that is within its control to prevent occurrences. --Training: New employees will be educated by the department manager, or designee, on issues related to abuse prohibition, practices and abuse reporting requirements during initial orientation. Annual education and training will be provided to all existing employees. Front line supervisors will provide education as situations arise. --Prevention: The facility will provide residents, families, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution, and will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. --Identification: The facility will identify events, occurrences, patterns and trends that may constitute mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property as defined above. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's Annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 9/22/24, showed: -He/she had diagnoses of bradycardia (excessively low heart rate), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), repeated falls, weakness and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). -He/she scored 4 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). A score of 4 indicates severely impaired cognitive abilities. -No impairment to arms or legs and used a manual wheelchair for ambulation. -He/she required partial to extensive assistance with activities of daily living, including bathing, toileting, dressing and personal hygiene. -He/she had two or more falls since being admitted to the facility. -He/she was not at risk or had any unhealed pressure ulcers/injuries. Review of the resident's comprehensive care plan, dated 3/18/24, showed no problems or interventions related to skin integrity. Review of the resident's facility Skin Checks showed: -9/26/24: The resident's skin was warm and dry, turgor (skin's elasticity) was within normal limits. The resident had no skin issues. -10/9/24: The resident's skin was warm and dry, turgor was within normal limits. The resident had no skin issues. -10/15/24: New laceration to forehead, resulting from a fall. No other skin issues noted. Review of the resident's medical records from a local hospital, dated 10/15/24, showed: -The resident was sent to the hospital after experiencing a fall at the facility. -Upon admission to the hospital, emergency room staff noted the resident had large bruises to each side of his/her body, just below the armpit, and to the lower part of each breast. The bruises varied in color from dark purple to yellowing. During an interview on 10/24/24 at 9:46 A.M., LPN A said: -LPN A worked the overnight shift from 10/13/24 into 10/14/24 and had gone into the resident's room to check on the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A noted large bruises to each of the resident's sides, just below the armpit and the bottom of the resident's breasts. -The bruises were not there when LPN A worked on 10/10/24. LPN A asked the staff working the night of 10/13/24, but no one had any information of how the bruises occurred. -LPN A did not document the bruises or notify the Director of Nursing (DON) or Administrator of the bruises. He/she did not notify administration of the bruising as LPN A got busy caring for other residents and it slipped his/her mind. During an interview on 10/22/24 at 11:34 A.M., Certified Nursing Assistant (CNA) A said: -He/she was not aware of any bruising on the resident. -If CNA A were to observe any bruises or injuries to a resident, he/she would notify the charge nurse, DON, or Administrator. -He/she received education from the facility regarding abuse and neglect, and reporting injuries during orientation. During an interview on 10/22/24 at 11:53 A.M., Nursing Assistant (NA) A said: -Bruises should be reported to the charge nurse or administrator as soon as possible. -On 10/15/24, NA A and CNA A were providing care to the resident. NA A took off the resident's soiled gown and noted bruising to the resident's sides and breasts. -NA A had not noticed the bruises before and did not know how the resident received these bruises. -NA A did not report the bruising to the charge nurse or administration. During an interview on 10/22/24 at 3:45 P.M., the Wound Nurse (WN) said: -The resident had fallen on the morning of 10/15/24 and the WN and Interim DON transferred the resident from the floor back to the wheelchair. -At that time, the WN noted the resident had bruising to one of the resident's breasts. He/she did not note any bruising to the other breast. The WN had no knowledge of the bruising before the morning of 10/15/24 and did not know where the bruises came from. -He/she did not report the bruising to administration as the staff were busy caring for Resident #1 and getting him/her sent to the hospital. -He/she received education regarding abuse and neglect and reporting bruising and injuries during orientation. -Staff are to report injuries to the charge nurse, DON, or administrator immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 9:14 A.M., Hospital Registered Nurse (HRN) A said upon admission to the hospital, HRN A noted large bruises to either side of the resident's upper body, from just below either armpit to the lower area of each breast. The bruising varied in color from dark purple to yellowing. During an interview on 10/22/24 at 4:45 P.M., the Assistant Director of Nursing (ADON)/Interim DON said: -He/she noted the bruising to Resident #1 on 10/15/24, after the resident fell and the WN and ADON were transferring the resident from the floor to the wheelchair. -The ADON did not know how the resident got the bruises. -They did not make a report to the state agency for the bruises of unknown origin. -It is his/her expectation that anytime a staff member notes bruises or injuries to a resident, the staff member notifies the charge nurse, ADON or Administrator. -The ADON, DON or Administrator should make a report to the State as soon as possible. During an interview on 10/24/24 at 11:44 A.M., the resident's Primary Care Physician said he/she had not been notified of the resident's bruising until he/she read the hospital records on 10/15/24. During an interview on 10/24/24 at 5:30 P.M., the Administrator said: -He/she did not know Resident #1 had bruises to his/her sides and breasts. -It is his/her expectation that staff report any injuries or bruises to the charge nurse or administration so the injuries can be reported to the state survey agency. -The ADON, DON or Administrator should make a report to the State as soon as possible. MO243716, MO243656, MO243662, MO243797

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44939 Based on interview and record review, the facility failed to follow facility policy and investigate an injury of unknown origin when staff discovered one resident, (Resident #1) with multiple bruises of unknown origin on the resident's sides and lower breasts. The facility census was 84. Review of the facility's Abuse and Neglect policy, dated 9/17/2024, showed: -Injuries of an unknown source includes circumstances when both the following conditions are met: The source of the injury was not observed by any person or could not be explained by the resident. The injury is suspicious because of the extent of the injury, location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. -Guidelines: The facility will develop and operationalize policies and procedures for screening and training employees, protection or residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure the the facility is doing all that is within its control to prevent occurrences. Training: New employees will be educated by the department manager, or designee, on issues related to abuse prohibition, practices and abuse reporting requirements during initial orientation. Annual education and training will be provided to all existing employees. Front line supervisors will provide education as situations arise. Prevention: The facility will provide residents, families, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution, and will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Identification: The facility will identify events, occurrences, patterns and trends that may constitute mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property as defined above. -This facility is committed to protecting our residents from abuse by anyone including but not limited to facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals. -Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway. -Investigation: The facility will investigate all allegations and types of of incidents as listed above in accordance to facility procedure for reporting/response as described below. -The administrator or designee will: --Complete an administrative investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, any unexpected medical emergency, or when the administrative staff feel uncomfortable in any situation involving resident care or treatment or staff treatment. --The administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including facts that prove or disprove the alleged situation occurred, the plan of correction or action by the Administrative staff, all statements attached from the residents and staff involved and any training or education that the administration feels needs to be provided to staff or residents to ensure education has been provided to prevent future similar situation. The administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified, the physician was made aware the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated, and the Plan of Care was updated to reflect the change in medical or behavioral status. 1. Review of Resident #1's Annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 9/22/24, showed: -He/she had diagnoses of bradycardia (excessively low heart rate), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), repeated falls, weakness and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). -He/she scored 4 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). A score of 4 indicates severely impaired cognitive abilities. -He/she had no impairment to arms or legs and uses a manual wheelchair for ambulation. -He/she required partial to extensive assistance with activities of daily living, including bathing, toileting, dressing and personal hygiene. -He/she had two or more falls since being admitted to the facility. -He/she was not at risk or had any unhealed pressure ulcers/injuries. Review of the resident's comprehensive care plan, dated 3/18/24, showed no problems or interventions related to skin integrity. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's facility Skin Checks showed: -9/26/24: The resident's skin was warm and dry, turgor (skin's elasticity) was within normal limits. The resident had no skin issues. -10/9/24: The resident's skin was warm and dry, turgor was within normal limits. The resident had no skin issues. -10/15/24: New laceration to forehead, resulting from a fall. No other skin issues noted. Review of the resident's medical records from a local hospital, dated 10/15/24, showed: -The resident was sent to the hospital after experiencing a fall at the facility. -Upon admission to the hospital, emergency room staff noted the resident had large bruises to each side of his/her body, just below the armpit, and to the lower part of each breast. The bruises varied in color from dark purple to yellowing. Review of the resident's facility record on 10/21/24 showed: -No investigation was completed in relation to the bruising found on the resident. During an interview on 10/24/24 at 9:46 A.M., Licensed Practical Nurse (LPN) A said: -LPN A worked the overnight shift from 10/13/24 into 10/14/24 and had gone into the resident's room to check on the resident. -LPN A observed large bruises to each of the resident's sides, just below the armpit and the bottom of the resident's breasts. -The bruises were not there when LPN A worked on 10/10/24. LPN A asked the staff working the night of 10/13/24, but no one had any information of how the bruises occurred. -LPN A did not document the bruises or notify the Director of Nursing (DON) or Administrator of the bruises. - He/she did not notify the Administrator of the bruising as he/she got busy caring for other residents and it slipped his/her mind. -He/she should have reported the injuries of unknown origin. - The DON or the Administrator would conduct the investigation into the injuries. During an interview on 10/22/24 at 11:53 A.M., Nursing Assistant (NA) A, said: -On 10/15/24, NA A and CNA A were providing care to the resident. NA A took off the resident's soiled gown and noted bruising to the this time and did not know how the resident received the bruises. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-NA A did not report the bruising to the charge nurse or administration. During an interview on 10/22/24 at 3:45 P.M., the Wound Nurse (WN) said: -The resident had fallen on the morning of 10/15/24 and the WN and Interim DON transferred the resident from the floor back to the wheelchair. -At that time, the WN noted the resident had bruising to one of the resident's breast. The WN had no knowledge of the bruising before the morning of 10/15/24 and did not know where the bruises came from. -He/she did not report the bruising to administration as the staff were busy caring for Resident #1 and getting him/her sent to the hospital. -He/she had received education during orientation, regarding abuse and neglect and reporting injuries of unknown origin for investigation and should have notified the administrator or DON. During an interview on 10/22/24 at 4:45 P.M., the Assistant Director of Nursing (ADON)/Interim DON said: -He/she observed the bruising on Resident #1 on 10/15/24, after the resident fell and the WN and ADON were transferring the resident from the floor to the wheelchair. -The ADON did not know the cause of the residents bruises and staff had not reported the bruising to him/her for investigation. -It is his/her expectation that anytime a staff member finds a resident to have bruising or an injury of unknown origin, for the staff member to notify the charge nurse, ADON or Administrator. -He/she knows he Administrator or DON should do an investigation of reported abuse, neglect or injuries of unknown origin. During an interview on 10/24/24 at 5:30 P.M., the Administrator said: -He/she did not know Resident #1 had bruises to his/her sides and breasts. -It is his/her expectation that staff report any injuries of unknown origin including bruises to charge nurse or administration so the injuries can be investigated. -He/she knows that any reporter accounts of injuries of unknown origin are to be investigated by the Administrator or DON. MO243716, MO243656, MO243662, MO243797

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265730	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Manor Care Center	1622 East 28th Street Trenton, MO 64683

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44939 Based on interview and record review, the facility failed to follow the facility's policies to notify the physician and obtain physician orders when pressure ulcers were found, continue to conduct and document assessments of the wounds, and notify the physician of accurate descriptions and deterioration of the wounds for one resident (Residents #1) who developed a large unstageable pressure ulcer. Additionally, the facility failed to notify the physician and obtain orders for an open area over the bony prominence of one resident's (Resident #2) coccyx and conduct and document assessments of the resident's wound per policy. The facility census was 84. The Administrator was notified on 10/25/24 at 5:54 P.M. of an Immediate Jeopardy (IJ) which began on 10/02/24. The IJ was removed on 10/31/24 as confirmed by surveyor onsite verification. Review of the facility's undated Wound Treatment Management Policy showed: -The purpose of the policy is to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse or the assigned licensed nurse. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. -Review of the facility's undated Documentation of Wound Treatments Policy showed: -The purpose of this policy is that the facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. 1. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment: a. Type of wound and location. b. State of wound or degree of skin loss. c. Measurements (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Description of wound characteristics. 3. Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift. Review of the facility's undated Special Wound Investigation policy showed: -The purpose of this policy is to ensure there is a process in place for a thorough investigation to be conducted in the event when there is an identified deterioration or progression in the stage of a pressure ulcer or the identification of a new pressure ulcer that may be determined as avoidable or unavoidable. 1. Upon notification of any deterioration of an existing pressure ulcer or the identification of a new pressure ulcer, the Director of Nursing will complete a Special Wound Investigation including completion of the Facility Acquired Investigation Tool and/or the Pressure Ulcer Letter of Unavoidability and immediately notify the Regional Director, Premier Nurse Consultant and primary care physician. This investigation will be completed within 24 hours. 2. The Special Wound Investigation will consist of any pertinent information describing the deterioration of the wound or change in staging of the pressure ulcer including the identification of unavoidable risk factors that have increased the resident's susceptibility to develop wound deterioration.; 3. After reviewing the Special Wound Investigation, the Director of Nursing will analyze the date and initiate a Pressure Ulcer Letter of Unavoidability if indicated after consultation with the primary care physician. The Director will notify the guardian, physician and family members. 4. An immediate review of the regulatory requirement and identification of any deficient practices will be determined. An immediate action plan shall be put into place including physician notification, wound care documentation, care plan documentation, and completion of the wound assessment sheet. 5. Weekly (or more frequent) wound assessment will be completed by nurses providing wound care and reviewed by the Director of Nursing. 6. The interventions put in place for the pressure ulcer will be monitored daily by the Director of Nursing/designee. 1. Review of Resident #1's Annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 9/22/24, showed: -Diagnoses of bradycardia (excessively low heart rate), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), repeated falls, weakness and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). -Scored a 4 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). A score of 4 indicates severely impaired cognitive abilities. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Had no impairment to arms or legs and used a manual wheelchair for ambulation. -Required partial to extensive assistance with activities of daily living, including bathing, toileting, dressing and personal hygiene. -Occasionally incontinent of bowel and bladder. -Was not at risk and did not have any unhealed pressure ulcers/injuries. Review of the resident's comprehensive care plan, dated 3/18/24, showed no problems or interventions related to skin integrity. Review of the resident's medical record showed no Braden scale assessment (an assessment to determine the risk to develop pressure ulcers) in the resident's medical record. Review of the resident's facility Skin Check, dated 9/26/24, showed the resident had no skin issues. Review of the resident's shower sheet, dated 10/2/24, showed: -During a shower, the resident was noted to have two small blisters, approximately the size of a pencil eraser, at the top of his/her buttocks. Licensed Practical Nurse (LPN) A documented he/she notified the Wound Nurse (WN), Director of Nursing (DON), primary care provider (PCP) and Administrator of the new skin area. LPN A also documented he/she applied a silicone bandage to the area above the resident's buttocks. Review of the resident's electronic medical record (EMR) from 10/2/24 through 10/10/24, showed: - No documentation of the physician being notified of the blisters found on the resident on 10/2/24. -No wound assessments. Review of Resident #1's physician orders dated October 2024 showed no orders for wound treatments for the blisters found on 10/2/24. During an interview on 10/24/24 at 9:46 A.M., LPN A said: -On 10/2/24, he/she noted two small blisters, approximately the size of a pencil eraser at the top of Resident #1's buttocks. The two blisters were not open at that time. The skin surrounding the blisters was red. -LPN A notified the WN of the blisters and asked what treatment LPN A should do for the blisters. The WN instructed him/her to do what ever treatment was being done for another resident. He/she asked the WN for clarification, as the other resident has had multiple different skin treatments. The WN instructed him/her to do whatever he/she felt was the best for the treatment of the wound. -He/She applied a silicone pad over the blistered area for protection. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She then notified the DON and Administrator of the blistered areas. -He/She did not notify the physician of the wound or get orders, because he/she began to care for other residents and it slipped his/her mind. Review of the resident's facility October 2024 Skin Checks showed: -10/9/24: The resident had no skin issues. -10/15/24: New laceration to forehead, resulting from a fall. No other skin issues noted. During an interview on 10/22/24 at 11:34 A.M., Certified Nursing Assistant (CNA) A said: -He/she was first aware the resident had a wound on his/her coccyx on 10/11/24. -The wound was approximately the size of a golf ball. CNA A was unsure if the wound had an odor. -He/She did not notify anyone of the wound. Further review of the resident's medical record from 10/11/24 - 10/15/24, showed no documentation or assessments of the wound on the resident's coccyx. Review of the resident's medical records from a local hospital, dated 10/15/24, showed: -The resident was sent to the hospital after experiencing a fall at the facility. -Upon being admitted to the hospital, Hospital Registered Nurse (HRN) A found a large, unstageable wound on the resident's coccyx. The wound had foul smelling drainage. During an interview on 10/25/24 at 9:14 A.M., HRN A said: -Upon admission to the hospital, HRN A removed a bandage from the area above the resident's buttocks. The bandage was approximately four inches by four inches and was curling up on itself and not covering the wound. The wound had a strong, foul odor and had a large amount of yellow drainage. The wound was approximately the size of a baseball with multiple black areas. During an interview on 10/22/24 at 11:53 A.M., Nursing Assistant (NA) A, said: -NA A first noted the area above the resident's buttocks on 10/15/24 when the he/she and CNA A got the resident up to change his/her linens. -He/She was unsure of how large the wound was. It had black areas and smelled of rotting meat. -He/She did not notify the charge nurse of the wound, as shortly after noting the area, the resident fell and was sent out to the hospital. During an interview on 10/22/24 at 3:45 P.M., the WN said: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She was notified of Resident #1's wound above his/her buttocks on 10/11/24. -LPN C told the WN, he/she had notified the Primary Care Provider (PCP) of the wound. He/She is unsure if the PCP gave LPN C any treatment orders. -He/She observed the wound on 10/11/24. It was about the size of a golf ball and had no odor or drainage. There was a black area at the top of the wound, about the size of a nickel. -He/She has had no formal education or training regarding wounds. He/She does rounds with the wound team that comes to the facility and takes pictures of the wounds. -He/She did not take pictures of the resident's wounds as he/she was in too much pain. The WN put a patch on the wound and laid the resident back down. -On 10/11/24, the WN did not document the wound assessment. He/She was more concerned with keeping the resident comfortable. -The charge nurse is responsible for notifying the DON, Administrator, and PCP of any new wounds. If the WN is not working, the charge nurse should call him/her to inform him/her of the any new wounds. -He/she does not recall LPN A informing him/her of Resident#1's wound. He/she is unsure who instructed LPN A to apply the silicone patch to the resident's wound. During an interview on 10/23/24 at 4:49 P.M., LPN C said: -He/she was the charge nurse on 10/11/24. He/she assisted staff in transferring the resident to his/her bed from the recliner. -The resident had been incontinent and he/she assisted staff in changing the resident's brief and gown. -He/She noted the wound to the resident's bottom. -He/She spoke to the PCP's nurse about the resident's wound. He/she doesn't recall how he/she described the wound. The PCP or nurse did not give treatment orders regarding the wound, but the PCP would see the resident on rounds on 10/15/24. -He/She put a dry dressing to the wound. It had some slough (tissue coming off of the wound) and a dark area, possibly on the left buttock. The wound was slightly bigger than a quarter. He/She did not notice any odor or drainage from the wound. -If a resident has any wounds or skin issues, the WN and PCP are to be notified. -He/She thought he/she notified the WN. During an interview on 10/22/24 at 4:49 P.M., CNA B said: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she was first aware of Resident #1's wound on 10/14/24 when CNA B gave the resident a shower. -The wound was approximately the size of a grapefruit, black with red around the edges and smelled strongly of rotting flesh. -CNA B did not notify anyone of the wound, as he/she thought the charge nurse was already aware. During an interview on 10/24/24 at 11:44 A.M., the resident's PCP said: -He/she was not notified of the resident's wound until 10/11/24, when LPN C notified the PCP's nurse. -The PCP intended on seeing the resident when he/she was in the facility for rounds on 10/15/24, but the resident was sent to the hospital that day. - The PCP did not give any treatment orders for the wound. He planned to assess it himself on rounds on 10/15/24. -The PCP said LPN C said the resident had an open area on his/her coccyx, but did not provide further detail. During an interview on 10/22/24 at 4:45 P.M., the Assistant Director of Nursing (ADON)/Interim DON said: -He/she was notified of Resident #1's wound on 10/15/24. -The wound was oval shaped, approximately the size of a computer mouse. The middle of the wound was black with an approximately one centimeter red edge around the wound. The wound had a very foul odor of rotting meat that the ADON noticed upon entering Resident #1's room. -The ADON said he/she and the WN were trying to get the resident sent out to the hospital due to a fall with a head injury. The ADON became aware of the wound when he/she went into the resident's room to assess him/her after the fall. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Diagnoses of cellulitis of the right lower leg (a common and potentially serious bacterial skin infection), diabetes mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), lymphedema (swelling, most often in an arm or leg, caused by a lymphatic system blockage), heart failure, bipolar disorder (a mental health condition characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). -Scored a 15 on the BIMS exam. A score of 15 indicates no cognitive impairment. -Was dependent on staff for all activities of daily living, including bathing, dressing, toileting, and personal hygiene. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident was at risk for the development of pressure ulcers; - The resident did not have any pressure ulcers. Review of the resident's comprehensive care plan, dated 6/17/24, showed: -The resident had limited physical mobility and prefers to sleep in his/her recliner. He/she will frequently refuse showers and other care. -The resident was at risk for development of pressure ulcers. Apply treatments as ordered, follow facility wound care policy, staff to do weekly treatment documentation and assessment. Review of the resident's Braden Risk Assessment, dated 9/14/24, showed the resident to be a high risk for skin breakdown. Review of the resident's physician orders showed: -6/24/24: Wound Care Plus to evaluate and treat. -9/17/24: Buttocks-cleanse with foam cleanser and pat dry. Apply triad (a zinc-oxide based cream used for wound care) every shift and evening soilage, and leave open to air. Continue pressure reduction with moisture prevention protocol. One time a day for wound care. -There was no documentation in the resident's record as to why this treatment was ordered. Review of the resident's weekly skin checks showed: -9/26/24: The resident's skin is warm and dry, turgor was within normal limits. The resident has a rash on right and left inguinal (groin) regions. -10/3/24: The resident's skin is warm and dry, turgor was within normal limits. The resident has a rash on right and left inguinal regions. -10/10/24: The resident's skin is warm and dry, turgor was within normal limits. The resident has a rash on right and left inguinal regions. -10/17/24: The resident's skin is warm and dry, turgor was within normal limits. The resident has a rash on right and left inguinal regions. Review of the resident's Monthly Nurses Note, dated 10/16/24 completed by LPN D, showed no ulcers or other skin issues were noted. Observation on 10/22/24 at 10:15 A.M., showed the resident had a crack that had peeling skin about the size of a nickel at the top of his/her buttocks over his/her coccyx, and then a cracked crease on the right buttock. During an interview on 10/22/24 at 10:45 A.M., CNA B said: (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she was not aware Resident #2 had open areas on his/her bottom. -He/she knew the staff were to put cream on resident's bottom, and he/she did apply the cream after the resident's shower. However, CNA B did not pull the resident's skin folds apart or look closely at his/her bottom to see if there was an open area. He/she thought the cream was for preventative measures. During an interview on 10/22/24 at 10:50 A.M., the resident said: -He/she has had the area on his/her bottom for a few weeks. -The area was really sore. Staff put some type of cream on it. He/she was unsure what type of cream it was. During an interview on 10/24/24 at 9:46 A.M., LPN A said: -He/she was aware the resident had an open area on his/her bottom when he/she worked on 10/16/24. He/she was not aware the resident had a second open area in a crease on his/her buttock. -He/she told the WN on 10/16/24 of the open area on the resident's coccyx. -He/she did not notify the physician of the open area because he/she thought it was the WN's duty to notify the physician of new areas and get treatment orders. During an interview on 10/23/24 at 4:49 P.M., LPN C said: -He/she knew Resident #2 had redness to his/her bottom. He/she did not know that he/she had an open area on his/her bottom. -Resident #2 had an order for Nystatin as needed (a medication used to treat fungal infections). -LPN C was unsure if the WN was aware of the open area. During an interview on 10/22/24 at 4:45 P.M., the ADON/Interim DON said: -He/she did not know the resident had an open area. -He/she would expect the WN to do a full body assessment, staging, pictures, what treatments are put in place. At least follow up on orders to ensure they were done. The WN is the nurse who does rounds with the wound care provider. -He/she expected the charge nurse or WN to notify the DON, Administrator, and PCP of any new or worsening wounds. During an interview on 10/23/24 at 5:33 P.M., the WN said Resident #2 does not have any open areas that he/she is aware of. 3. During an interview on 10/24/24 at 5:30 P.M., the Administrator said: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she did not know either Resident #1 or Resident #2 had wounds. -It is his/her expectation the WN or charge nurse notify the DON, Administrator and physician of any new wounds. -It is also his/her expectation that the WN assess the wound, take measurements, and get physician orders for treatment to the wound. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation. MO243716, MO243656, MO243662, MO243797

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44939 Based on interview and record review, the facility failed to provide supervision to prevent an accident for one resident (Resident #1), when on [DATE] staff transferred the resident into a transport wheelchair (a wheelchair designed for short-term use) and left the resident unsupervised. Approximately ten minutes later, the resident was found face down on the floor in a pool of blood with his/her bottom sitting on his/her feet and forehead against the floor. The resident was sent to the hospital, sustained bleeding in his/her brain and was placed on end of life care on [DATE]. The resident passed away while at the hospital on [DATE]. In addition, the facility failed to keep resident's safe when, on [DATE], the Housekeeping Supervisor (HS) used toilet bowl cleaner to clean a stain on the floor of the beauty shop, causing a chemical reaction, resulting a smoky haze in the facility and setting off the fire alarm. The facility census was 84. The Administrator was notified on [DATE] at 6:55 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's undated Fall Prevention Program policy showed: -Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. -The facility utilizes a standardized risk assessment for determining a resident's fall risk. The assessment categorizes the residents according to low, moderate or high risk. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. -Upon admission, the nurse will complete the resident's fall risk assessment along with the admission assessment to determine the resident's level of fall risk. -The nurse will refer to the facility high risk or low/moderate risk protocols when determining primary interventions. -When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. -When any resident experiences a fall the facility will: a. assess the resident b. complete a post-fall assessment (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. complete an incident report d. notify the physician and family e. review the resident's care plan and update as indicated f. document all assessments and actions g. obtain witness statements in the case of injury. Review of the facility's Fall Risk Protocol dated 2022, showed: Low/Moderate: -Fall Risk Assessment score of ,d+[DATE]. -Implement universal environmental interventions: A clear pathway to the bathroom and bedroom doors; Bed is locked and lowered to a level that allows the resident's feet be flat on the floor when the resident is sitting on the side of the bed; Call light and frequently used items are within reach; Adequate lighting; Wheelchairs and assistive devices are in good repair; -Implement routine rounding schedule. -Monitor for changes in resident's condition, gait, ability to rise/sit, and balance. -Encourage residents to wear shoes or slippers with non-slip soles when ambulating. -Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. -Complete a Fall Risk Assessment every 90 days and as indicated when the resident's condition changes. High Risk: -Fall risk assessment score of ,d+[DATE], or recent change in functional status, or dizziness/postural hypotention (low blood pressure) or experiences a fall in the facility. -Implement interventions from the Low/Moderate Fall Risk Assessment. -Place resident on the Fall Prevention Program. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Manor Care Center	1622 East 28th Street Trenton, MO 64683

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Indicate fall risk on care plan. Place Fall Prevention Indicator on the name plate to the resident's room. Place Fall Prevention Indicator on resident's wheelchair. -Provide interventions that address unique risk factors: medications, phsychological, cognitive status, recent change in functional status, or root causes of recent falls. -Consider additional interventions as directed by the resident's assessment: Assistive devices, increased frequency of rounds, sitter/one on one observation, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education, therapy services referral. Review of the owner's manual for the Drive Fly-Lite Transport Chair showed: -The transport chair should not be operated without the assistance of an attendant. -Before entering or leaving the chair, engage the dual wheel locks against the tires on both rear wheels. -Do not move forward on the seat while leaning forward in the chair. Leaning out of the transport chair without proper assistance could cause tipping. 1. Review of Resident #1's Annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated [DATE], showed: -Diagnoses of bradycardia (excessively low heart rate), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), repeated falls, weakness and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). -Scored a 4 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). A score of 4 indicates severely impaired cognitive abilities. -No impairment to arms or legs and uses a manual wheelchair for ambulation. -Required partial to extensive assistance with activities of daily living, including bathing, toileting, dressing and personal hygiene. -Occasionally incontinent of bowel and bladder. -Had two or more falls since admission to the facility. -Had falls prior to admission to the facility and two or more falls at the facility since admission. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's comprehensive care plan, dated [DATE], showed: -He/she was a high fall risk. -Interventions in place include anticipating the resident's needs, make sure call light is within reach and encourage the resident to use it, encourage the resident to participate in physical activities, make sure the resident is wearing appropriate footwear, follow facility fall protocol, review information from previous falls and determine cause and remove cause if possible, and educate family and care givers of fall risks and interventions. Review of the resident's progress note, dated [DATE], showed the resident tested positive for COVID (a respiratory infection). He/she was displaying increased weakness, not eating as much, and requiring increased assistance with care. Review of the resident's the progress note, dated [DATE], showed fall assist was called to resident's room. Upon entering the room, resident noted to be laying prone (face down) on the floor. Assistant Director of Nursing (ADON) and Wound Nurse (WN) rolled resident and noticed blood. The resident was assessed for injuries. The resident was noted to be bleeding from forehead, left hand, and bilateral elbows. The resident's vitals were taken. WN called Emergency Medical Services (EMS) for resident to be sent to the local hospital for evaluation and treatment. Director of Nursing (DON), Administrator, Primary Care Physician (PCP) notified of fall. Review of the resident's medical record from the local hospital, dated [DATE] at 8:10 A.M., showed: -The resident was seen in the emergency roiagnom on [DATE] after falling forward from his/her wheelchair at the facility, and hitting his/her head. He/she sustained a large laceration to the left side of the forehead and skin tears to both arms. Computed Technology (CT) scan showed the resident sustained a head injury that resulted in bleeding in the front and back of the brain. The resident was unresponsive and admitted to the hospital to receive end of life care. Review of the resident's undated medical record from the local hospital showed: -The resident died at the hospital on [DATE] at 11:34 P.M.; -The preliminary cause of death was traumatic subarachnoid hemorrhage resulting from a fall from non-moving wheelchair. Review of the resident's facility electronic medical record showed: -[DATE] at 6:45 P.M., Fall Risk Assessment, showed the resident is a high risk for falls. -There were no other Fall Risk Assessments found in the resident's medical record. Observation of the resident's wheelchair on [DATE] at 10:15 A.M., showed the wheelchair was a Drive Fly-Lite Transport Chair. During an interview on [DATE] at 11:53 A.M., Nurse Aide (NA) A said: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she was aware Resident #1 was a fall risk. He/she was unsure what fall prevention interventions should have been in place for the resident, only that the resident was to have two staff members to provide care. NA A was not sure where to find what interventions needed to be in place. -Since testing positive for COVID earlier in the month, the resident needed more help with care, like increased incontinence and needing more help with eating and drinking. The resident seemed weaker. -On [DATE], around breakfast time, NA A and Certified Nurse Aide (CNA) A went into Resident #1's room to provide care. The resident was found to have wet the bed and needed his/her clothing and bed linens changed. NA A and CNA A transferred the resident to the wheelchair and stripped the linens from the bed. NA A and CNA A then left the room, leaving the resident sitting in the wheelchair next to the bed. NA A went to get clean linens and was unsure what CNA A was doing after they left the room. -Approximately ten minutes later, NA A heard a commotion in the hall and saw staff running toward the resident's room. A staff member told him/her the resident had fallen, but NA A did not enter the resident's room again that day. During an interview on [DATE] at 11:34 A.M., CNA A said: -CNA A was aware the resident was a fall risk. He/she did not know what interventions the resident should have in place. CNA A said the interventions could be found on the care plan. -CNA A would try to make sure the resident's bed was in the lowest position and have a fall mat on the floor next to the bed. The resident had a chair and bed alarm at one time, but he/she kept taking it off, so the staff quit using it. - On [DATE], CNA A and another staff member entered the resident's room shortly after breakfast to provide care. CNA A thinks the other staff member may have been Licensed Practical Nurse (LPN) C. The resident had urinated in the bed and needed his/her clothing and bed linens changed. CNA A and the other staff member transferred the resident to the wheelchair and stripped the bed. CNA A left the room to get supplies and to let housekeeping know the bed needed to be cleaned. The other staff member also left the room, but CNA A was not sure what that staff member went to do. -While in the hall, CNA A saw other staff members running towards the resident's room and someone told him/her the resident was on the floor. CNA A reentered the resident's room and observed the resident on the floor. He/she was laying on his/her side on the floor, one arm under him/her and one arm beside him/her. His/her legs were bent to the side. The WN and LPN C were in the room and picked the resident up off the floor and placed him/her back in the wheelchair. The resident had scrapes on his/her left hand and a cut to the forehead. The WN instructed CNA A to hold a bandage to the resident's forehead. The WN and LPN C left the room to call EMS and get the paperwork ready. The ADON took over holding the bandage to the resident's forehead and stayed in the room with the resident until EMS arrived and CNA A left the room. During an interview on [DATE] at 3:45 P.M., the WN said: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Two staff members went into the resident's room to check on him/her and to provide care around 7:45 and 8:00 A.M. The staff found the bed was wet. He/She is unsure of who the two staff members were but thinks it may have been CNA A and NA A. He/She instructed the staff to get the resident up, put clean linens on the bed and clean the resident up. He/She then left the room to assist another resident. While in the other resident's room, the ADON informed him/her Resident #1 was on the floor. -He/She returned to the resident's room. The resident was on the floor, with his/her head on the floor and knees under him/her. He/she was between the bed and the wall. The WN observed blood on the resident's left hand from a skin tear. There were linens on the floor near the resident's head. When staff moved the linens, he/she noted additional blood on the floor. He/She and the ADON made the decision to move the resident from the floor to the wheelchair. After the resident was transferred to the wheelchair, he/she and the ADON assessed the resident. He/she was found to have two skin tears to the left hand, one skin tear to the left elbow and one skin tear to the right hand. He/she was also noted to have a laceration to the left side of the forehead. The WN conducted vitals on the resident. -The WN then left the room to call EMS and get the paperwork ready for the resident's transfer. During an interview on [DATE] at 4:45 P.M., CNA B said: -He/She entered the resident's room after he/she was told of the resident's fall. The resident was already in the wheelchair. CNA B observed the resident had an injury to the forehead and some skin tears to his/her arms. He/she sat with the resident to help keep him/her calm while the ADON and WN assessed the resident. After the assessment, the ADON and CNA B left the room. The WN and CNA A were still in the room with the resident. During an interview on [DATE] at 4:49 P.M., LPN C said: -LPN C was not working the day the resident fell . -The resident tested positive for COVID on [DATE]. After testing positive, he/she became weaker and needed more assistance with cares. During an interview on [DATE] at 6:14 P.M., the ADON said: -He/she believed the resident was a fall risk. He/she is unsure what exact interventions the resident should have had in place. He/She believes the interventions in place should have included proper footwear, bed in lowest position, and a fall mat by bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she did not witness the fall on [DATE]. The resident's roommate yelled out the door of their room that the resident had fallen. He/She instructed CNA B to go get the WN, who was also the charge nurse that day. This was about 7:40 A.M. The WN and ADON entered the resident's room. The resident was on the floor, face down, with his/her head on the floor. The resident was squirming on the floor, and the ADON noted blood on the resident's right arm. The resident was between the bed and wall. His/her arms were under him/her. The resident's head was on a pile of folded bed linens. The linen had no blood on them when the ADON and WN moved the resident. The ADON did not believe at that time the resident had a head wound. When the resident was rolled to rest on his/her back, the ADON noted the resident had skin tears to both arms and also had an injury to his/her forehead. The ADON and WN decided to transfer the resident to the wheelchair so they may better assess the injuries. Either CNA A or CNA B stayed in the room with the resident while the ADON and WN went to the desk to call EMS and get the paperwork together. -As the resident was weak from COVID, the ADON believes the resident should not have been left alone in the wheelchair. During on interview on [DATE] at 10:40 A.M., Emergency Medical Technician (EMT) A said: -EMS was called to the facility the morning of [DATE] for a resident who had fallen out of a wheelchair and hit his/her head. -When EMS arrived at the resident's room, the resident was in the bed. -The resident had lacerations to both forearms and left hand. He/she also had a laceration to the forehead. -Facility staff in the room where unable to tell EMS when the resident fell . -EMS transferred the resident to the stretcher and transported him/her to the local hospital. During an interview on [DATE] at 5:35 P.M., the DON, said: -He/she believes that Resident #1 was a high fall risk. -It is his/her expectation that at least one staff member remain with the resident while he/she was up in the wheelchair, due to the resident's decline in condition. During an interview on [DATE] at 5:30 P.M., the Administrator said: -He/she believed that Resident #1 was a fall risk due to his/her recent decline. -He/she expects that a staff member should have stayed with the resident when he/she was up in the transport wheelchair, as the resident was COVID positive and in a weakened state. 2. Review of the Material Safety Data Sheet (MSDS), [DATE], for the cleaner showed: -The cleaning product's name is Acid Bowl Clean. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-It's recommended use is as a clinging toilet bowl cleaner. -It has the hazards of skin corrosion, serious eye damage/irritation, and is corrosive to metal. -Users should not breathe fumes/gas/vapors/spray of the product. Users must wash face, hands and any exposed skin after handling. Users should wear protective gloves/protective clothing/eye protection/face protection when using the product. -If inhaled, remove the person to fresh air and keep at rest in a position comfortable for breathing. Immediately call a poison control center or doctor/physician. -The cleaner is incompatible with Acids, Bases, Oxidizing Agents, and uncontrolled contact with water. Observation of the facility on [DATE] at 11:45 A.M., showed: -The fire alarm sounded. -A white, smoke-like haze was in hallways and dining room. This was accompanied with a strong chemical smell. -The DON said the Housekeeping Supervisor (HS) was using a chemical to clean a stain on the floor of the beauty shop and it started to smoke. They were opening the windows and doors to the facility to help air out the smoke. During an interview on [DATE], at 3:22 P.M., the HS said: -He/she has been the HS since February 2024. -He/she was cleaning the floor today in the beauty shop. He/she put a fresh mop head on the mop and ran it under water. He/she then squeezed the water out with the mop wringer. He/she then put some of the acid toilet bowl cleaner on a spot on the floor, mopped it up and then put some more of the cleaner on the spot and used a paper towel to wipe it up. Then it began to smoke. -He/She did not think anything else was on the floor. The HS said he/she did not mix it with anything, only the water on the mop -He/she had used this cleaner in the same way many times and it had never reacted this way. -He/she worked in housekeeping before becoming a supervisor. -The facility has had the cleaner as long as the HS has worked at the facility. He/she has not received education on safe chemical usage. The old housekeeping supervisor trained him/her before he/she took over. No one had instructed the HS to use the cleaner on the floor. During an interview on [DATE] at 5:35 P.M., the DON, said: - He/she had told the HS not to use toilet bowl cleaner on surfaces other than the toilet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Residents were present in the dining room and hallways when the smoke was observed. -It is his/her expectation that all chemicals in the facility be used appropriately and safely. During an interview on [DATE] at 5:30 P.M., the Administrator said: -It is his/her expectation that all chemicals be used safely and appropriately within the facility. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation. MO243716, MO243656, MO243662, MO243797

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44939 Based on interview and record review, the facility failed to ensure the wound nurse had the appropriate competency and skill set, when one resident's (Resident #1) wound was not appropriately identified, assessed, and treated. The facility census was 84. The facility did not provide a job description or requirements for the Wound Nurse (WN). Review of the facility's undated Wound Treatment Management Policy showed: -The purpose of the policy is to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse or the assigned licensed nurse. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. -Review of the facility's undated Documentation of Wound Treatments Policy showed: -The purpose of this policy is that the facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. 1. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment: a. Type of wound and location. b. State of wound or degree of skin loss. c. Measurements d. Description of wound characteristics. 3. Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the WN's employee file on 10/23/24 showed: -WN obtained his/her Licensed Practical Nurse (LPN) license on 4/20/18. -WN was hired by the facility on 11/27/19. -Certificate that the WN had completed a 0.5 hour online Skin and Wound eCourse on 3/20/21. 1. Review of Resident #1's Annual Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 9/22/24, showed: -Diagnoses of bradycardia (excessively low heart rate), osteoarthritis (a chronic degenerative joint disease that causes cartilage in the joints to break down over time), repeated falls, weakness and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). -He/she scored 4 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). A score of 4 indicates severely impaired cognitive abilities. -He/she had no impairment to arms or legs and used a manual wheelchair for ambulation. -He/she required partial to extensive assistance with activities of daily living, including bathing, toileting, dressing and personal hygiene. -He/she was occasionally incontinent of bowel and bladder. -He/she was not at risk and did not have has any unhealed pressure ulcers/injuries. Review of the resident's comprehensive care plan, dated 3/18/24, showed no problems or interventions related to skin integrity. During an interview on 10/22/24 at 3:45 P.M., the WN said: -He/she had not had adequate training or education regarding wound care. He/She only had wound training that was received in nursing school and the online wound training. He/she goes around with the wound care team and they give him/her treatment orders. He/She takes photos of the residents wounds. The pictures are to be uploaded into the electronic medical record. -He/She became aware of Resident #1's wound on 10/11/2024. He/She did not assess, document, or take any pictures of the resident's wound as the resident appeared to be in pain, so the WN instructed the staff to put a patch on it and lay the resident back down. He/She did not attempt to obtain pictures later in the day. -He/She did not inform the Director of Nursing (DON) or physician of the wound. During an interview on 10/22/24 at 4:45 P.M., the Assistant Director of Nursing (ADON)/Interim DON said: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It is his/her expectation the WN do a full body assessment of residents, stage the wounds, take photos of wounds, and document what treatments are in place. He/she also expects the WN follow up on physician orders to ensure they are being done. -The WN is the staff member that goes on rounds with the wound team. -The ADON does not know what education the WN has had regarding wound care. During an interview on 10/25/24 5:54 P.M., the Administrator said: -He/she did not know what education the WN had or training that had been provided to perform his/her duties. -It is his/her expectation the WN be provided with the education and training needed to perform her duties as the wound nurse. MO243716, MO243656, MO243662, MO243797

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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. 44939 Based on interview and record review, the facility failed to ensure three of three sampled nurse aides (NA) were enrolled in a state-approved training and competency evaluation program and completed a nurse aide training program within four months of his/her employment in the facility. The census was 84. The facility did not provide a policy on education and Certified Nurse Aide (CNA) training. The facility did not provide a policy for the Hall Monitor position. Review of the facility's Hall Monitor Job Description, dated 9/17/24, showed: -The Hall Monitor position is a way to ensure there is extra support within the facility to help assist with non-nursing duties. -Duties: Walking rounds, intensive monitoring (frequent checks and 1:1 monitoring, assisting with smoking breaks for residents, cleaning of facility/resident equipment, assist with transportation of residents throughout the unit, facility or outings that do not require hands on care, and assist with activities. -Items the Hall Monitor may not assist with on their assigned units include: Direct patient care, vital signs, bathing, dressing, grooming, turn and repositioning, feeding, passing snacks, hands on assistance of residents found on the floor or witnessed falls, activities of daily living cares, peri-care, catheter care, passing of fluids, and intake/output measuring/documenting. 1. Review of NA A's facility employment file showed: -He/she was hired on 4/19/24, initially in the maintenance department as a floor tech. -He/she was now employed as a Hall Monitor. -There was no record of enrollment or completion of a CNA course. Observation on 10/21/24 at 12:35 P.M. showed NA A assisted the resident in the dining room with eating and drinking. During an interview on 10/22/24 at 11:53 A.M., NA A said: -He/she has been working at the facility since April 2024. -He/she was initially a floor tech. -When he/she was done with the floor work, he/she would jump in and assist the NAs on the floor with resident care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265730	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Manor Care Center	1622 East 28th Street Trenton, MO 64683

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she switched to the nursing department about four months ago. -He/she has not participated in a NA class. He/she was with another NA for a couple days on the floor training. He/she is unsure if that NA was a CNA. -He/she provided care independently to residents, including bathing, dressing, transferring, and personal hygiene. -He/she has not been approached by anyone from the facility about enrolling in a CNA class. Observation on 10/24/24 at 3:45 P.M., showed NA A assisted another staff member in changing a resident into clean clothing. 2. Review of NA B's facility employee file showed: -He/she was hired on 3/17/2021 as a Hall Monitor. -There was no record of enrollment or completion of a CNA course. During an interview on 10/25/24 11:30 A.M., NA B said: -He/she had worked at the facility for about 3 years. -He/she had not been enrolled in a CNA course. -He/she worked with another staff member for a few days on the floor before working alone. -He/she assisted residents in bathing, dressing, transferring, changing soiled briefs, and things like brushing their hair. 3. Review of NA C's facility employee file showed: -He/she was hired on 10/3/2024 as a Hall Monitor. -There was no record of enrollment in a CNA course or any education or training. During an interview on 10/25/24 at 11:50 A.M., NA C said: -He/she had worked at the facility for a couple of weeks. -He/she had no training or classes regarding NA skills. -He/she spent a day or two on the floor with another staff member learning what to do. -No one had approached NA C about enrolling in a CNA course. -He/she assisted residents in bathing, dressing, transferring, changing soiled briefs, and things like brushing their hair. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 10/22/24 at 4:45 P.M., the Assistant Director of Nursing/Interim Director of Nursing said: -There are NAs or hall monitors working in the building, but he/she is unsure how many. -He/She was not sure why NA A, NA B, and NA C were not in training. -He/she knows that NAs are supposed to complete a CNA course, but is unsure what timeframe that needs to be done. -He/she did not know who was responsible for enrolling NAs in the course. -NAs work with a CNA on the floor when they first start at the facility to learn what to do. During an interview on 10/31/24 at 10:45 A.M., the Administrator said: -He/she was unaware there were NAs working on the floor who were not certified or not enrolled in a CNA class. -He/She was not sure why NA A, NA B, and NA C were not in training. -It is his/her expectation that all NAs are enrolled and complete a CNA course within four months of starting employment.