STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, interview, and record review, the facility failed to ensure three sampled residents (Resident #6, #34, and #31) were assessed as safe to self-administer medications when medications were left at bedside table unattended by licensed staff. This affected three of the twelve sampled residents. The facility census was 37. Review of facility policy, self-administration of medications, dated March 2017, showed: -Staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. -In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including the resident's: -ability to read and understand medication labels; -comprehension of the purpose and proper dosage and administration time of his or her own medications; -ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; -ability to recognize risks and major adverse consequences of his or her medications. -Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. -Staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications. 1. Review of Resident #6's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 5/30/24, showed: -He/She was cognitively intact; -He/She had a hearing aide, minimal difficulty with hearing; (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had clear speech; -He/She made self understood and usually understood others; -He/She required partial/moderate assistance with all activities of daily living, -Diagnoses included: High blood pressure, heart failure, diabetes (too much sugar), depression, asthma (condition making it difficult to breathe, neuropathy (condition resulting in nerves that are damaged resulting in pain, numbness, weakness, or tingling in one or more parts of the body), generalized muscle weakness, hearing loss, gastroparesis (a chronic condition that affects the stomach's motility), aphasia (inability to swallow) Review of care plan, dated 3/29/24, showed: -Be alert for any drug or medication interactions including over the counter medications; -Observe for signs of confusion, drowsiness, poor coordination due to low fluid intake; -Nurse to give medication as ordered by physician; -Medications at bedside were not care planned. Review of the physician's orders, dated 8/27/24, showed: -Ordered 1/22/24, Biofreeze Professional Gel 5%, a menthol topical analgesic), apply to affected area topically as needed for pain, may keep at bedside. -Ordered 10/17/23, Spray to clean eyelids/lashes two times per day for eyes; -No physician orders for vapor rub; -No physician orders for cough drops. Review of the resident's electronic medical record showed no assessment completed by the facility staff for the safety of self-administration of medications. Observation on 8/27/24 at 4:41 P.M. showed resident had medications at bedside including biofreeze, halls cough drops, and vapor rub. During an interview on 8/27/24 at 4:41 P.M. resident said: -He/She did not do his/her own medications; -His/Her right elbow had been hurting for some time and the biofreeze helped relieve his/her pain; -He/She applied biofreeze when he/she went to bed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/28/24 at 11:17 A.M., showed that the resident had a container of vapor rub by side of bed, saline adhesive for sting free skin barrier to prevent skin friction and protective barrier. During an interview on 8/29/24 at 9:23 A.M., the Director of Nursing said he/she was not sure if Resident #6 self-administered medications. 2. Review of Resident #34's Quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She felt down or depressed or hopeless 2-6 days per week; -He/She required set up or clean up assistance with eating; -He/She was independent with oral care, toileting, upper and lower body dressing, -Diagnoses included: Dementia (condition that causes a decline in brain function and impairment of a person's ability to think, remember, and make decisions), Parkinson's disease (a chronic, progressive brain disorder that causes movement problems), malnutrition, depression, muscle weakness, and need for assistance with personal care. Review of care plan, dated 2/13/24, showed administer medications as ordered by physician. Review of physician's orders, dated 8/27/24, showed: -Ordered 2/22/24, artificial tears ophthalmic solution 1.4%, polyvinyl alcohol, instill 2 drops in both eyes every 8 hours as needed for dry eyes both eyes; -No orders for any medications at bedside. Review of the resident's electronic medical record showed no assessment completed by facility staff for the self-administration of medications by the resident. Observation on 8/26/24 at 9:53 A.M. showed xlldra eye drops at bedside, 10 vials of unmarked clear tubes that appeared like breathing treatments vials were sitting in a metal tin container beside resident's chair, open container of Vaseline, and nasal spray. During an interview on 8/29/24 at 9:23 A.M., Director of Nursing said Resident #34 did not self-administer medications. During an interview on 8/28/24 at 11:14 A.M., LPN A said: -Medications were not allowed to be left at residents bedside unless a doctor gave facility an order; -Residents who have medications at bedside should have a self-administration of medication assessment completed; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not aware of any resident who had an order to keep his/her medications at bedside or who had been assessed. During an interview on 8/29/24 at 9:10 A.M., Administrator said: -There was one or two residents who self-administer medications; -He/She was not sure which residents were able to self-administer medications; -He/She did not know if self-administration assessments were done on those residents; -Self-Administration assessments were to be done on residents who self-administer their medications on a quarterly basis; -Assessments for self-administration of medications would be found on the assessments tab in the electronic medical record; -Resident #31 was the only resident that self-administers his/her medications. During an interview on 8/29/24 at 9:23 A.M., Director of Nursing said: -He/She was aware of a couple of residents who self-administer mediations; -Resident #31 had eye drops that he/she could self-administer; -He/She had not completed any self-administration of medication assessments on those residents; -He/She did not know if self-administration of medications had been done prior to his/her taking on Director of Nursing role. 50980 3.Review of Resident #31's Quarterly MDS, dated [DATE] showed: - Admission to the facility on [DATE] - BIMS score of 15, indicating no cognitive deficit. - Diagnoses include: Parkinson's Disease (a brain disorder that affects balance and coordination), Hypertension (high blood pressure), Diverticulosis of Intestine (infection that affects the colon) Review of the resident's medical record showed: - No orders on the POS (Physician Order Sheet) were present as of 8/27/24 for resident to self-administer medications. - Physician orders for Refresh Ophthalmic Solution- staff to instill 3 drops in both eyes every 4 hours as needed for dry eyes. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Sinemet Oral Tablet give 1.5 tablets by mouth four times a day for Parkinsons. - The facility staff had not documented a resident medication self-administration assessment. Review of 8/24 ADL (Activities of Daily Living) care plan showed no care plan completed for the resident to self-administer of medications. During an observation and interview on 8/26/24 at 9:18 A.M. showed: - A medicine cup of pills, one pink and one blue pill on the resident's bedside table. One 1.5 oz bottle of Equate brand nasal spray and one bottle of Refresh Tears 15 ml on the bedside table. - The resident said the staff left the medicine cup on his/her bedside table to take at 9:00 A.M. for Parkinson's Disease. The Refresh Tears need to be administered by the staff on Resident's request since he/she cannot self-administer the eye drops. The nasal spray is administered by the resident as needed without staff assistance. During an interview on 8/29/24 at 9:10 A.M., the Administrator said Resident #31 was the only resident that self-administers his/her own medications. During an interview on 8/29/24 at 9:23 A.M., the Director of Nursing said Resident #31 had eye drops that he/she could self-administer; During an interview on 8/29/24 at 11:30 A.M. the Director of Nursing (DON) said he/she expects that all medications held by a resident in their room are to be care planned and authorized by a Doctor's order.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 50980 Based on interviews and record review, the facility failed to consider the views of the resident council and act promptly upon grievances and recommendations made by the group concerning issues of resident care and life in the facility when the facility failed to demonstrate their response and rationale for such responses. The facility additionally failed to maintain documentation of attempts to resolve concerns, or the facility's communication to the council on follow up actions. This affected eight of eight residents serving on the resident counsel and potentially other residents of the facility. The facility census was 37. Review of facility policy, Resident Council, 4/2017, showed: - A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI Committee, if applicable. Review of facility policy, Resident Rights, undated, showed: - Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; have the facility respond to his or her grievances. 1. During a group interview on 8/28/24 at 2:00 P.M., eight of eight residents stated: -They did not have access to grievance forms or know about the Council Response Form for receiving feedback on grievances. - They did not know who the Grievance Officer was at the facility. - They did not receive formal feedback between meetings or at the start of next month's meeting about each of their past grievances. Review of resident council minutes, dated June 2024- August 2024, showed: -On 6/5/24: Old minutes were read with no concerns noted. No council president assigned, and the meeting was led by the Activity Director. New Business showed: request for Adult Daily Living (ADL) support with glasses, complaint about staff member being rude and not helping with ADL toileting, complaint regarding the lack of clean towels and trash not being emptied. - There is no facility responses to review for past complaints or requests. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/3/24: Old minutes were read with no concerns noted. No council president assigned, and the meeting was led by the Activity Director. New Business showed: two food item suggestions for the menu. - There is no facility responses to review for past complaints or requests. -On 8/6/24: Old minutes were read with no concerns noted. No council president assigned, and the meeting was led by the Activity Director. New Business showed: one complaint about medications not being administered in a timely manner and a resident feeling that they are treated differently by staff if he/she makes a staff complaint, two complaints about food being overcooked or burnt. - There is no facility responses to review for past complaints or requests. During an interview on 8/28/24 at 3:30 P.M., Activity Director said the facility does not formally reply to the resident council on resolutions or steps the facility took to address resident issues. The feedback process is informal and not tracked by the facility.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47195 Based on interview and record review, the facility failed to obtain a signature from the resident or or resident's legal representative on the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms prior to discharging from Medicare services for two residents (Resident #23 and #13) out of three sampled residents. The facility census was 37. Review of form instructions skilled nursing facility advance beneficiary notice of non-coverage (SNFABN) Form CMS-10055, dated 4/8/2014, showed: -Signature and date: The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The skilled nursing facility may fill in the date if the beneficiary needs help. The date should reflect the date the SNF gave therm notice to the beneficiary in-person or when appropriate, the date contact was made with the beneficiary's authorized representative by phone. If an authorized representative signs for he beneficiary, write 'rep' or representative next to the signature. If the authorized representatives signature is not clearly legible, the authorized representative's name bust be printed. If the beneficiary refuses to choose an option and/or refuses to sign the SNFABN when required, the SNF should annotate the original copy of the SNFABN indicating the refusal to sign and may list a witness to the refusal. -Basic delivery requirements: -Who may sign: Beneficiary, Beneficiary's authorized representative, legally appointed representative or guardian of the beneficiary, in case of emergency, a disinterested third party/ -Delivery requirements: Must be signed 1. Review of Resident #23's NOMNC and SNF ABN forms showed: -The resident discharged from skilled Medicare services on 8/9/24, however remained in the facility. -The NOMNC form showed documentation of a phone call to resident's durable power of attorney on 8/7/24 and a letter was mailed on 8/7/24. -The SNF ABN form showed documentation of a phone call to resident's durable power of attorney on 8/7/24 and a letter was mailed on 8/7/24. -The facility failed to get the legal representative's signature on the forms. 2. Review of Resident #13's NOMNC and SNF ABN forms showed: -The resident discharged from skilled Medicare services on 6/17/24, however remained in the facility. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The NOMNC form showed documentation of a phone call to resident's durable power of attorney on 6/12/24 and a letter was mailed on 6/12/24. -The SNF ABN form showed documentation of a phone call to resident's durable power of attorney on 6/12/24 and a letter was mailed on 6/12/24. -The facility failed to get the legal representative's signature on the forms. During an interview on 8/30/24 at 11:30 A.M., Administrator said he/she expected the beneficiary notices to be signed by the responsible party.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observations, interviews and record review, the facility failed to maintain the privacy of three of the 12 sampled residents, (Resident #10, #17 and #32), when staff failed to post signage at the front door or outside each sampled resident's rooms to indicate 24 hour camera surveillance was in progress and failed to obtain consents from the responsible parties of the sampled residents. The facility census 37. Review of the facility's policy for videotaping, photographing, and other imaging of residents, revised April, 2027, showed, in part: - Residents will be protected from invasion of privacy and/or abuse that might occur from photographs, videotapes, digital images, and recordings during resident care or other facility activities; - For the purpose of this policy, resident image means the likeness of a resident captured through still digital images, and recordings during resident care or other facility activities; - The facility policy did not address the use of camera surveillance, posting of camera surveillance or consents required. 1. Review of Resident #10's consent for photo release, dated 10/30/23 showed: - Consent was given to the facility to be photographed while living or visiting the facility; - The term photograph includes video, still photography (in digital or any other format) and any [NAME] means of recording or reproducing images; - The purpose of these images will be used for marketing, public relations, news media, social media and employee training to promote the services by the facility; - The consent did not address the use of camera surveillance with audio capabilities. Review of the resident's care plan, revised 4/26/24, showed: - The resident was at risk for falls. Per family request, a camera is in the room to monitor the resident for frequent falls at home; - The resident had cognitive fluctuation /dementia (inability to think); - Activities of daily living (ADL) - the resident required moderate assistance with walking with the walker in his/her room. The resident used a wheelchair most of the time and was able to propel him/herself. The resident required maximum assistance of one staff for toileting and is incontinent of bowel and bladder. The resident required moderate assistance of one staff for transfers. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/29/24 showed:- Cognitive skills moderately impaired; (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Required partial to moderate assistance of staff for transfers; - Dependent on the assistance of staff for toilet use and personal hygiene; - Occasionally incontinent of bowel and bladder; - Diagnoses included seizure disorder (a brain condition that causes recurring seizures), renal insufficiency (poor function of the kidneys that may be due to a reduction in blood flow to the kidneys caused by renal artery disease), and depression; - Had one fall and no injury. Review of the resident's medical record showed:- Did not have a consent signed by the responsible party for 24 hour camera surveillance. Observation on 8/26/24 at 10:59 A.M., showed: - There was a baby monitor on the resident's dresser; - Did not have a sign outside the resident's room to indicate there was camera surveillance. Observation on 8/28/24 at 12:09 P.M., showed: - There was a monitor at the nurse's desk which showed the resident in his/her room; - It was a VTECH monitor Model L:VM818HD PU. - The volume on the monitor was able to be adjusted and staff could be heard talking in the resident's room; During an interview on 8/28/24 at 12:21 P.M., Licensed Practical Nurse (LPN) said: - They had two baby monitors at the nurse's station and they used them for the resident's who were a fall risk; - The monitors had audio and staff can hear what is being said in the resident's room. 2. Review of Resident #32's consent for photo release, doted 9/26/23, showed: - Consent was given to the facility to be photographed while living or visiting the facility; - The term photograph includes video, still photography (in digital or any other format) and any [NAME] means of recording or reproducing images; - The purpose of these images will be used for marketing, public relations, news media, social media and employee training to promote the services by the facility; - The consent did not address the use of camera surveillance with audio capabilities. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Admission MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Required partial to moderate assistance with toilet use, dressing and transfers; - Diagnoses included dementia (inability to think), anxiety, depression, and renal insufficiency. Review of the resident's care plan, revised 8/26/24 showed:- The resident's ADL function showed the resident required moderate assistance of one staff for transfers and toilet use; - The care plan did not address the room mate having 24 hour camera surveillance with audio capabilities. Review of the resident's medical record showed no consent from the responsible party to indicate they were aware of the roommate having 24 hour camera surveillance with audio in the shared room. Observation on 8/26/24 at 10:59 A.M., showed: - The resident's roommate had a baby monitor on the resident's dresser; - Did not have a sign outside the resident's room to indicate there was camera surveillance. 50980 3. Review of Resident #17's Significant Change MDS, dated , 8/15/24, showed: - Brief interview for mental status (BIMS) score of 2, indicating the resident was severely cognitively impaired; - Diagnoses included: Reduced mobility, Amnesia (Memory Loss), Hypertensive Heart Disease with Heart Failure, Malignant Neoplasm of Uterus (Cancer). - Dependent upon staff for toileting, shower/bath, dressing, personal hygiene, and mobility. Review of Resident #17's Consent for Photo Release agreement signed by DPOA dated, 11/29/22, showed in part: - Consent to photograph which included video, still photography and any other means of recording or reproducing images for the purpose of marketing, public relations, news media, social media and employee training to promote services provided by [NAME] Heights. -There is no statement of full-time installation of a camera with sound to be placed in the Resident's room. Review of the resident's care plan dated, 8/26/24, showed: -Activities of daily living deficit and dependent on 2 staff for care. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Terminal prognosis for cancer requiring staff to provide maximum comfort for resident. - Indwelling urinary catheter which staff will change monthly, monitor and document intake and output. - Cognitive deficit of which staff will be respectful and treat resident as an adult. - Fall risk with interventions for keeping a call light within reach and for staff to keep pathways clear. -The care plan did not indicate that surveillance was being used in the resident's room. Review of the resident's medical record did not show the resident or his/her responsible party gave consent to 24 hour video monitoring with sound in the resident's room. Observation on 8/26/24 at 10:30 A.M. showed no signage that the resident's room was under 24 hour camera surveillance. Observation at 8/28/24 at 12:06 P.M. showed a video monitor at the Nurse's station displaying the resident's room with sound which could be turned up. Resident was observed in bed pulling at his/her brief and a conversation between the resident and staff could be heard from the room through the monitor at the nurses desk. Monitor is VTECH Model VM5255-22. During an interview on 8/29/24 at 11:30 A.M., the Director of Nursing (DON) said: -There is no video recorded in the resident's room, so no signs indicating camera coverage are needed. The DON also stated, that the family had requested the cameras and that it is care planned. - She did not feel there should be signs posted to indicate the use of a camera with audio surveillance in the residents room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 47195 Based on observation, interview, and record review, the facility failed to develop individualized person centered comprehensive care plans for five residents when the care plan failed to address five resident's code status wishes (Resident #18, #34, #6, #8, and #25). This affected five of twelve sampled residents. The facility census was 37. Review of facility policy, care plans, comprehensive person-centered, undated, showed: -A comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. -The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The care planning process will incorporate the resident's personal and cultural preferences in developing the goals of care. -Reflect on the resident's expressed wishes regarding care and treatment goals. -Identify the professional services that are responsible for each element of care. 1. Review of code status book, showed an Resident#18 had an Out of hospital do not resuscitate sheet was signed 6/23/23. Review of Resident #18's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 6/20/24 showed: -No cognitive status available; -He/She had unclear speech and was rarely or never understood; -He/She had highly impaired vision and wore corrective lenses; -He/She had impairment on both sides of upper extremities; -He/She was dependent on a wheelchair; -He/She was dependent for eating, oral care, toileting, bathing, upper and lower body dressing, hygiene, and all mobility; -He/She was on hospice care; (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included: Heart failure, high blood pressure,, anxiety disorder, depression, , tendency to fall, heart disease, corneal transplant status, overactive bladder, urinary tract infections Review of physician's orders, dated 8/27/24, showed: -Ordered 3/19/24, Hospice to evaluate and treat; -Ordered 1/4/24, Do Not Resuscitate; Review of care plan, revised 6/12/24, showed: -He/She planned to stay in facility for long term care; -He/She had a terminal prognosis due to senile degeneration of brain; -His/Her comfort will be maintained through the review date; -Work with nursing staff to provide maximum comfort for resident; -Care plan did not address resident's do not resuscitate orders. 2. Review of code status book showed Resident #34 with an Out of hospital do not resuscitate sheet signed 11/22/23. Review of Resident #34's Quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She felt down or depressed or hopeless 2-6 days per week; -He/She was dependent on walker or wheelchair; -Diagnoses included: Peripheral vascular disease (a condition that can cause blood vessels to narrow, block or spasm), dementia (condition that causes a decline in brain function and impairment of a person's ability to think, remember, and make decisions), Parkinson's disease (a chronic, progressive brain disorder that causes movement problems), malnutrition, depression, inflammation of gallbladder, acute cardiovascular insufficiency (a condition that occurs when there is deficiency in blood flow to the brain), restless leg syndrome (uncomfortable feeling in legs and an irresistible urge to move them), gastroesophageal reflux disease, muscle weakness, need for assistance with personal care. Review of physician's orders, dated 8/27/24, showed a physician order dated 11/22/23 to Do Not Resuscitate. Review of care plan, revised 2/13/24, showed: -He/She planned to stay in facility for long term care. -His/Her code status was not addressed. (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of code status book showed Resident #6 with an Out of Hospital Do Not Resuscitate sheet signed 9/15/22. Review of Resident #6's Quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech; -He/She made self understood and usually understood others; -He/She was dependent on a wheelchair; -Diagnoses included high blood pressure, heart failure, diabetes (too much sugar in the blood), depression, asthma (condition making it difficult to breathe), neuropathy (condition resulting in nerves that are damaged resulting in pain, numbness, weakness, or tingling in one or more parts of the body), and muscle weakness. Review of physician's orders, dated 8/27/24, showed an order dated 11/19/22 to Do Not Resuscitate. Review of care plan, revised 3/29/24, showed: -He/She planned to remain in facility for long term care; -Care plan did not address resident's do not resuscitate orders. During an interview on 8/28/24 at 11:14 A.M., LPN A said the care plan should address resident's code status. During an interview on 8/28/24 at 2:58 P.M., MDS Coordinator said: -He/She had been in position a couple of months; -He/She had not written any actual care plans; -Care plans should address resident's code status. During an interview on 8/29/24 at 9:10 A.M., Administrator said: -He/She expected the care plan to be updated with significant changes, when desired outcomes were not met, when a resident was readmitted the facility, and quarterly with MDS; -If a resident's code status is in resident's chart then the resident's chart was considered part of his/her care plan; -Code status was reviewed at every care plan meeting.

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51166 Based on observation, interview, and record review, the facility failed to ensure they developed a comprehensive person-centered plan of care consistent with measurable objectives and timeframe's to meet the residents medical, nursing, mental, and psychosocial needs for six residents (#7, #27, #34, #17, #18,#6) of the12 sampled residents. The facility census was 37. Review of the facility's undated Care Plan Policy showed: - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. - The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and -The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The comprehensive, person-centered care plan will: Reflect the resident's expressed wishes regarding care and treatment goals. -Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 1.Review of Resident #7's Quarterly MDS dated [DATE] (a federally mandated assessment tool completed by facility staff) showed: -Resident is cognitively intact. -Diagnoses included: Heart failure; hypertension (high blood pressure), dementia; anxiety disorder; depression; non-traumatic spinal cord dysfunction. Review of the resident's physician's orders, 12/14/2023 showed the resident had an order of DNR (Do Not Resuscitate), No life saving measures, code status. Review of the resident's undated care plan on 8/29/24., showed the facility did not care plan the resident's code status wishes. 2.Review of Resident #27's Annual MDS dated [DATE] showed: (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident has significant cognitive decline impairment, and unable to make needs known. -Diagnoses include: Non-traumatic brain dysfunction(what is that-put that here); hypertension (high blood pressure); end-stage renal disease(kidney failure) diabetes mellitus; Alzheimer's disease; malnutrition or at risk for malnutrition; depression; impaired vision. Review of the resident's undated care plan on 8/29/24., showed the facility did not care plan the resident's code status wishes, nor did the facility care plan the risk for resident falling. Review of the resident's physician's orders, 11/19/22 showed the resident had an order of DNR (Do Not Resuscitate) code status. Review of electronic medical record progress notes showed on 7/10/2024 at 9:13 P.M.: -Res was observed walking up hallway with quilt draped over him/her and dragging part of it on floor. He/She did not have walker. NA B told him he needed walker and walked back to room with res. Review of Fall assessment dated [DATE] showed Resident was a fall risk of 12, which indicates a high-risk for falls score. Review of the resident's care plan, dated 7/4/24.,showed: -Resident has history of Falls. -Resident will be free of falls through the review date. -Staff are to anticipate and meet Resident's needs. -Be sure Resident's call light is within reach and encourage him to use it for assistance as needed. -Ensure that Resident is wearing appropriate footwear when ambulating with his walker. -Follow facility fall protocol. -Resident has very poor vision. Assist him/her throughout the facility as needed. -Resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night and his walker within his reach. 50980 3. Review of Resident #17's Significant Change Minimum Data Set, dated dated [DATE], showed: - Brief interview for mental status (BIMS) score of 2, indicating the resident was severely cognitively impaired; (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included: Reduced mobility, Amnesia (Memory Loss), Hypertensive Heart Disease with Heart Failure, Malignant Neoplasm of Uterus (Cancer). - Dependent on staff for toileting, shower/bath, dressing, personal hygiene, and transferring. Review of the resident's care plan dated, 8/26/24, showed: - Activities of daily living deficit and dependent on 2 staff for care. - Terminal prognosis for cancer requiring staff to provide maximum comfort for resident. - Indwelling urinary catheter for bladder draining, staff will change monthly, monitor and document intake and output. - Cognition deficit of which staff will be respectful and treat resident as an adult. - No interventions documented for 24 hour video and audio surveillance of resident's room. Observation at Nurse's station showed a video monitor of resident's room with sound which could be turned up. Resident was observed in bed pulling at his/her brief and conversation between resident and staff could be heard from the room from the monitor. Monitor as VTECH Model VM5255-22. 47195 4. Review of Resident #6's Quarterly minimum data set (MDS), dated [DATE], showed: -He/She was cognitively intact; -He/She had a hearing aide, minimal difficulty with hearing; -He/She had clear speech; -He/She made self understood and usually understood others; -He/She was dependent on a wheelchair; -He/She required partial/moderate assistance with toileting, bathing, upper and lower body dressing, personal hygiene, sit to lying rolling left and right, transitioning from lying to sitting on side of bed, sit to stand, chair to bed transfers, toilet/tub transfers, -Diagnoses included neuropathy (condition resulting in nerves that are damaged resulting in pain, numbness, weakness, or tingling in one or more parts of the body), and generalized muscle weakness. Review of physician's orders, dated 8/27/24, showed: -Ordered 6/30/23, side rails if indicated, no directions specified with order. Review of care plan, dated 8/21/24, showed: (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Bed Mobility: He/She required extensive assistance by 1 staff to turn and reposition in bed and as necessary. -Care plan did not address use of side rails. Observation on 8/26/24 at 10:19 A.M. showed u shaped cane rails on both sides of bed. During an interview on 8/26/24 at 10:19 A.M. resident said: -He/She used cane rail when he/she got up during the night to get back into his/her bed. Review of bed rail assessment showed: -Quarterly assessment completed 8/18/24 showed side rails were not indicated at that time; -Quarterly assessment completed 5/24/24 showed side rail placement side rails/assist bar were not indicated at that time; -Quarterly assessment completed 3/19/24 showed the resident had expressed a desire to have side rail/assist bar, side rails / assist bar were indicated and served as enabler to promote resident's independence. The side rail placement was bilateral to provide assist with toileting for the resident at night. -Quarterly assessment completed 6/1/23 showed Resident had expressed a desire to have side rails/assist bar, side rails/assist bar were indicated and served as an enabler to promote independence and the recommended placement was bilateral. 5. Review of Resident #18's Quarterly MDS, dated [DATE], showed: -No cognitive status available; -He/She had unclear speech and was rarely or never understood; -He/She had highly impaired vision and wore corrective lenses; --He/She had impairment on both sides of upper extremities; -He/She was dependent on a wheelchair; -He/She was dependent for eating, oral care, toileting, bathing, upper and lower body dressing, hygiene, and all mobility; -Diagnoses included tendency to fall, corneal transplant status, and anxiety disorder. Physician's orders, dated 8/27/24, showed: -He/She had no orders for side rails. (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ordered 6/30/23, side rails if indicated, was discontinued 12/13/23 by physician. Observation on 8/26/24 at 9:23 A.M. showed side rail up on the right side of the bed. Observation on 8/26/24 at 3:28 P.M. showed side rail up on the right side of the bed. Review of bed rail assessment showed: -No assessments found. 6. Review of Resident #34's Quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She was dependent on walker or wheelchair; -He/She required partial to moderate assistance with mobility; -He/She had 2 or more falls with no injuries since prior assessment -Diagnoses included peripheral vascular disease (a condition that can cause blood vessels to narrow, block or spasm), dementia (condition that causes a decline in brain function and impairment of a person's ability to think, remember, and make decisions), Parkinson's disease (a chronic, progressive brain disorder that causes movement problems), restless leg syndrome (uncomfortable feeling in legs and an irresistible urge to move them), muscle weakness, need for assistance with personal care. Review of physician's orders, dated 8/27/24, showed: -He/She had no orders for side rails. -Ordered 7/24/24, Immobilizer to right arm on at all times except showers. Review of care plan, revised 7/30/24, showed: -Bed Mobility: He/She was able to independently move self in bed (Revised 12/6/23); -Transfer: He/She required limited assistance of 1 staff to move betwen surfaces (Revised 12/6/23); -He/She was at risk for falls (revised 11/24/23); -He/she will be free from injury resulting from a fall through the next review date (Revised 2/13/24); -A fall risk assessment is completed quarterly (Initiated 11/24/23); -Assist him/her to the bathroom and with peri cares often (initiated 11/24/23); (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At times resident will crawl to the bathroom when feeling unsteady with walking or his/her Parkinson's symptoms are worse so he/she does not fall. Educate and remind [NAME] to use her call light to allow staff to assist her with going to the bathroom so she does not have to crawl (Revised 8/11/24); -He/She needed limited assistance of 1 staff member with transfers and walking. Staff to educate and remind her to use her call light for assistance (Revised 3/29/24); -Keep call light within reach and encourage [NAME] to use it (Initiated 11/24/23); -Keep pathways clear and free from clutter to allow for safe passage (Initiated 11/24/23); -Per family request there will be a monitor placed in Joys room to assist in alerting staff to falls (Initiated 7/30/24); -Respond to resident's needs and/or wants promptly (Revised 3/29/24); -Resident had a bone fracture of right clavicle (Initiated 7/24/24) -Resident will be free from signs and symptoms of pain, or will express/exhibit relief of pain after administration of ordered meds, alternative comfort measures. -Resident will not develop complications or permanent loss of mobility related to fracture through review date. -Give pain, anti-inflammatory medications as ordered. Monitor/document side effects and effectiveness. -Handle gently when moving or positioning. Maintain body alignment. -If orthopedic fixation device or traction is present, follow MD orders for monitoring, maintaining device and providing skin care. -Instruct resident regarding fracture healing process, diagnostic procedures, treatments and its complications, home care, daily activities, diet, restrictions, and follow-up. - Parkinson's Disease: Monitor for risk of falls (initiated 12/6/23); -Side rails were not care planned; -No new fall interventions care planned after each fall occurred. Review of fall history in electronic medical record showed: -On 7/24/24 fall with injury resulting in right clavicle fracture; -On 7/20/24 fall with no injuries occurred at 12:35 A.M.; (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 6/29/24 fall with no injuries occurred at 8:50 P.M.; -On 6/27/24 unwitnessed fall with injury at 1:30 P.M. resulting in skin tear on right lower shin and small abrasion on right knee. Review of fall risk assessments showed a score of 10 or greater the resident was considered high risk for potential falls: -On 6/10/24 a quarterly assessment showed he/she was at high risk with score of 10; -On 2/22/24 a quarterly assessment showed he/she was not high risk with score of 8; -On 12/10/23 an admission assessment showed he/she was not at high risk with score of 9. Observation on 8/26/24 at 9:55 A.M. showed resident had a U -shaped cane rail that was up on the right side of his/her bed. During an interview on 8/26/24 at 9:55 A.M. resident said his/her side rail was up to hold his/her call light in place. During an interview on 8/26/24 at 11:32 A.M. resident said he/she had multiple falls due to restless leg and parkinson's and he/she broke his/her collar bone a few weeks ago when a fall occurred. He/She was wearing the immobilizer on his/her arm from the fall with injury. Observation on 8/27/24 at 8:15 A.M. showed resident had bruising to the right side of his/her face. During an interview on 8/27/24 at 2:17 P.M., Director of Nursing (DON) said: -He/She did not know if physicians orders were required for bed rails; -Side rail assessments were completed quarterly and with significant changes; -When side rail assessments showed side rails were not indicated, he/she would expect side rails to be removed; -He/She completed areas of entrapment measurements monthly; During an interview on 8/27/24 at 2:24 P.M., DON said: -Administrator stated facility had physician's orders for residents who had side rails. During an interview on 8/28/24 at 11:14 A.M., Licensed Practical Nurse (LPN) A said: -He/She would assess resident for injuries, obtain vitals, notify family, physician, Director of Nursing (DON), Administrator, and complete risk management form after each fall; (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-After a resident had falls he/she would get a urinalysis order, have physical therapy evaluate and treat, keep resident's call light close, ensure appropriate footwear was worn, and walker was in reach; -After a resident falls the social service staff, MDS Coordinator, or DON updates residents care plans; -The nurses did not update resident care plans; -Care plans should address new interventions after each time resident has fallen. DON and Administrator on 8/28/24 at 11:30 A.M. said: - It is not regulation to include code status in the care plan and DON said they do not put code status in the care plan because it is documented in resident's chart. During an interview on 8/28/24 at 2:58 P.M., MDS Coordinator said: -New interventions should be added to the care plan after each new fall with dates; -Care plans should address assist bars or side rails and falls. During an interview on 8/29/24 at 9:10 A.M., Administrator said: -When a resident falls the nurse completed an investigation known as the risk management form; -He/She expected care plans to be updated with significant changes, when desired outcome was not met, when resident was readmitted ot the facility, and quarterly with their MDS; -He/She believes the resident's medical record or chart is part of resident's care plan; -He/She expects staff to do side rail assessments; -The side rail assessments are a part of the residents chart so are included in the resident's care plan.

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	265746	A. Building B. Wing	08/29/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observations, interviews, and record review, the facility failed to ensure staff followed professional standards of care for four of the 12 sampled residents when staff installed side rails without a physician's order which affected one sampled resident, (Resident #18); failed to obtain orders for self-administration of drugs for one sampled resident, (Resident #34); failed to follow physician orders for medications (Resident #31) and immobilizer (Resident #34), and left blanks in the documentation on the MAR (Medication Administration Record) for one resident (Resident #6). The facility census was 37. The facility did not provide a policy on professional standards of care. Review of the facility policy regarding documentation of medication administration, showed: - The facility shall maintain a medication administration record to document all medications administered. - Administration of medication must be documented immediately after (never before) it is given. Review of the facility policy regarding storage of medications, showed: - The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Review of the facility policy, Medication Therapy, showed: -The resident's clinical record must contain a written order for all prescription, including over-the-counter medications taken by the resident. 1. Review of Resident #31's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 8/29/24 shows: - admitted [DATE] - BIMS score of 15, indicating no cognitive deficit. - Diagnoses include: Parkinson's Disease (disease of the nervous system), Hypertension (high blood pressure) Diverticulosis of Intestine (inflammation of the intestine) -Requires monitoring and some nursing assistance of one for activities of daily living. - Resident requires a walker for mobility. Review of the resident's physician order sheet (POS), dated, 8/27/24, showed: - Order for Pataday Ophthalmic Solution for allergies, 1 drop in both eyes at bedtime; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Order for Polyethylene Glycol 17 grams by mouth one time a day for Constipation; Review of the resident's medication administration record (MAR), dated, August, 2024, showed: - Pataday Ophthalmic Solution instill one drop in both eyes at bedtime, medication was not documented as administered for 27 days. - Polyethylene Glycol administered only 12 times out of 27 days. Review of the resident's care notes from October 2023 to August 2024, showed no documentation that the resident refused to allow staff to administer eye drops. During an interview on 8/28/24 at 2:25 P.M. the resident said he/she had not received eye drops for months and was told by staff that they were out of the medication. During an observation and interview on 8/28/24 at 3:45 P.M., CMT B stated: - Pataday eye drops are kept in the medication cart. CMT B was not able to find any eye drops and said they were out of stock. CMT B stated that the standard procedure would be to order the medication if they were out. CMT B confirmed there were no eye drops on order and requested a refill of Pataday eye drops during the interview. CMT B stated that resident had refused to take this medication in the past. 47195 2. Review of Resident #18's Quarterly MDS, dated [DATE] showed: -Cognition was not evaluated on the MDS; -He/She had unclear speech and was rarely or never understood; -He/She had impairment on both sides of upper extremities; -He/She was dependent on a wheelchair; -He/She was dependent for all ADL (Activities of Daily Living) assistance; -He/She had no falls since admission; -Diagnoses included heart failure, high blood pressure, anxiety disorder, depression, tendency to fall, heart disease, corneal transplant status, overactive bladder, urinary tract infections Physician's orders, dated 8/27/24, showed: -He/She had no orders for side rails. -Ordered 6/30/23, side rails if indicated, was discontinued 12/13/23 by physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/26/24 at 9:23 A.M. showed side rail up on the right side of the bed. Observation on 8/26/24 at 3:28 P.M. showed side rail up on the right side of the bed. Review of bed rail assessment showed: -No assessments found. During an interview on 8/27/24 at 2:17 P.M., Director of Nursing (DON) said: -He/She did not know if physician's orders were required for bed rails; During an interview on 8/27/24 at 2:24 P.M., DON said: -He/She checked with administrator and facility had physician's orders for all residents who had side rails. 3. Review of Resident #34's Quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She felt down or depressed or hopeless 2-6 days per week; -He/She was dependent on walker or wheelchair; -He/She required set up or clean up assistance with eating; -He/She was independent with oral care, toileting, upper and lower body dressing, -Diagnoses included: Dementia (condition that causes a decline in brain function and impairment of a person's ability to think, remember, and make decisions), Parkinson's disease (a chronic, progressive brain disorder that causes movement problems), malnutrition, depression, muscle weakness, need for assistance with personal care. Review of care plan, dated 7/24/24, showed: -Administer medications as ordered by physician. -Resident had a bone fracture of right clavicle; -Resident will not develop complications or permanent loss of mobility related to fracture through review date. -Handle gently when moving or positioning. Maintain body alignment. -If orthopedic fixation device or traction is present, follow MD orders for monitoring, maintaining device and providing skin care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Instruct resident regarding fracture healing process, diagnostic procedures, treatments and its complications, home care, daily activities, diet, restrictions, and follow-up. Review of physician's orders, dated 8/27/24, showed: -Ordered 2/22/24, artificial tears ophthalmic solution 1.4%, polyvinyl alcohol, instill 2 drops in both eyes every 8 hours as needed for dry eyes both eyes; -No orders for medications at bedside. -Order started 7/24/24, for Immobilizer to be in place to right arm and on at all times except showers. Review of electronic medical record showed: -No assessment for self-administration of medications. -On 7/24/24 an x-ray was completed at the emergency room of resident's right shoulder which showed there was an acute displaced fracture of the right clavicle. Review of facility electronic medical record showed: -On 7/24/24 at 1:18 P.M., Resident returned from the emergency room . His/Her right clavicle was fractured and he/she will be wearing an immobilizer at all times except during showers for 6-8 weeks. Observation on 8/26/24 at 9:53 A.M. showed Xlldra eye drops at bedside, 10 vials of unmarked clear tubes that appeared like breathing treatments vials were sitting in a metal tin container be side resident's chair, along with an open container of Vaseline, and nasal spray. During an interview on 8/26/24 at 11:32 A.M. resident said he/she had multiple falls and he/she broke his/her collar bone. An observation on 8/27/24 at 1:57 P.M. showed resident was sitting in his/her wheelchair in his/her room and did not have immobilizer on. An observation on 8/27/24 at 4:10 P.M. showed resident sitting in front of nurses station with no immobilizer on. During an interview on 8/28/24 at 11:14 A.M., LPN A said: -Medications were not allowed to be left at residents bedside unless a doctor gave facility an order; -Residents who have medications at bedside should have a self-administration of medication assessment completed; -He/She was not aware of any resident who had an order to keep his/her medications at bedside or who had been assessed. (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 9:10 A.M., Administrator said: -He/She expected resident's physician's orders to be followed regarding wearing an immobilizer at all times except while showering; -He/She was aware that resident would voluntarily take his/her immobilizer off; -He/She did expect staff to reapply immobilizer when they noticed it was off. During an interview on 8/29/24 at 9:23 A.M., Director of Nursing said: -Resident did not self-administer medications. During an interview on 8/29/24 at 11:30 A.M., Director of Nursing said: -He/She expected resident with orders to have an immobilizer on at all times but showering to have immobilizer on if resident did not refuse; -It was resident's right to refuse to wear immobilizer. 4. Review of Resident #6's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 5/30/24, showed: -He/She was cognitively intact; -He/She had a hearing aide, minimal difficulty with hearing; -He/She had clear speech; -He/She made self understood and usually understood others; -He/She was dependent on a wheelchair; -He/She required partial/moderate assistance with ADLS; -Diagnoses included high blood pressure, heart failure, diabetes (too much sugar), depression, asthma (condition making it difficult to breathe), Hypothyroidism (Low functioning thyroid gland hormone). Review of care plan, revised 3/29/24, showed: -Nurse to give medications as ordered; Review of physician's orders, dated 8/27/24, showed: -Order started 12/19/22, Accucheck every Monday 0600 one time a day every Monday related to Type 2 diabetes mellitus without complications; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order started 12/1/22, Fluticasone Propionate Suspension 50 MCG/ACT, 1 spray in each nostril one time a day related to allergic rhinitis; -Order started 4/12/24, Levothyroxine Sodium Oral Tablet 100 MCG, Give 1 tablet by mouth one time a day for thyroid stimulating hormone (TSH); Review of Medication Administration Record (MAR), dated August 2024, showed: -Accucheck every Monday 0600 one time a day related to Type 2 Diabetes Mellitus without complications -No entry on 8/5, 8/12, and 8/26; -Fluticasone Propionate Suspension 50 MCG/ACT, 1 spray in each nostril one time a day related to Allergic rhinitis at 0600: -No entry on 8/1, 8/12, and 8/15; -Levothyroxine Sodium Oral Tablet 100 MCG (Levothyroxine Sodium), Give 1 tablet by mouth one time a day for TSH at 0600: -No entry on 8/1, 8/12, and 8/15; During an interview on 8/29/24 at 9:10 A.M., Administrator said: -He/She expected there to be no blanks in the MAR; -Facility staff had to chart something in the MAR and were not allowed to lave blanks; -He/She believed the electronic medication administration system did not allow staff to not document something in the MAR, therefore a blank would not be possible in the charting system. During an interview on 8/29/24 at 11:30 A.M., Director of Nursing said: -There should not be blanks in the MAR; -There should be an annotation as to why medication was not given or orders not completed; -He/She did not think it was possible for a blank to be left in the MAR with the electronic medication administration system.

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	265746	A. Building B. Wing	08/29/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation, interview and record review, the facility failed to provide an ongoing activity program to support residents in their choice of activities designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident when residents were not offered activities. This affected two residents (Residents #12 and #29) out of 12 sampled residents. The facility census was 37. Review of the facility's Activities policy, revised August 2006, showed, in part: - Activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs; - Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs; Review of the facility's Activities Documentation policy, revised December 2009, showed, in part: -Recordkeeping is a vital part of the activity programs; - Activity Department personnel will maintain records of: activity assessment with a copy in the medical record of the resident, attendance records, activity progress notes, individualized activity Care Plan or activities portion of the Comprehensive Care Plan, Resident Council minutes and record reviews and updates; -The Activity Director/Coordinator is responsible for obtaining, charting, and filing required reports; Review of the facility's Activities Attendance policy, revised August 2006, showed, in part: - The Activity department records activities attendance and participation of all residents; - Attendance and participation are recorded for every resident in group and individual activities on a daily basis; - Records are reviewed on a regular basis to determine any changes in resident participation that might indicate a change in condition and lead to reassessment and care plan review; - Attendance records are filed for a minimum of three years; Review of the facility's Individual Activities and Room Visit Program policy, revised August 2006, showed, in part: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities. Residents who are able to maintain an independent program will have supplies available to them. - The activities offered are reflective of the resident's individual activity interests, as identified in the Activity Assessment, progress notes and the resident's Comprehensive Care Plan. - It is recommended that residents on a full room visit program receive, at a minimum, three room visits per week. Typically, a room visit is ten to fifteen minutes in length. - Residents who choose not to attend group activities will maintain an independent program. It is the responsibility of the facility and the activity staff to make regular contacts and offer supplies, as needed. 1. Review of Resident #12's Significant Change MDS, dated [DATE], showed: - Cognitive skills moderately impaired; - Dependent assistance for eating, oral and personal hygiene, dressing, toileting, mobility, and transfers; - Diagnoses included: Atrial Fibrillation (Irregular rapid heartbeat), Coronary Artery Disease (Heart condition), Thrombosis (Blood cots), Heart Failure, Hypertension (High blood pressure), Peripheral Vascular Disease (Circulation Disorder), Renal Insufficiency (Kidney disease), and Depression. - Staff did not perform an assessment of daily activity preferences for the resident. Review of Resident Care Plan revised 4/12/24 showed: - Encourage resident to participate in group activities - Have resident read his/her own mail - Encourage resident to sit outside and transport on their own - Goal for resident was two activities each day Review of Resident participation in activities from Activity Director logs did not have any documented activities for the last 90 days. 2. Review of Resident #29's quarterly MDS, dated [DATE], showed: - Cognitive skills severely impaired; - Dependent assistance required for toileting and transferring; - Substantial assistance required for bathing, dressing and personal hygiene; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included Alzheimer's Disease (Memory loss), Sjogren syndrome (Immune system disorder), Schizoaffective Disorder (mental health mood disorder), Depressed and Severe Protein-Calorie Malnutrition (Diet deficiency), Hypertension (High blood pressure) Review of Resident Care plan, revised 5/28/24, showed: - Staff will invite and encourage resident to attend activities to improve his/her mood - Resident is expected to participate in two activities daily - Activity Director will continue to read resident his/her mail - Resident will attend the pet therapy activity Review of Resident Activity Preferences dated, 8/7/24 showed: - Pet therapy and family visits with his/her son are very important activities for the resident; - Resident is not interested in group activities; Review of Resident participation in activities from Activity Director logs did not have any documented activities for the last 90 days. 3. Observations from 8/26/24 through 8/29/24 at various times from 7:45 A.M. to 4:30 P.M., showed there were no one on one individualized activities in progress for residents #12 or #29. 4. During an interview on 8/28/24 at 3:30 P.M., the Activities Director stated: - Resident #12 sleeps often and is hard to reach for activities. Mainly activities have consisted of reading the mail to resident and sitting outside when the weather is good. - Activities Director uses only one source for Pet therapy and can only have that activity once every 90 days due to scheduling. The Activity Director could not recall exactly when the last time pet therapy was conducted. During an interview on 8/29/24 at 11:30 A.M., the Administrator stated he/she would expect more than weekly one on one activity engagements for residents that do not want to or cannot engage in group activities.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31102 Based on observations, interviews, and record review, the facility failed to assure staff provided catheter (a sterile tube inserted into the bladder to drain urine) care in a manner to prevent a urinary tract infection(UTI) or the possibility of a UTI for one of the 12 sampled residents, (Resident #1). The facility census was 37. Review of the facility's undated policy for indwelling urinary catheter, showed, in part: - Position the resident on their back; - Wash around the catheter insertion site and then from the tip of the skin fold down to the body, including all skin folds; - Cleanse approximately 1/3 of catheter tubing from the insertion site. 1. Review of Resident #1's care plan, revised 5/28/24 showed: - The resident had an indwelling catheter related to obstructive uropathy (a urinary tract condition that occurs when urine flow is blocked, causing urine to back up into the kidneys). Position the catheter bag and tubing below the level of the bladder and away from entrance room door. Change the 18 french (fr.) catheter monthly. Monitor, record, report to physician for signs and symptoms of a UTI; Focus: bowel and bladder. Change catheter monthly and as needed. The resident is dependent on staff for all toileting needs. The resident is incontinent of bowel and wears incontinent briefs. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/25/24 showed:- Cognitive skills for daily decision making severely impaired; - Dependent on the assistance of staff for toilet use, dressing, personal hygiene and transfers; - Always incontinent of bowel; - Diagnoses included cancer, renal insufficiency (when the kidneys are not functioning properly and may need treatment or further evaluation), obstructive uropathy, dementia (inability to think), and depression. Review of the resident's physician order sheet (POS), dated August, 2024 showed:- Order date: 8/12/24 - Urinalysis (UA) reflux to culture (a test that includes a dipstick urinalysis, microscopic examination, and culture); - Order date: 5/30/24 - urinary catheter care every shift. (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's UA, dated 8/13/24 showed:- The presence of bacteria indicative of a possible UTI; - Keflex (antibiotic used to treat UTIS), 500 milligrams (mg.) three times daily for ten days per the physician. Observation on 8/27/24 at 1:39 P.M., showed: - Certified Nurse Aide (CNA) A and Nurse Aide (NA) A removed the residents pants and unfastened the incontinent brief; - CNA A did not separate and clean all areas of the front skin folds and used the same area of the wipe to clean different areas of the front skin folds; - CNA A and NA A turned the resident on his/her side; - CNA A wiped from front to back multiple times with fecal material on each wipe; - CNA A did not clean the catheter tubing. During an interview on 8/28/24 at 10:52 A.M., NA A said: - We should separate and clean all the skin folds; - We should not use the same area of the wipe to clean different areas of the skin; - The catheter tubing should be cleaned with catheter care. During an interview on 8/28/24 at 10:55 A.M., CNA A said: - He/she should not have used the same area of the wipe to clean different areas of the skin; - He/she should have separated and cleaned all the skin folds; - He/she should have cleaned the catheter tubing with catheter care. During an interview on 8/29/24 at 11:30 A.M., the Director of Nursing (DON) said;- Staff should not use the same area of the wipe to clean different areas of the skin. It should be one wipe, one swipe; - Staff should separate and clean all the skin folds; - The catheter tubing should be cleaned during catheter care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on record review and interview, the facility failed to ensure they obtained a signed and dated statement from the pharmacist when no irregularities were identified during the medication regimen review, and when the pharmacist date of review and name was not listed on any medication regimen reviews. Failed to provide documentation that a monthly medication regimen review was completed, and failed to provide documentation that the medication regimen review was provided to the physician monthly. This affected five of the twelve sampled residents (Resident #6, #18, #3, #7 and #27). The facility census was 37. Review of facility policy, Medication Regimen Review, Revised April 2007, showed: -The consultant pharmacist shall review the medication regimen of each resident at least monthly. -Consultant pharmacist will perform a medication regimen review (MRR) for every resident in the facility. -The Consultant Pharmacist will document his/her findings and recommendation on the monthly drug/medication regimen review report. -The Consultant Pharmacist will provide a written report to physicians for each residents with an identified irregularity. If situation is serious enough to represent a risk to a person's life, health, or safety the consultant pharmacist will contact the physician directly to report the information to the physician and will document such contacts. If the physician did not provide a pertinent response, or the consultant pharmacist identifies that no action had been taken, he/she will then contact the Medical director, or-if the medication director is the physician of record-the administrator. -The Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed, and dated copy of the report, listing the irregularities found and recommendations for their solutions. -Copies of the drug/medication regimen review reports, including physician responses, will be maintained as part of the permanent medical record. Review of facility policy, Medication Therapy, revised April 2007, showed: -Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. -Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether: -there is clear indication for treating that individual with the medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the dosage is appropriate; -the frequency of administration and duration of use are appropriate, and -potential and suspected side effects are present. -the physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example: -when a medication is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale; -when the results of ongoing assessment, or the presence of clinically significant adverse consequences monitoring, suggest that a medication should be reduced or discontinued entirely; and -when a medication is being prescribed to treat, or in anticipation of, an adverse consequence of another prescribed drug. -The Consultant Pharmacist shall review each resident's medication regimen monthly as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected. -The Medical Director and Consultant Pharmacist shall collaborate to address issues of medication prescribing and monitoring with the practitioners and staff. 1. Review of Resident #6's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 5/30/24, showed: -He/She was cognitively intact; -Diagnoses included high blood pressure, heart failure, diabetes (too much sugar), depression, asthma (condition making it difficult to breathe, neuropathy (condition resulting in nerves that are damaged resulting in pain, numbness, weakness, or tingling in one or more parts of the body), and generalized muscle weakness, -He/She had been on schedule pain medications, no PRN pain meds in last 5 days; -He/She was taking an antidepressant, anticoagulant, and diuretic Review of the Resident's care plan showed: -He/She uses antidepressant medication Sertraline for Depression -He/She Will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. -Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Sertraline. Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes Review of the resident's physician's orders, dated August 2024, showed: -Order started 1/30/24, Sertraline HCL tablet 25MG, give 1 tablet by mouth one time a day for depression, was discontinued on 7/10/24; -Order started 7/11/24, Sertraline HCL Tablet 25mg, Give 1 tablet by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Friday, Saturday for depression. Review of progress notes from September 2023 to August 2024 showed: -On 9/5/23, the DON wrote the pharmacy consult was received and no irregularities noted. -On 10/25/23, the DON wrote, no new irregularities this month. -On 11/22/23, the DON pharmacy consult received and no irregularities noted. -On 12/7/23, the DON wrote pharmacy consult received and no irregularities noted. -On 1/29/24, the DON wrote pharmacy consult received with no irregularities noted. -On 2/6/24, the DON wrote pharmacy consult notes receives with no new irregularities. -On 3/12/24, the Director of Nursing (DON) wrote pharmacy consult review received with no new irregularities noted. -April 2024 had no drug regimen review; -May 2024 had no drug regimen review; -June 2024 had no drug regimen review; -July 2024 had no drug regimen review; Review of facility provided notes to attending physician from the pharmacist showed: -Documented notes from 9/5/23 through 8/1/24 the following statement: It is my professional judgment that at such time, the resident's medication regimen contained no new irregularities, did not identify name of consultant pharmacist, no signature from pharmacist or physician/prescriber, or date medication regimen review was completed; (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility gradual dose reduction tracking form showed: -On 5/29/24 the physician was faxed by the Director of Nursing- That a gradual dose reduction was due on resident's sertraline 25 mg daily. -On 7/3/24 the physician wrote orders and signed to decrease resident's sertraline 25 mg to 6 days per week. 2. Review of Resident #18's Quarterly MDS, dated [DATE], showed: -Cognitive status was not assessed; -He/She took an antipsychotic medication, anticoagulant, and diuretic medications; -He/She had an antipsychotic received, a GDR (Gradual dosage reduction) had been attempted on 5/8/24, -A GDR has not been documented by a physician as clinically contraindicated. -Diagnoses included: Dementia (group of conditions characterized by impairment of at least two brain functions such as memory loss and judgement), anxiety disorder, and depression; Review of care plan, revised 7/11/23, showed: -He/She used psychotropic medications Haloperidol related to behavior management; -He/She would be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. -Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. -Consult with pharmacy, and physician to consider dosage reduction when clinically appropriate at least quarterly. -Discuss with Medical Director, family regarding ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Review of care conference held 6/27/24, showed: -Reviewed medications with hospice nurse; -Requested to continue decreasing Haloperidol, divalproex sodium and clonazepam; -Hospice nurse agreed with plan to decrease medications. Review of physician's orders, dated August 2024, showed: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order started 6/20/24, clonazepam oral tablet .5 mg, give .5 tablet by mouth in evening related to anxiety disorder; -Order started 6/20/24, divalproex sodium oral capsule delayed release sprinkle 125mg, Give 2 capsule by mouth in the evening for behavior management. -Order started 6/27/24, haloperidol oral tablet .5 mg, give .5 mg by mouth one time a day related to anxiety disorder; Review of facility provided notes to attending physician from the pharmacist showed: Documented notes from 9/5/23 through 8/1/24 the following statement: It is my professional judgment that at such time, the resident's medication regimen contained no new irregularities, did not identify name of consultant pharmacist, no signature from pharmacist or physician/prescriber, or date medication regimen review was completed. Review of facility gradual dose reduction tracking showed: -On 5/6/24 the physician was faxed by the Director of Nursing that resident had been doing much better in the afternoon and evening but became very tired when taking the 2:00 P.M. dose of Haloperidol .5mg three times a day and clonazepam .25mg three times a day. Would it be acceptable to go down to twice daily to encourage activity and interaction with family in the afternoon; -On 5/7/24 the physician wrote orders to decrease haloperidol .5mg to twice a day and clonazepam to .25 twice a day. Review of progress notes from September 2023 to August 2024 showed: -On 1/29/24, DON wrote the pharmacy consult received and no irregularities noted. -On 2/6/24, DON wrote the pharmacy consult notes received with no new irregularities. -On 3/12/24, DON wrote the pharmacy consultant notes showed based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgment that at such time, the resident's medication regimen contained no new irregularities. -April 2024 had no drug regimen review; -May 2024 had no drug regimen review; -June 2024 had no drug regimen review; -July 2024 had no drug regimen review; 51166 3. Review of Resident #3's Quarterly Minimum Data Set, dated dated [DATE], showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	08/29/2024

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cognitive skills intact. - Received PRN pain medication in the last five days. - Diagnoses included: Fractures and other multiple trauma; cancer; heart failure; hypertension; kidney failure; anxiety disorder; depression; lung disease. Review of the Consultant Pharmacist's Medication Regimen Review, dated 6/28/24, showed: - The resident had an order for Xarelto 15 milligrams (mg) daily. - A recommendation to add with food to the instructions on the physician order sheet (POS) and medication administration record (MAR). Review of the POS, dated 7/30/24, showed: -Sertraline 100 mg daily at 8 A.M. one time a day for depression; Cyclobenzaprine HCl Tablet 5 MG Give 1 tablet by mouth every 8 hours as needed for Pain Muscle spasms; oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl), give 1 tablet by mouth every 6 hours as needed for moderate to severe pain; ALPRAZolam Oral Tablet 0.25 MG (Alprazolam), give 0.25 mg by mouth two times a day related to GENERALIZED ANXIETY DISORDER; DULoxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG (Duloxetine HCl), give 1 capsule by mouth two times a day related to MAJOR DEPRESSIVE DISORDER. Review of 7/1/24, 6/6/24, 5/6/24, and 4/3/24 Medication Record Review showed: No recommendations noted; consulting pharmacist did not sign; physician did not sign or date to indicate reviewed. Review of Significant Correction, dated 6/28/2024, showed the resident is not prescribed AP (antipsychotics). Resident is prescribed anti-anxiety meds, antidepressant, and opioids. 4. Review of Resident #7's Quarterly Minimum Data Set, dated dated [DATE], showed: - Cognitive skills intact. - Diagnoses included: non-traumatic spinal cord dysfunction; heart failure; high blood pressure; dementia; anxiety disorder, depression. Review of Pharmacy Consultant Medication Review Reports dated 1/16/24, 2/1/24, and 3/7/24 showed: No recommendations noted; consulting pharmacist did not sign; physician did not sign or date to indicate reviewed. Review of Resident's current Physicians Orders showed: - Take Doxycycline 100 mg BID x 10 days two times a day for redness to outer right thigh and knee for 10 Days Start 6/5/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Doxycycline Hyclate Tablet 100 MG Give 1 tablet by mouth two times a day for infection for 14 Days -Discontinued 04/29/2024. 5. Review of Resident #27's Quarterly Minimum Data Set, dated dated [DATE], showed: - Cognitive skills are significantly impaired. - Received seven insulin injections in the last seven days. - Diagnoses included: non-traumatic brain dysfunction; hypertension; kidney failure; diabetes; Alzheimer's disease; at risk for malnutrition; depression. Review of 7/4/24 Care Plan Showed: - Resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. - Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. - Educate resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Mirtazapine. - Monitor/document/report as needed any adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts. Review of Pharmacy Consultant Medication Review Reports dated 1/16/24, 3/7/24 and 4/2/24 showed: - No recommendations noted; consulting pharmacist did not sign; phys. did not sign or date to indicate reviewed. During an interview on 8/27/24 at 10:16 A.M., Administrator said: -The Director of Nursing (DON) maintained a gradual dose reduction book; -He/She followed the book closely and kept tabs on residents who required a gradual dose reduction; -He/She notified the physician prior to the pharmacist prior to the pharmacist coming in regarding the need for a gradual dose reduction; -The DON got the gradual dose reduction orders signed from the doctor prior to the pharmacist doing his/her reviews. During an interview on 8/27/24 at 1:44 P.M., Director of Nursing (DON) said: -The pharmacist came to facility to do drug regimen reviews; (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When resident has no recommended changes to their drug regimen, the reviews were not sent to the physicians; -Physician's do their own reviews of the resident's medical records; In an interview with Director of Nursing, on 08/29/24 at 11:23 AM, he/she said the pharmacist signs a cover sheet and the physicians sign off on orders monthly. During an interview on 8/29/24 at 11:30 A.M., Administrator said: -Drug Regimen Reviews only need to be signed by the physician if there was drug irregularities per their facility policy. During an interview on 8/29/24 at 11:30 A.M., DON said the drug regimen review was handed to him/her by the pharmacist with a cover letter that included a signature from the pharmacist.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 31102 Based on observations, interviews and record review, the facility failed to ensure staff maintained a medication error rate of less than five percent. Staff made two medication errors out of 25 opportunities for error, resulting in a medication error rate of 8%. This affected two of the 12 sampled residents, (Resident #16 and #32). The facility census was 37. Review of the facility's undated policy for nasal drops/spray medication administration showed: - Withdraw the medication into the dropper or uncap the spray or squeeze bottle if this is the type of dispenser used; - Ask the resident to breathe through the mouth during the administration. Review of the package leaflet for Flonase nasal spray, revised March 2016, showed, in part: - Shake the bottle gently; - Blow your nose to clear the nostrils; - Close one side of the nostril. Tilt your head forward slightly and carefully insert the nasal applicator into the other nostril; - Start to breathe in through your nose, and while breathing in press firmly and quickly down one time on the applicator to release the spray; - Repeat in the other nostril; - Wipe the nasal applicator with a clean tissue and replace the cap. 1. Review of Resident #32's physician order sheet (POS), dated August, 2024 showed:- Order date: 7/31/24 - Flonase Allergy Relief Nasal Suspension, one spray in both nostrils daily for allergies. Review of the resident's medication administration record (MAR), dated August, 2024 showed: Flonase Allergy Relief Nasal Suspension, one spray in both nostrils daily for allergies. Observation on 8/27/24 at 8:33 A.M., showed: - The resident sat in a chair in the hallway; - Licensed Practical Nurse (LPN) A shook the bottle and handed it to the resident; - LPN A did not give the resident any instructions; - The resident gave him/herself one spray in the right nostril then gave him/herself one spray in the left nostril; (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident did not close either side of the nares. During an interview on 8/27/24 at 1:18 P.M., LPN A said:- He/she should have given the resident instructions; - He/she just follows the physician's orders. During an interview on 8/29/24 at 11:30 A.M., the Director of Nursing (DON) said:- Staff should give the resident instructions on how to use the medication; - Staff should follow the manufacturer's guidelines unless there are different guidelines. 2. Review of the facility's undated policy for eye drops administration showed: - Prevent tip of the eye dropper from touching the resident; - Ask the resident to look upward if resident is able; - While holding the bottle in a vertical position and slightly to the side of the eye and about one-half inches above the eye, instill the ordered number of drops into the conjunctive sac (the space between the bulbar and palpebral conjunctiva in the eye). Review of the website, https://www.webmd.com for Systane eye drops showed: - Place the dropper directly over the eye and squeeze out one or two drops as needed; - Look down and gently close your eye for one or two minutes; - Place one finger at the corner of the eye near the nose and apply gentle pressure; - This will prevent the medication from draining away from the eye. Review of the resident's POS, dated August, 2024 showed: - Order date: 11/25/22 - Systane solution 0.4-0.3%, instill one drop in both eyes twice daily for dry eyes. Review of the resident's MAR, dated August, 2024 showed: - Systane solution 0.4-0.3%, instill one drop in both eyes twice daily for dry eyes. Observation on 8/27/24 at 8:43 A.M., showed: - LPN A instilled two drops in the left eye and two drops in the right eye; - LPN A did not apply lacrimal pressure (apply pressure to the inner corner of the eye). During an interview on 8/27/24 at 1:18 P.M., LPN A said: (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/she did not know what lacrimal pressure was; - He/she should give the amount of eye drops that was ordered. During an interview on 8/29/24 at 11:30 A.M., the DON said: - Staff should administer the amount of eye drops that were ordered; - Was not aware of lacrimal pressure or for how long.

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	265746	A. Building B. Wing	08/29/2024

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31102 Based on observations, interviews and record review, the facility failed to follow their policy for storage of medications when they stored food and medication in the medication refrigerator. This had the potential to affect all the residents in the facility. The facility census was 37. Review of the facility's undated policy for storage of medications showed, in part: - The facility shall store all drugs and biologicals in a safe, secure, and orderly manner; - Medications requiring refrigeration must be stored in a refrigerator per the manufacturer recommendation and located in the drug room at the nurse's station or other secured location; - Medications must be stored separately from food and must be labeled accordingly. 1. Observation and interview on 8/27/24 at 11:46 A.M., of the medication room showed: - The medication refrigerator had at least 15 containers of applesauce and nine containers of Med Pass (oral nutritional supplement) and two small containers of tomato juice; - Licensed Practical Nurse (LPN) A said it was used for medication pass. During an interview on 8/29/24 at 11:30 A.M., the Director of Nursing (DON) said the Med Pass, applesauce and tomato juice could be in the refrigerator as long as it is separated from the medication.

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	265746	A. Building B. Wing	08/29/2024

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observations, interviews and record review, the facility failed to ensure staff served food to the residents that was palatable, attractive, and served at a safe and appetizing temperature when cooked foods were not temperature checked and finished products were held on the steam line in excess of three hours for 6 of 8 residents sampled (Resident #6, #7, #17, #27, #34, #36). The facility census was 37. No policy on required temperature checks of cooked food was provided. Review of facility policy, food safety and sanitation, undated, showed: -There was no guidance on how to prepare, distribute, and serve food in accordance with professional standards for food safety. Review of facility policy, assistance with meals, revised September 2013, showed: -For all residents, hot foods shall be held at a temperature of 136 degrees or above until served. Cold foods shall be held at 40 degrees or below until served. Nursing and Dietary Services will establish procedures such that delivery of food to serving areas accommodates this requirement. Direct observation of lunch service on 8/28/24 showed: Cook A completed all the below tasks: -Spinach preparation complete and on the steam line at 9:15 A.M.; Staff observed taking final cook temperature 160 degrees and recording. -Au Gratin potatoes complete and on the steam line at 9:15 A.M.; Staff observed taking final cook temperature 160 degrees and recording. -Ham and Pineapple main course complete and on the steam line at 10:15 A.M.; Ham was medium pink in color coming out of the oven. Staff observed taking final cook temperature 165 degrees and recording. - Banana pudding set up for lunch service from refrigerator to counter 11:30 A.M. -First lunch tray is prepared at 12:16 P.M. with Spinach and Au Gratin potatoes warming for 3 hours and main course Ham warming for 2 hours. -No temperatures were observed taken for any items on the steam line before serving or during their time on the steam line. Banana pudding was served but no temperatures were observed taken to ensure below 41 degrees. Observation of test tray from lunch 8/28/24 at 12:42 P.M., received directly after the last resident was served their meal showed: (continued on next page)

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	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ham and Pineapple 2.5 hours on the steam line before serving is at 118 degrees which is below the appropriate serving temperature of 135 degrees. Observation of meat is dried out, hard, and dark red in color with an overcooked texture. - Spinach 3.5 hours on the steam line before serving is very mushy in texture at 150 degrees. -Au Gratin Potatoes 3.5 hours on the steam line before serving is bland at temperature 156 degrees. -Banana Pudding 1.25 hours sitting on the countertop covered with wax paper is at 57 degrees which is above appropriate serving temperature of 41 degrees. 1. Review of Resident #7's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/6/24 showed: - Resident is cognitively intact. - Diagnoses of heart failure; hypertension (High blood pressure); hyperlipidemia (Excess fats in the blood); dementia (loss of memory); anxiety disorder; depression; non-traumatic spinal cord dysfunction. During an interview on 8/26/24 12:00 P.M., the resident stated: -Food temperatures are appropriate, but the food does not taste good. 2. Review of Resident #27's Quarterly MDS, dated [DATE], showed: - Cognitive skills are significantly impaired. - Received seven insulin injections in the last seven days. - Diagnoses included: Non-traumatic brain dysfunction; hypertension (High blood pressure); renal failure (kidney disease); diabetes (pancreas disorder); Alzheimer's disease (memory loss); depression; During an interview on 8/27/24 at 7:21 A.M., the resident stated: - He/she eats in the dining room and the food is sometimes cold. The vegetables are either overcooked or undercooked. 3. Review of the Resident #17's Significant Change MDS, dated [DATE], showed: - Brief interview for mental status (BIMS) score of 2, indicating the resident was severely cognitively impaired; - Diagnoses included: Reduced mobility, Amnesia (Memory Loss), Hypertensive Heart Disease with Heart Failure, Malignant Neoplasm of Uterus (Cancer). During an interview on 8/26/24 at 1:15 P.M., the resident's responsible party stated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Heights	1531 Nebraska Street Mound City, MO 64470

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident dislikes the food and thinks it is horrible and does not taste good. Additionally, the temperatures are sometimes cold when the food arrives to the resident's room. 4. Review of Resident #36's quarterly (MDS), dated [DATE], showed: - cognitive skills intact; - Upper/lower extremities no impairment; - Diagnoses included high blood pressure, COPD, hyperlipidemia, and renal insufficiency; - Independent with oral hygiene, dressing, transfers, personal hygiene, and toilet use; During an interview on 8/26/24 at 11:31 A.M., resident stated: -Food could be better, it has a lot of turkey and chicken on the menu and the vegetables are under cooked. She eats in the dining room. 5. Review of Resident #34's Quarterly MDS, dated [DATE], showed: -He/She was cognitively intact; -He/She required set up or clean up assistance with eating; -Diagnoses included: (condition that causes a decline in brain function and impairment of a person's ability to think, remember, and make decisions), Parkinson's disease (a chronic, progressive brain disorder that causes movement problems), malnutrition, depression. Review of care plan, revised 2/13/24, showed: -He/She was not to be served chicken [NAME], Brussel sprouts, lima beans; -He/She came to dining room for meals and fed self; -He/She had full set of dentures; -He/She had no preferences on chicken; -He/She was ordered to be on regular diet; -He/She preferred to have scrambled eggs and bacon and sometimes oatmeal for breakfast; -He/She preferred to have boost, no juice, tea, or coffee; -Monitor his/her food and fluid intake throughout the day; -Offer him/her alternative meal options if he/she did not like what was being served; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265746	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Weigh him/her weekly. Review of physician's orders dated 8/27/24, showed an order started on 3/5/24, he/she was on a regular diet with regular texture, regular/thin consistency. During an interview on 8/26/24 at 11:28 A.M. resident stated: -Food is terrible, always having corn, lima beans, green beans, fish and no seasoning to it; -Eggs are supposed to be hot and they are served cold. 6. Review of Resident #6's Quarterly MDS dated [DATE], showed: -He/She was cognitively intact; -He/She had clear speech; -He/She made self understood and usually understood others; -He/She required set up or clean up assistance with eating, -Diagnoses included: Diabetes (too much sugar), neuropathy (condition resulting in nerves that are damaged resulting in pain, numbness, weakness, or tingling in one or more parts of the body), generalized muscle weakness, hearing loss, gastroparesis (a chronic condition that affects the stomach's motility), aphasia (inability to swallow) Review of care plan, revised 3/29/24, showed: -He/She will consume 75% of ordered diet each day; -He/She should not be served fish, sausage patty, coleslaw, lettuce spinach, hot rolls, or beans of any kind; -Monitor and record his/her food and fluid intake throughout the day; -He/She came to dining room for meals and fed self; -He/She liked chocolate but prefers to not have too much; -He/She liked cottage cheese; -He/She did not have a preference on chicken; -He/She preferred to have cranberry juice and hot chocolate with breakfast; -He/She preferred to have oatmeal, bacon, fried egg, and toast for breakfast; -He/She preferred to have only water at lunch and supper; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Offer alternative meal options when he/she did not like what was being served; -Offer snacks and fluid in between meals; -Serve him/her a regular diet with regular fluids; -Weigh resident weekly. Review of physician's orders, dated August 2024, showed an order started 4/11/24, Regular diet, mechanical soft texture, regular/thin consistency, moist ground meat. During an interview on 8/26/24 at 10:30 A.M., resident stated: -The food here is terrible and not fit to eat. [NAME] A prepares a good breakfast and lunch but the evening meal after [NAME] A leaves is crappy. Resident had cold oatmeal this morning and the eggs were just warm. This happens often. -Last week the meatloaf was served black which is the same color as my hair. That cook no longer works here. Today they are serving something I don't feel is fit to eat so I will order a baked potato. During a group interview of the resident council on 8/28/24 at 2:00 P.M., four of eight residents stated: - Food was bad to terrible at times due to being burnt or cold when served in the rooms; - Menu was not varied and served carrots multiple times in one week; - Food suggestions are made for the menu but are slow to be adopted; During an interview on 8/28/24 at 14:28 P.M., Dietary Manager said he/she would expect food to be on the serving line no more than two hours maximum for any meal from start to end of service. During an interview on 8/29/24 at 11:30 A.M., Administrator stated: - They would not expect food to be on a steam line for 3 hours before serving residents; - They would expect temperature checks to be conducted in the kitchen according to facility policy; - They would expect food temperatures to be checked immediately prior to serving the first resident.

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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** 47195 Based on observations, interviews, and record review the facility staff failed to maintain an effective infection control program when staff did not ensure residents with open wounds (Resident #18) and catheters (#17) were placed on enhanced barrier precautions (EBP) and when clean laundry was not covered during transportation in the facility. This affected two of the 12 sampled residents (Residents #18, and #17). The facility census was 37. Review of facility policy, infection control, dated 3/2020, showed: -It was the policy of the facility to protect residents and staff from communicable diseases and infections. -For residents for whom enhanced barrier precautions (EBP) are indicated, EBP is employed when performing the following high -contact resident care activities: -Dressing -Bathing/Showering -Transferring; -Providing Hygiene; -Changing linens -Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter, feeding tube tracheostomy/ventilator; -Wound care: any skin opening requiring a dressing -Residents are not restricted to their room or limited from participation in group activities. Because EBP do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 1. Review of Resident #18's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 6/20/24, showed: -He/She had impairment on both sides of upper extremities; -He/She was dependent on a wheelchair; -He/She was dependent for eating, oral care, toileting, bathing, upper and lower body dressing, hygiene, and all mobility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had one stage 3 pressure ulcer -He/She used a pressure reducing device for chair, bed, turning and repositioning program, pressure ulcer care, application of nonsurgical dressings, applications of ointments/medications other than to feet. -Diagnoses included heart failure, high blood pressure, anxiety disorder, depression, , tendency to fall, heart disease, corneal transplant status, overactive bladder, and urinary tract infections Review of care plan, revised 6/20/24, showed: -He/She had actual impairment to skin integrity of the coccyx suspected deep tissue injury; -He/She needed pressure reducing wedge allowing for healing and relief from deep tissue injury. Staff was to use the pressure reducing wedge at all times while he/she was in bed. Review of physician's orders, dated 8/27/24, showed: -Order started 7/23/24, clean coccyx (tailbone), cut calcium alginate to size, and cover with padded dressing two times a day. Observation on 8/26/24 at 8:22 A.M. showed resident did not have any EBP signage on his/her door or Personal protective equipment for EBP in his/her room or outside room. Observation on 8/27/24 at 1:41 P.M. showed resident did not have any EBP signage on his/her door or personal protective equipment for EBP in his/her room or outside room. Observation on 8/28/24 at 11:34 A.M. showed resident did not have an EBP signage on his/her door or personal protective equipment for EBP in his/her room or outside room. 2. The facility did not provide a policy of transportation of laundry in regards to infection control. Observation on 8/27/24 at 8:35 A.M. showed Laundry Aide A was transporting clean laundry containing bed pads and towels in a rolling cart that was uncovered. Observation on 8/27/24 at 1:54 P.M. showed Laundry Aide A was transporting clean laundry cart with shelves full of towels, gowns, blankets, sheets, and towels that was uncovered. Observation on 8/28/24 at 11:27 A.M. showed Laundry Aide A was transporting clean laundry on 3 tiered tall laundry cart with no covering. The cart contained gowns, blankets, bed pads, sheets, and pillows. During an interview on 8/28/24 at 10:40 A.M., Laundry Aide A said: -He/She should cover clean laundry when transporting laundry in facility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not have anything big enough to cover the large 3 tiered laundry cart when he/she transported the clean laundry. 31102 3. Review of Resident #17's Significant Change MDS, dated , 8/15/24, showed: -Re-Admission on 8/7/24 ; -Severely cognitively impaired; -Set-up and clean-up assistance for eating; -Substantial staff assistance for oral hygiene; -Dependent on staff for toileting, bathing, dressing, personal hygiene, positioning, and transferring; -Indwelling urinary catheter, always incontinent of bowel; -Diagnoses included cancer, anemia (red blood cell deficient), heart failure, high blood pressure, neurogenic bladder (lack of bladder control), arthritis, osteoporosis (lack of bone density), dementia (memory loss), depression; Review of resident's care plan, dated 8/26/24, showed: - Resident has an indwelling urinary catheter and staff completes all catheter cares; - Catheter changed monthly, monitor intake and output as per facility policy; Observation from 8/26/24 to 8/29/24 during room visits showed no enhanced barrier precautions in place for resident with indwelling urinary catheter and no signage; During an interview on 8/28/24 at 7:58 A.M., LPN B said: -He/She did not know what enhanced barrier precautions meant; -He/She had no residents that were on enhanced barrier precautions; -He/She had two residents with catheters including resident # (Gene Young and [NAME]); -He/She had a few residents with wound cares but had no precautions in place in regards to those residents wounds; -He/She had not received any training in regards to enhanced barrier precautions. During an interview on 8/28/24 at 9:05 A.M., Infection Preventionist said he/she completed his/her infection preventionist training on 7/31/24; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 9:05 A.M., the Administrator said: He/She completed his/her infection preventionist training on 11/1/23; -He/She expected that the facility should have enhanced barrier precautions in place; -The facility had not put precautions in place yet for enhanced barrier precautions; -The facility had ordered materials to ensure signage was in place but had not yet put signs up on resident rooms; -The facility had ordered personal protective equipment (PPE) holders for residents rooms who should be on enhanced barrier precautions but the containers ordered did not fit facility doors so the PPE containers had not yet been hung on resident rooms; -He/She had identified two residents with catheters and three residents with wounds that should be placed on enhanced barrier precautions; During an interview on 8/28/24 at 9:19 A.M., Director of Nursing (DON) said: -He/She tried to implement EBP last month but he/she had not been able to get door hangers long enough to go over facility doors for the PPE containers that were ordered. During an interview on 8/29/24 at 11:30 A.M., DON said Residents with catheters and wounds should have enhanced barrier precautions in place. 50980