STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265752	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence County Manor	915 Carl Allen Street Mount Vernon, MO 65712

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents' environments were free of accident hazards when the facility failed to implement a process to ensure resident accessible hot water temperatures in all resident access areas were maintained at a safe temperature resulting in the hot water in 12 residents rooms (Resident #2, #12, #24, #25, #6, #68, #36, #34, #15, #44, #55, and #38) and a common bath/shower room to measure between 125.6 to 138 degrees Fahrenheit (F). The facility census was 70.The Administrator was notified on 08/08/25, at 1:55 P.M., of an Immediate Jeopardy (IJ) which began on 08/05/25. The IJ was removed on 08/09/25 as confirmed by surveyor on-site verification. Review of the American Burn Association website, updated 2002, showed the following:-Hot water caused third degree burns (full thickness burns which go through the skin and affect deeper tissue resulting in white of blackened, charred skin) at the following temperatures and time parameters:-In 1 second at 156 degrees F;-In 2 seconds at 149 degrees F;-In 5 seconds at 140 degrees F;-In 15 seconds at 133 degrees F;-In 1 minute at 127 degrees F;-Older adults, like young children, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Review of the facility's policy, Water Temperatures, Safety of, dated December 2009, showed the following: -Tap water in the facility shall be kept within a temperature range to prevent scalding of residents;-Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperature of no more than (blank) degrees F, or the maximum allowable temperature per state regulation;-Maintenance staff are responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log;-Maintenance staff should conduct periodic tap water temperature checks and record the water temperatures in a safety log;-If at any time water temperatures feel excessive to the touch, staff will report this finding to the immediate supervisor;-Direct-care staff shall be informed of risk factors for scalding/burns that are more common in the elderly such as decreased skin thickness; decreased skin sensitivity; peripheral neuropathy (the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged. This condition often causes weakness, numbness and pain, usually in the hands and feet.); reduced reaction time; decreased cognition; decreased mobility; and decreased communication. 1. Review showed the facility did not provide hot water temperature logs. 2. Review of Resident #2's (resided on 200 hall) face sheet (a brief resident profile sheet) showed the following:-admission date of 12/03/24;-Diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder that affects thinking, movement, behavior, and sleep), dementia (a group of thinking and social symptoms that interferes with daily functioning), psychosis not due to a substance or known physiological condition, type II diabetes (body doesn't produce enough insulin), (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and anxiety disorder. Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment tool completed by facility staff), dated 06/12/25, showed the following:-Severally impaired cognition;-Minimal upper and lower extremity impairments;-Used a walker to assist with ambulation. Review of the resident's care plan, updated 08/04/25, showed the resident had impaired cognitive function or impaired thought processes. Observation on 08/08/25, at 9:20 A.M., showed the sink hot water temperature in the resident's room measured at 130 degrees F. During an interview on 08/08/25, at 9:24 A.M., Certified Nurse Aide (CNA) G said the resident was able to ambulate to the bathroom on his/her own and was encouraged to wash his/her hands after using the restroom. During an interview on 08/08/25, at 9:25 A.M., CNA H said the resident was able to ambulate to the bathroom on his/her own and use the sink. During an interview on 08/08/25, at 9:28 A.M., the Activities Director said the resident used a walker and can get to the bathroom and sink on his/her own. During an interview on 08/08/25, at 9:30 A.M., Licensed Practical Nurse (LPN) F said the following:-The resident can ambulate in his/her room independently;-The resident has dementia and is confused most of the time;-The resident had not had any injury from the hot water, but the water was hot down the resident's hall. 3. Review of Resident #12's (resided on 200 hall) face sheet showed the following:-admission date of 03/18/24;-Diagnoses included chronic kidney disease (progressive damage and loss of function in the kidneys). Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was cognitively intact;-The resident used a wheelchair to assist with mobility. Observation on 08/08/25, at 9:25 A.M., showed the sink hot water temperature in the resident's room measured at 138 degrees F. 4. Review of Resident # 24's (resided on 200 hall) face sheet showed the following:-admission date of 10/05/20;-Diagnoses included dementia, type II diabetes, and peripheral venous insufficiency (veins in the legs have trouble sending blood back to the heart). Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was severely cognitively impaired;-The resident used a wheelchair to assist with mobility. Observation on 08/08/25, at 9:20 A.M., showed the sink hot water temperature in the resident's room measured at 130 degrees F. 5. Review of Resident #25's (resided on 300 hall) face sheet showed the following:-admission date of 08/25/23;-Diagnoses include dementia, Alzheimer disease (a progressive disease that destroys memory and other important mental functions), and type II diabetes. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was severely cognitively impaired;-The resident used a walker to assist with mobility. Observation on 08/05/25, at 10:00 A.M., showed the sink hot water temperature in the resident's room measured at 136 degrees F. 6. Review of Resident #63's (resided on 200 hall) face sheet showed the following:-admission date of 02/27/25;-Diagnoses included dementia and Alzheimer disease. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was severely cognitively impaired;-The resident used a wheelchair to assist with mobility. Observation on 08/08/25, at 9:35 A.M., showed the sink hot water temperature in the resident's room measured at 136 degrees F. 7. Review of Resident #6's (resided on 200 hall) face sheet showed the following:-admission date of 10/31/22;-Diagnoses included peripheral vascular disease (narrowed blood vessels), epilepsy (seizure), hypertension (high blood pressure), other speech and language deficits following cerebral infarction (stroke), abnormalities of gait (manner to walk) and mobility, other lack of coordination, paranoid schizophrenia (a mental health disorder causing a feeling of distrust, suspicion, and fear of someone without good reason), and aphasia (a language disorder that affects a person's ability to communicate). Review of the resident's significant change MDS, dated [DATE], showed the following:-Severely impaired cognitive skills for daily decision making;-Resident used a wheelchair. Observation on 08/05/24, at 1:51 P.M., showed the hot water temperature in the sink of the resident's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	room measured 133.1 degrees F. Observation on 08/08/24, at 10:50 A.M., showed the water temperature in the sink of the resident's room measured 132 degrees F. 8. Review of Resident #68's (resided on 200 hall) face sheet showed the following:-re-admission date of 09/12/24;-Diagnoses included stroke, high blood pressure, type II diabetes mellitus without complications, and chronic pain. Review of the resident's annual MDS, dated [DATE], showed the following:-Moderately impaired cognitive status;-Resident used a wheelchair. Observation on 08/05/24, at 1:51 P.M., showed the hot water temperature in the sink of the resident's room measured 133.1 degrees F. Observation on 08/08/24, at 10:50 A.M., showed the hot water temperature in the sink of the resident's room measured 132 degrees F. 9. Review of Resident #36's (resided on 200 hall) face sheet showed the following:-admission date of 02/03/25;-Diagnoses included anxiety disorder, high blood pressure, gout (painful arthritis in the joints), and chronic pain. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Resident used a wheelchair. Observation on 08/05/24, at 2:02 P.M., showed the hot water temperature in the sink of the resident's room measured 133.3 degrees F. 10. Review of Resident #34's (resided on 200 hall) face sheet showed the following:-re-admission date of 03/31/21;-Diagnoses included Alzheimer's disease, senile degeneration of brain (a decline in memory, reasoning, and the ability to perform everyday activities), schizoaffective disorder (a mental health condition that involves seeing things or hearing voices that others do not observe), bipolar type (episodes of mood swings ranging from low to high), major depressive disorder (mental health disorder causing depressed mood or loss of interest in activities), unspecified dementia (loss of memory), cognitive communication deficit (difficulties with communication due to a lack of memory and problem solving abilities) , other abnormalities of gait (manner of walking) and mobility, and other lack of coordination (poor muscle coordination that causes unusual movements). Review of the resident's quarterly MDS, dated [DATE], showed cognitive pattern not assessed due to resident rarely/never understood. Observation on 08/05/24, at 2:02 P.M., showed the hot water temperature in the sink of the resident's room measured 133.3 degrees F. 11. Review of Resident #15's (resided on 300 hall) face sheet showed the following:-admission date of 05/11/23;-Diagnoses included dementia, anxiety disorder, major depressive disorder, type two diabetes mellitus, and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Required a wheelchair for ambulation. Observation on 08/08/25, at 12:15 P.M., showed the resident's hot water temperature measured at 127.9 degrees F. 12. Review of resident #44's (resided on 300 hall) face sheet showed the following:-admission date of 08/15/23;-Diagnoses included dementia, unspecified psychosis (delusions or hallucinations), multiple sclerosis (disease in which the immune system eats away at the protective covering of the nerves), legal blindness, anxiety disorder, and major depressive disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Does not require assistive devices. Observation on 08/08/25, at 12:15 P.M., showed the resident's hot water temperature measured at 127.9 degrees F. 13. Review of Resident #55's (resided on 300 hall) face sheet showed the following:-admission date of 06/19/25;-Diagnoses included Alzheimer's disease early unspecified psychosis, and anxiety disorder. Review of the resident's admission MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Independent with walking. Observation on 08/08/25, at 12:15 P.M., showed the resident's hot water temperature measured at 125.6 degrees F. 14. Review of Resident #38's (resided on 300 hall) face sheet showed the following:-admission date of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12/04/17;-Diagnoses included vascular dementia, hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) affecting left non-dominant side, aphasia, high blood pressure, and major depressive disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Totally dependent on staff for all ADLs except eating. Observation on 08/08/25, at 12:15 P.M., showed the resident's water temperature at 126.8 degrees F. 15. Observation on 08/08/25, at 10:00 A.M., showed main bathroom/shower room on 200 hall, located just past room [ROOM NUMBER] and across from rooms [ROOM NUMBERS], with door unlocked and accessible to all residents had a hot water temperature in the sink that measured 138 degrees F. The water temperature in the shower measured 127 degrees F. 16. Observation on 08/08/25, at 9:45 A.M., showed the water heater on the 200 hall, which was behind a locked door, with a temperature set at 140 degree F. 17. During an interview on 08/08/25, at 9:40 A.M., the Maintenance Supervisor said the following:-He/she had been the maintenance supervisor for four months and had not tested any hot water temperatures in any resident rooms or the public restrooms;-He/she was under the impression that another department was doing that;-He/she just found out yesterday that the other department was not doing any hot water temperature testing;-The last water temperature logs were from 2023;-The water heater on the 200 hall was turned up to 140 degrees F. During an interview on 08/08/25, at 10:35 A.M., CNA I said the following:-He/she has been the shower aide for about three months;-The door to the main bathroom/shower room was always unlocked during the day shift and night shift;-Many residents use the bathroom and sink in the main shower room throughout the day as it is easier for the residents to use because of the larger size;-He/she didn't know who checked the water temperatures. During an interview on 08/08/25, at 11:05 A.M., the Housekeeping Supervisor said the following:-He/she did not check any resident hot water temperatures currently;-He/she checked resident water temperatures about ten years ago. He/she would test every resident room monthly and do random spot checks weekly. He/she also checked all the main bathroom/shower rooms on each hall weekly because a lot of residents use those bathrooms and wash their hands in those bathrooms;-Water temperatures should be between 105 to 115 degrees F;-Elderly skin is thin and frail and burns easier than an average adult;-Maintenance should be checking the water temperatures weekly. During an interview on 08/08/25, at 9:24 A.M., CNA G said the following:-He/she didn't know what temperature the hot water should be set at;-He/she didn't know who checked the hot water temperature or how often it was to be checked. During an interview on 08/08/25, at 9:25 A.M., CNA H said the following:-He/she didn't know what temperature the hot water should be set at;-He/she didn't know who checked the hot water temperature or how often it was to be checked. During an interview on 08/08/25, at 9:30 A.M., LPN F said he/she was not sure who monitored the water or how often. During an interview on 08/08/25, at 2:45 P.M., the Director of Nursing (DON) said the following:-He/she didn't have anything to do with testing of the hot water;-He/she didn't know who was to be monitoring the water temperatures;-He/she expected staff to notify him/her if the water was too hot;-He/she was not sure what the water temperature should be;-Anything over 120 degrees F was too hot;-A resident with dementia should not have a water temperature above 120 degrees. During an interview on 08/08/25, at 3:44 P.M., the Medical Director said the following:-He/she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	expected staff to be monitoring the hot water temperature;-He/she expected the thermostat on the hot water heater to be set per regulation;-He/she expected staff to notify maintenance or administration if the water temperature feels too hot;-He/she expected staff to follow the regulations. During an interview on 08/08/25, at 11:35 A.M., the Administrator said that water temperature checks were not being done and logged per protocol. The Maintenance Supervisor was under the assumption the Housekeeping Supervisor was doing the checks. The hot water temperatures be kept between 105 to 120 degrees F. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level K. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the E level.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare and distribute and serve food in accordance with professional standards of practice and in a manner to prevent possible contamination when the facility staff failed to ensure all food items were properly labeled and sealed, failed to ensure expired foods were discarded, and failed to ensure the dishwasher washed and rinsed the dishes at the recommended temperatures. This had the potential to affect all residents who consumed food from the facility kitchen. The facility census was 70 residents.1. Review of the 2022 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location, and where it is not exposed to splash, dust, or other contamination. Review of the facility policy titled, Date Marking and Food Storage Policy and Procedure. revised 09/19/24, showed the following: -All food stored for more than 24 hours will be properly identified and marked according to the following guidelines;-Unopened cases of dry food items will be dated with the date the case was received into the facility and will be stored in such a manner to ensure the first in-first out (FIFO) method of rotation;-Once a case is opened, the individual food items from the case are dated with the date the items were received into the facility and placed in/on the proper storage unit utilizing the FIFO method of rotation;-Expiration dates on commercially prepared, dry storage food items will be followed;-Unopened cases of refrigerated food items will be dated with the date the item was received into the facility and will be stored in such a manner to ensure FIFO;-Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility and placed in the proper storage, ensuring FIFO;-Once opened, all ready to eat, potentially hazardous food will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date;-Unopened cases of frozen food items will be dated with the date the item was received into the facility and will be stored in such a manner to ensure FIFO;-Frozen food packages removed from the case will be dated with the date the item was received into the facility and placed in the proper storage, ensuring FIFO;-Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date;-Discard food items when the food item has been refrigerated for seven days, the food items is leftover for more than three days, or the food items is older than the expiration date. Observation on 08/04/25, at 9:38 A.M., in the kitchen showed the following:-A 57-ounce carton of mashed potatoes unsealed and open to air;-Inside the walk-in cooler was an opened bag of mozzarella cheese in an unsealed plastic bag open to air; tomato soup in a covered pitcher dated 07/30/25; minestrone soup in a covered pitcher dated 07/30/25; and angel food cake in sealed bag dated 07/28/25;-Inside the walk-in freezer was a bag of unlabeled, unsealed and open to air chicken fingers; an unsealed and open to air, unlabeled bag containing a pizza with visible ice crystals; and an unsealed and open to air, unlabeled bag of hamburger patties. Observation on 08/06/25, at 10:06 A.M., in the kitchen showed the following:-Inside the walk-in cooler was an opened bag of mozzarella cheese in an unsealed plastic bag open to air and minestrone soup in a covered pitcher dated 07/30/25;-Inside the walk-in freezer was an unsealed and open to air, unlabeled bag containing a pizza with visible ice crystals, and a box container unsealed and opened to air big blue bag of chocolate chips. During an interview on 08/07/25, at 2:00 P.M, Dietary Aide (DA) M said the following:-Staff should wrap or seal opened food and label with date opened, item name, and employee number;-Staff can refrigerate some leftovers and some open food for five days. Some food items must be discarded the same day. During an interview on 08/07/25, at 2:10 P.M., Dietary [NAME] (DC) N said the following:-Staff should ensure opened food in a sealed container with the date opened and date use by;-Refrigerated food can be stored for three to five days, but most should be thrown out after three days;-Any food item with ice crystals should be discarded.During an interview on 08/08/25, at 10:53 A.M., DC L said the following:-Staff should seal and label opened (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	foods with date opened and use by, and initials;-Staff should discard leftovers and warmed foods after three days.During an interview on 08/7/25, at 2:21 P.M., the Dietary Manager (DM) said the following:-Staff should date, seal, and label opened food;-Leftovers can be stored for five days, but he/she preferred not storing over three days;-Soups can be refrigerated for five days after opening;-Staff should discard food with ice crystals.During an interview on 08/14/25, at 10:21 A.M., the Registered Dietitian said the following:-Staff should seal, label and date opened food items;-Staff should keep opened refrigerated foods for three days. During an interview on 08/07/25, at 5:44 P.M., the Administrator said the following:-Staff should label, date, and seal opened food;-Refrigerated food should be kept for three days and discarded after. 2. Review of the facility policy titled, Dishwashing Machine, revised 09/24/24, showed the following: -The food services staff shall maintain the operation of the dish machine according to established procedure and manufacture guidelines posted or contained in this policy to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food;-All dishwashing machines should be operated according to manufacturer recommendations. Tableware, utensils, and pots and pans should be cleaned and sanitized in either a high temperature dishwashing machine that uses hot water, or a chemical-sanitizing dishwashing machine that uses a chemical sanitizing solution;-Monitor that the machine is maintaining operating guidelines for wash, rinse, and final rinse temperatures to reach 150 degrees Fahrenheit (F) for wash and 180 degrees F for rinse, and log after each meal service. Review of the manufacturer's recommendations of the CMA-180 high temperature commercial dishwasher temperature should reach 155 to 160 degrees F for the wash cycle and 180 to 195 degrees F for the rinse cycle. Observations of the kitchen and review of the temperature record for the dishwasher on 08/07/25, at 1:50 P.M., showed the following:-The manufacturer minimum temperature levels for the wash at 155 degrees F and rinse 180 degrees F were visible on the side of the dishwashing unit;-The wash cycle showed a temperature of 130 degrees F and the rinse cycle showed a temperature of 175 degrees during the first observation;-The wash cycle showed a temperature of 134 degrees F and the rinse cycle showed a temperature of 172 degrees during the second observation;-The wash cycle showed a temperature of 130 degrees F and the rinse cycle showed a temperature of 168 degrees during the third observation;-The temperature record for the wash cycle from 08/01/25 to 08/06/25, showed the highest temperature documented at 152 degrees F. During an interview on 08/07/25, at 1:50 P.M., DA R said the following:-The dishwasher manufacturer recommendations were for the temperature of the wash cycle to be a minimum of 150 degrees F and the rinse cycle to be a minimum of 180 degrees F;-Staff should log temperatures after every meal service;-He/she drained the dishwasher if the temperature was not reaching minimum levels;-If the temperature was still not reaching minimum levels, he/she would notify the DM. During an interview on 08/07/25, at 2:00 P.M, DA M said the following:-The dishwasher wash cycle temperature should be a minimum of 150 degrees F and rinse at a minimum of 180 degrees F;-Staff should log dishwasher temperatures after each meal service;-He/she would notify the maintenance supervisor if the dishwasher temperatures were not reaching minimum degrees. During an interview on 08/07/25, at 2:10 P.M., DC N said the following:-The dishwasher wash cycle temperature should be a minimum of 150 degrees F and rinse at a minimum of 180 degrees F;-Staff should log dishwasher temperatures after each meal service;-He/she would notify maintenance if the dishwasher temperatures were not reaching minimum degrees.During an interview on 08/08/25, at 10:53 A.M., DC L said the dishwasher wash cycle temperature should be a minimum of 150 degrees F and rinse at a minimum of 180 degrees F. During an interview on 08/07/25, at 2:21 P.M., the DM said the following:-The dishwasher wash cycle temperature should be a minimum of 150 degrees F and rinse at a minimum of 180 degrees F;-If the temperatures were not reaching minimum levels, staff would wash, rinse, and sanitize dishes by hand;-She notified the technician with any concerns.During an interview on 08/14/25, at 10:21 A.M., the RD said staff should follow the manufacturer recommendations for minimum temperatures for the dishwasher and if not meeting the minimum, wash and sanitize by hand or have a process to run (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bleach through until repaired. During an interview on 08/07/25, at 5:44 P.M., the Administrator said the following:-The dishwasher wash cycle temperature should be a minimum of 155 degrees F and rinse at a minimum of 180 degrees F;-Staff should log dishwasher temperatures after each meal service;-Staff should notify maintenance if not reaching minimum levels.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their abuse and neglect prevention policies, when they failed to complete an employee disqualification list (EDL - a list of individual prohibited from working in a long-term care facility in Missouri due to a finding of abuse or neglect) check and a check of the Nurse Aide (NA) Registry (a list checking for a Federal Indicator (a marker given to a potential employee who has committed abuse, neglect, or misappropriation of property against residents) prohibiting them from working in a certified facility) for four staff members (Housekeeper (HK) S, Certified Nurse Aide (CNA) T, Dietary Aide (DA) U, and Dietary [NAME] (DC) N) of ten sampled records. The facility census was 70.Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021, showed the facility will conduct employee background checks and not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property; or a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. 1. Review of HK S's personnel record showed the following:-Hire date of 06/18/25;-Facility staff did not document completion of an EDL check or check of the NA registry. 2. Review of Certified Nurse Aide (CAN) T's personnel record showed the following:-Hire date of 06/11/25;-Facility staff did not document completion of an EDL check or check of the NA registry. 3. Review of DA U's personnel record showed the following:-Hire date of 03/27/24;-Facility staff did not document completion of an EDL check or check of the NA registry. 4. Review of DC N's personnel record showed the following:-Hire date of 07/03/24;-Facility staff did not document completion of an EDL check or check of the NA registry. During an interview on 08/13/25, at 12:40 P.M., the Administrator said the following:-The Business Office Manager completed EDL and NA registry checks on all staff prior to hire;-Periodic EDLs should be completed quarterly on all staff.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were appropriately screened prior to placement in a nursing home when the facility failed to obtain documentation of Preadmission Screenings and Resident Reviews (PASARR) for two residents (Resident #2 and #69). The facility census was 70.Review of the document the facility provided as their policy titled Missouri Department of Health & Senior Services Level One Form Training, dated 02/08/24, showed the following:-The PASARR process requires that all applicants to Medicaid-certified nursing facilities (regardless of whether their stay will be covered by private funds, Medicare, or Medicaid) be given a preliminary assessment to determine whether they might have a serious mental illness (SMI) or an intellectual disability (ID);-PASARR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care;-All applicants to a Medicaid-certified nursing facility will be evaluated for a serious mental disorder and/or intellectual disability;-Nursing homes may not admit a resident suspected of having a SMI or ID diagnosis without the Level II screening being completed;-The Level II screening provides a comprehensive review of the resident's past and current behavioral health conditions, and the services needed to ensure their health and safety;-All clients entering/residing in a Medicaid certified bed must have a Level I form completed. 1. Review of Resident #2's face sheet (a brief resident profile sheet) showed the following:-admission date of 12/03/24;-Diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder that affects thinking, movement, behavior, and sleep), dementia (a group of thinking and social symptoms that interferes with daily functioning), psychosis not due to a substance or known physiological condition, and anxiety disorder. Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment tool completed by facility staff), dated 06/12/25, showed severally impaired cognition. Review of the resident's care plan, updated on 08/04/25, showed the resident had impaired cognitive function or impaired thought processes. Review of the resident's electronic medical record (EMR) showed staff did not have documentation of a Level I or Level II PASARR completed. During an interview on 08/07/25, at 4:30 P.M., the Bookkeeper said the following:-Resident #2 was a private resident;-The facility did not do any PASARRs on private pay residents. 2. Review of Resident #69's face sheet showed the following-admission date of 07/31/24;-Diagnoses schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar disorder (mood swings ranging from depressive lows to manic highs), major depressive disorder, anxiety disorder, and unspecified dementia. Review of the resident's care plan, revised 05/12/25, showed the following:-Resident had a public administrator as his/her guardian;-Resident wandered due to dementia and had a history of destructive and inappropriate behaviors due to schizophrenia. Resident received care from a psychiatric physician;-Resident has impaired cognitive function and impaired though processes related to dementia and schizophrenia;-Resident has delirium related to dementia and delirium;-Resident used antipsychotic, antianxiety, and antidepressant medications. Review of the resident's quarterly MDS, dated [DATE], showed the resident was moderately cognitively impaired. Review of the resident's EMR showed staff did not have documentation of a Level I or Level II PASARR completed During an interview on 08/07/25, at 4:30 P.M., the Bookkeeper said the resident came to the facility from another facility that is not required to complete a Level I or Level II PASARR. The resident was a private pay resident. The facility does not do any PASARRs on private pay residents. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/07/25, at 4:30 P.M., the Bookkeeper said the following:-He/she had been doing PASARRs at the facility for the last 11 years;-He/she does all the PASARRs for the facility;-All Medicaid/Medicare residents should have a Level I PASARR and a Level II PASARR (if indicated) on file;-The facility does not do any PASARRs on private pay residents;-All the beds in the facility were dually certified as Medicare/Medicaid and private pay beds. During an interview on 08/13/25, at 11:15 A.M., the Administrator said the following:-The Bookkeeper completed all the PASARRs;-The Administrator expected that all residents have a Level I and Level II PASARR, if indicated, upon entering the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the nutritional needs of all residents were met when staff failed to prepare pureed diets per approved recipes and failed to provide the approved serving size for pureed meals. The facility census was 70.Review of the facility policy titled, Puree Step by Step Guide, undated, showed the following:-Count items needed for puree as you are placing it into the food processor, and make two additional portions above your number of puree diets;-Gradually add hot liquid of choice with food to puree to a pudding like consistency (gravy/broth/hot milk-never use water);-Scrape sides of food processor and continue blending until there are no lumps/bumps in puree;-Use tongs to take blade out of food processor and use spatula to scrape product into serving pan;-Re-heat puree product in steam water bath on stove to 165 degrees Fahrenheit (F) or greater. 1. Review of the facility's recipe for pureed jambalaya showed the following:-Prepare according to the regular jambalaya recipe;-Blend until smooth and serve one cup portion or two #8 scoops (four ounce (oz) per serving. Review of the facility's recipe for pureed white rice with gravy showed the following:-Bring two cups and three tablespoons of water to a boil;-Add three fourths of a teaspoon of salt and six and three fourth ounces of rice to the boiling water, stir, cover tightly, and cook on low heat until rice is tender and all the water is absorbed (about 20 minutes);-Remove from heat and let stand, covered, for five to ten minutes and then add three fourths teaspoon of margarine;-Dissolve one and three fourth ounces of any chicken base in one cup and three tablespoons of hot water to make broth. Remove portions needed from regular prepared recipe of white rice and place in food processor. Add the broth and blend until smooth;-Prepare any gravy mix according to package instructions and serve one fourth a cup (four oz) over one half cup of rice.Review of the facility's menu spread sheet for 08/06/25 showed residents should have one cup of pureed jambalaya (eight ounces) and one-half (four ounces) cup of pureed white rice with gravy.Observation on 08/06/25, at 11:12 A.M., showed the following;-Dietary [NAME] (DC) L began to puree the lunch meal for six puree diets;-DC L used six oz scoops to place six servings of jambalaya with the rice mixture into the processor (the recipe called for 8 ounces of jambalaya per serving and one cup of rice per serving and or them to be pureed separately);-DC L used a total of seven tablespoons of powdered thickener while pureeing the jambalaya to puree to the correct consistency;-DC L said did not consult a recipe during the puree process.Observation on 08/06/25, at 11:56 A.M., showed the following:-DC L placed a three-ounce scoop in the pureed jambalaya mixed together with rice and gravy;-DC L used two three-ounce scoops equal to six ounces for serving one pureed portion of jambalaya mixed together with rice and gravy.During an interview on 08/08/25, at 10:53 A.M., DC L said the following: -He/she does not follow a recipe to prepare puree meals;-Staff have menus to tell them what scoops to use for serve out, but he/she did not use them and just goes by what the Dietary Manager (DM) tells him/her to use;-He used six-eight ounces scoops for meat and four-six ounces scoops for vegetables or whatever the DM tells him/her to use;-DM has trained there is a set number for meats and vegetables. During an interview on 08/07/25, at 2:21 P.M., the DM (DM) said the following: -Staff do not follow a recipe for preparing puree meals;-She trained staff to use a three oz green scoop for meats to puree lunch and dinner meals and two oz scoop for meats to puree for breakfast meals, four oz scoop to puree fruits and vegetables, and doubles to six oz to puree meals such as jambalaya;-Staff do not use menus to thicken puree meals. She trains them on consistency, and how to thin out if necessary. The staff all know how much to use;-Staff do not follow a menu to determine which scoops/amounts to serve residents;-She has trained staff to use four ounces for fruits and vegetables and three ounces for meat. If meat is combined with other ingredients like the jambalaya with rice, double the three ounces for total of six or eight;-She followed menus for serve out when she first came to the facility, but stopped after she had all staff trained.During an interview on 08/14/25, at 10:21 A.M., the Registered Dietician (RD) said staff should (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow the menu for portion sizes for puree, get the correct amount, and puree it. Staff should also follow the menu for portions sizes for serve out.During an interview on 08/07/25, at 5:44 P.M. the Administrator said staff should follow a menu for preparing and serving pureed meals.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standard and the resident's choices when the facility failed to follow-up regarding a cardiology referral for one resident (Resident #40), who had a pacemaker, in a timely manner. This would place the resident at an increased risk for a cardiac incident due to lack of oversite on his/her pacemaker. The facility census was 70.Review of the facility provided policy titled, Verbal Orders, revised February 2014, showed the following:-Verbal orders shall only be given in an emergency or when the attending physician is not immediately available to write or sign the order;-Verbal orders will always be based on verbal exchange with the prescribing practitioner or on approved written protocols;-Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record;-Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf;-A telephone order is a verbal order given over the telephone;-The individual receiving the verbal order must write in on the physician's order sheet as v.o. (verbal order) or t.o. (telephone order);-The individual receiving the verbal order will read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed, record the ordering practitioner's last name and his or her credentials (MD, NP, PA, etc.), and record the date and time of the order;-The practitioner will review and countersign verbal orders during his or her next visit;-If a treatment, test, or another intervention is included in a written protocol that has been reviewed and approved by the medical director, then a verbal order may be written for a situation that is covered by the protocol;-Otherwise, a verbal order will not be written that is not based on a conversation with the practitioner;-Anyone writing an unauthorized verbal order will be subject to disciplinary action.Review of the facility provided policy titled, Telephone Orders, revised February 2014, showed the following:-Verbal telephone orders may be accepted from each resident's attending physician;-Verbal telephone orders may only be received by licensed personnel;-Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record;-The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information;-Telephone orders must be countersigned by the physician during his or her next visit.1. Review of Resident #40's face sheet (gives basic profile information) showed the following:-admission date of 03/03/25;-Diagnoses included chronic systolic (congestive) heart failure (CHF), paroxysmal atrial fibrillation (irregular and rapid heart rate), and presence of cardiac pacemaker.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 06/10/25, showed the following:-Cognitively intact;-Resident used walker and wheelchair;-Primary medical conditions show debility and cardiorespiratory conditions, including heart failure.Review of the resident's progress note dated 03/31/25, at 1:29 P.M., showed Licensed Practical Nurse (LPN) O noted the resident complained of skin being taut around pacemaker site. Resident complained of needing follow-up with cardiologist for pacemaker checkup. Skin around pacemaker site is clean, dry, and intact with no redness, discoloration, edema (swelling), or drainage noted or reported.Review of the resident's physician order summary report showed an order dated 03/31/25 for a cardiologist referral.Review of the resident's medical record showed staff did not document regarding the cardiologist referral or if an appointment was scheduled. Review of the resident's care plan, revised on 08/11/25, showed the following:-An activities of daily living self-care performance deficit because of weakness from CHF;-Has a pacemaker related to atrial fibrillation;-Will remain free of signs and symptoms of altered cardiac output;-Monitor, document, and report as needed any signs and symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficulty breathing, pulse rate lower than programmed rate, or lower than baseline blood pressure.During an interview on 08/04/25, at 1:13 P.M., the resident said he/she had been at the facility since March of 2025. He/she had a history of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heart problems, went to the hospital, and now was at the facility. He/she told the Medical Records staff member that made appointments for residents that he/she would like to see his/her heart doctor. He/she also told LPN F that he/she would like to see his/her heart doctor. He/she has had a difficult time getting his/her appointments scheduled and to his/her appointments since he/she has been in the facility. During interviews on 08/08/25, at 10:12 A.M. and 10:19 A.M., LPN F said the following:-He/she did not recall the resident mentioning to him/her that he/she needed to see a cardiologist;-The resident has not been able to find his/her pacemaker box;-If the resident would have mentioned needing to see a cardiologist, the facility Medical Director would have written a referral;-He/She was not aware of the Medical Director providing an order for a cardiology referral for the resident;-He/she checked the nursing notes and found the 03/31/25 referral note for the cardiologist and said an agency nurse put the cardiologist referral order into the resident's electronic record;-The issue with the referral appointment not being scheduled was because no one knew the referral was there;-The agency nurse should have made a copy of the referral order and placed it in the box at the nurses' station for the Medical Records staff member to pick up;-Resident medical appointments are made by the Medical Records staff member;-If Medical Records staff is too busy or not available to make an appointment, then the facility charge nurse, or the facilities Medical Director office staff makes the appointments;-When any nurse puts in or takes an order, including a referral for an appointment, they need to put it on the nursing treatment administration record (TAR) or medication administration record (MAR) otherwise, it just sits there, and no one knows about it;-Agency nurses are not educated on the process that needs to be followed when physician orders are received.During an interview on 08/08/25, at 11:10 A.M., the Medical Records staff member said the following:-The resident never told him/her that he/she needed to see a cardiologist and he/she has not seen an order from the Medical Director to schedule a cardiology appointment;-He/She was not aware of the nurse's progress note or the physician's cardiology referral for the resident;-The nurse should have put the order in the box at the nurse's station for him/her, but he/she must not have put it in there;-He/She has made appointments for residents for a year or longer;-When the facility gets an admission staff should let him/her know if a resident needs an appointment;-He/She does not always know if a resident needs an appointment because the process does not always get passed on to him/her;-If the Medical Director is in the facility and orders an appointment, he/she puts it in his/her mailbox basket;-When an appointment is made, he/she puts it on the calendar and in his/her appointment book;-If the nurses take an appointment order by phone, they should print off the order and put it in his/her basket at the nurses' station;-He/She empties the basket at the nurses' station every morning and sorts it out.During an interview on 08/08/25, at 2:25 P.M., Housekeeper D said the following:-The resident has a pacemaker and when he/she was admitted to the facility he/she did not have any paperwork or the machine for his/her pacemaker;-He/She has looked everywhere for the resident's pacemaker paperwork and equipment, but he/she has not found it;-Today, the facility called to schedule the resident an appointment with a cardiologist.During interviews on 08/08/25, at 3:20 P.M., and on 08/13/25, at 11:00 A.M., the Director of Nursing (DON) said the following:-The first week in the facility the resident needed an appointment for a cardiologist;-He/she knew the resident had a pacemaker, so he/she investigated to find out what needed to be done with it;-An agency nurse messaged the facility Medical Director about the resident's request to see a cardiologist;-They facility did not have the resident's doctor's information or know who put the pacemaker in;-He/she called 20 to 30 cardiologists and could not get anyone to take the resident on because they did not put the pacemaker in;-The resident had a machine he/she was supposed to keep and use for the pacemaker, but the resident had not had it since he/she was admitted to the facility in March of 2025;-Today, an appointment was made with a cardiologist for September of 2025;-The agency nurse passed along in report that a cardiology referral was provided by the Medical Director, so the Medical Records staff should have made the appointment;-The agency nurse should have put a note in the Medical Records staff members box regarding the cardiology (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referral so he/she would have known to schedule the appointment.-His/Her expectation was for a resident to see an outside physician if they feel they need to.During an interview on 08/08/25, at 3:50 P.M., the Medical Director said the following:-He/She was unsure if an appointment has been made for the resident to see a cardiologist;-If the resident had a pacemaker, they would want to keep his/her pulse rate above 60;-If no pacemaker box was available for the resident, then the resident should be set up with a cardiologist appointment;-The resident did not have any information regarding the pacemaker when he/she was admitted ;-If he/she ordered a cardiologist referral in March of 2025, he/she would expect the facility to have the appointment scheduled before now.During an interview on 08/13/25, at 12:00 P.M., the Administrator said the following:-Medical records staff member was very organized, so someone probably did not do their job and give him/her the message that a cardiology appointment needed to be scheduled;-His/Her expectation is for a resident to see an outside physician if they feel they need to;-All appointments go the Medical Records staff member to be scheduled;-If the Medical Director provides a referral order or if residents come back to the facility with paperwork, staff are expected to put the order or referral on the Medical Records staff member's desk;-If staff was aware that a resident wanted to be seen by a physician outside the facility, he/she would expect the staff to help get it scheduled to the best of their ability.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview and record review, the facility failed to ensure each resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence possible when staff failed to provide restorative nursing services three times weekly per the restorative therapy program for one resident (Resident #52). The facility census was 70.Review of the facility policy titled, Restorative Nursing Services, revised July 2017, showed the following:-Residents will receive restorative nursing care as needed to help promote optimal safety and independence;-Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational, or speech therapies);-Residents may be started on a restorative nursing program upon admission, during the course of stay, or when discharged from rehabilitative care;-Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care;-The resident or representative will be included in determining goals and the plan of care;-Restorative goals may include but are limited to supporting and assisting the resident in adjusting or adapting to changing abilities; developing and maintaining or strengthening his/her physiological and psychological resources; maintaining his/her dignity, independence, and self-esteem; and participating in the development and implementation of his/her plan of care. 1. Review of Resident #52's face sheet (a brief resident profile) showed the following:-admission date of 04/28/25;-Diagnoses included congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), morbid obesity, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of the resident's Prospective Payment System (PPS) Part A Discharge (Medicare discharge) Minimum Data Set (MDS-a federally mandated assessment tool administered by staff) dated 06/10/25, showed the following:-Cognitively intact;-Required partial/moderate staff assistance with most activities of daily living (ADLs), including transfers, bed mobility, and walking 10 feet. Review of the resident's care plan, revised on 05/07/25, showed the following:-Resident had an ADL self-care performance deficit related to weakness;-Resident will improve current level of function in ADLs through the review date. Resident's goal is to rehab to home;-Physical therapy and/or occupational therapy evaluation and treatment as per physician orders. Review of the resident's restorative nursing program, effective date 06/06/25, showed the following: -Frequency three times weekly for 90 days;-Active range of motion (AROM - the extent to which a joint can be moved by a person's own muscle contractions, without any external assistance) of left and right upper extremities;-Resident to perform bilateral upper extremity therapy exercises with green resistance band all planes, times 10 to 15 repetitions, times one to two sets, with rest breaks as needed;-Resident to perform bilateral upper extremities therapy exercises with arm bike, time 10 minutes, as resident tolerates;-Resident to perform five sit to stands at grab bar, with rest breaks as needed, with moderate assistance;-Resident to perform functional ambulation with moderate assistance transfer, minimal assistance with rolling walker times 100 feet, with rest breaks as needed. Review of the resident's June 2026 nursing notes showed the resident received restorative therapy on 06/08/25, 06/12/25, 06/17/25, 06/21/25, 06/26/25, and 06/30/25. Staff did not document any resident refusals of therapy. (The resident did not receive restorative therapy three times weekly per the restorative nursing program.) Review of the resident's July 2026 nursing notes showed the resident received restorative therapy on 07/04/25, 07/14/25, 07/18/25, 07/19/25, 07/23/24, and 07/24/25. The resident declined therapy on 07/05/25. (The resident did not receive restorative therapy three times weekly per the restorative nursing program.)During an interview on 08/05/25, at 9:38 A.M., the resident said he/she was placed on restorative therapy a couple of months ago, but only receives the therapy on average one time per week and needs more. He/she wanted to ambulate again and return home. During an interview on (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/07/25, at 3:32 P.M., Restorative Aide (RA) K said the following:-He/she had been the RA for two years;-Residents typically come to restorative therapy for maintenance following completion of physical or occupational therapy, if the Director of Nursing (DON) recommends due to falls, or upon recommendation of the physician;-He/she always documents restorative therapy sessions or if the resident is unable/declines, in progress notes in the electronic record;-All residents are planned for restorative therapy three times per week;-The resident does not decline restorative therapy sessions;-He/she was not able to complete restorative therapy three times weekly with each resident, because he/she is often pulled to work the floor due to staffing issues. During an interview on 08/07/25, at 5:00 P.M., the DON said the following:-Residents are placed on restorative therapy through therapy recommendations, resident requests, or if the risk team recommends based on a resident's decline with ADLs;-The facility has a standing physician order for restorative therapy;-Residents are typically planned for restorative therapy three times per week;-The RA is the first to get pulled to work the floor when staff call in on the shift, and is unable to meet the needs the way he/she prefers for restorative therapy;-The RA documents each restorative therapy session or if a resident is unable or chooses not to participate in the electronic record;-The resident does not decline to participate in restorative therapy. During an interview on 08/07/25, at 5:44 P.M. the Administrator said the following:-Residents were placed on restorative therapy when Medicare-A stopped paying for skilled therapy for maintenance or if referred by the risk team due to a decline;-The facility has a standing physician order for restorative therapy;-Resident frequency of restorative therapy varies, but typically is three times per week;-The resident is supposed to receive restorative therapy three times per week;-Residents are not receiving 100% of planned restorative therapy sessions due to short staffing and the RA being pulled to work the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265752	A. Building B. Wing	08/13/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure correct installation and maintenance of bed rails when the bed rail of one resident (Resident #11) was loose and improperly secured. The facility census was 70.Review of the facility policy titled, Bed Rail Policy, dated 2017, showed the following:-It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use;-A duo-faceted approach will be used to achieve sustainable quality outcomes, including regular bed maintenance and individual bed rail evaluations;-In response to the requirement of providing for a safe, clean, comfortable, and homelike environment, the facility's regular maintenance program will include regular inspection of all bed systems (e.g. rails, frames, and mattresses, and operational components) to ensure they are clean, comfortable, and safe;-The facility will also ensure individual resident bed rail evaluations are performed on a regular basis;-Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use;-When bed rail(s) are deemed necessary and appropriate, the facility will provide education to resident or resident's representative pertaining to the risk and benefits of bed rail use;-The facility's priority is to ensure safe and appropriate bed rail use;-No matter the purpose of use, bed rails, although prescribed to improve functional independence with bed mobility and transfers, can increase resident safety risk;-Precautions include following manufacturer equipment alerts and recommendations for installing and maintaining bed rails;-The interdisciplinary team will use data collected from regular bed inspections and individual bed rail evaluations to bolster care planning and positive resident outcomes;-The facility will conduct regular bed inspections, utilizing an interdisciplinary, team-based approach (e.g. nursing and maintenance) to risk identification and prevention;-The Director or Nursing (DON) and Maintenance Director (or qualified designees) cooperatively will be responsible for completion of bed inspections on a regular basis;-All employees will be trained on the bed rail policy;-Education will be provided to any resident or his/her representative pertaining to risks and benefits of bed rail(s) use;-Before admission, prospective residents will be screened to help determine if care needs may necessitate specialized beds or accessories (e.g. side rails);-Upon admission, readmission, or change of condition, residents will be screened to determine their level of independence with bed mobility, bed comfort level, if the bed meets manufacturers recommendations and specifications pertaining to resident height and weight;-Upon admission, readmission, or change of condition, residents will be screened to assess the need for special equipment or accessories (e.g. side rails);-Assess the resident to identify appropriate alternative prior to installing bed rails;-Assess the resident for risk of entrapment from bed rails prior to installation;-Facility will have indicated documentation that the side rail is the least restrictive alternative for the least amount of time;-The facility will document the ongoing need for the use of a bed rail;-Review the risk and benefits with resident and resident representative;-Obtain informed consent;-Obtain physician order for medical symptom assessed for need for bed rail use;-Resident care plan will include use of bed rails as assessed;-When installing or maintaining bed rails, the maintenance department staff will follow the manufacturer's recommendations and specifications, or provide another bed or appropriate alternative in accordance with individual bed inspections;-The maintenance department will conduct regular (*facility to designate frequency) inspection of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment;-The interdisciplinary team will identify resident-specific bed adaptions and pertinent safety risks on the resident care plan. 1. Review of Resident #11s face sheet (gives basic profile information) showed the following:-admission date of 05/19/25;-Diagnoses included fracture of unspecified part of neck of left femur (thigh bone), unspecified symptoms and signs involving cognitive functions and awareness, anxiety (worry and fear about everyday (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situations), and depressed mood. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 05/26/25, showed the following:-Cognitively intact;-Dependent on staff for going from sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfer, and with wheelchair use;-Substantial/maximum assistance required for rolling left to right;-Resident used walker and wheelchair;-History of falling in the past month prior to admission. Review of the resident's progress note, dated 06/04/25, showed the following: -Care conference held this date. The resident and family attended, along with the facility administration, Social Services Director (SSD), and MDS Coordinator;-Quarter bed rails requested by the family;-Family further requested quarter rails for bed mobility as resident had them on his/her bed at home;-The team explained the risks to using rails and family understood and accepted the risks;-Resident continued dependent on staff for all cares.Review of the resident's Side Rail Assessment, dated 06/05/25, showed the following:-Bed rails used for increased bed mobility;-Quarter rails used at home for bed mobility;-Quarter rails for increase in independence in bed mobility;-Used rails to enhance bed mobility;-Past history of rail use;-Side rails were indicated and serve as an enabler to promote independence;-Resident, family, and Durable Power Of Attorney informed of the risks and benefits of side rails;-Based on the summary findings, bilateral assist bar was indicated;-Signed on by family, the MDS Coordinator, and physician. Review of the resident's August 2025 Physician Order Sheet (POS) showed an order, dated 06/05/25, for bilateral 1/2 side rails for increased independence with bed mobility, repositioning, and safety. Review of the resident's care plan, initiated and revised on 06/12/25, showed the following:-Side Rails: Two half rails up as per physician order for safety during care provision, to assist with bed mobility;-Observe for injury or entrapment related to side rail use;-Resident used rails on his/her bed at home prior to admission to the facility;-My family was aware of the risks. Review of the facility weekly bed rail audits showed the following:-Week of 06/16/25, resident had 1/3 bed rails bilateral;-Week of 06/25/25, the resident had 1/3 bed rails bilateral;-Week of 07/01/25, the resident had 1/4 bed rails bilateral;-Staff did not document a weekly audit report from 07/02/25 through 07/13/25;-Week of 07/14/25, the resident had 1/4 bed rails bilateral;-Staff did not document a weekly audit report from 07/15/25 through 07/22/25;-Week of 07/23/25, the resident had 1/4 bed rails bilateral. Observation and interview on 08/04/2025, at 12:56 P.M., showed 1/4 bed rails to each upper side of the resident's bed in place and in the upright position. The resident wiggled the right upper bed rail with his/her right hand and said the bed rail was loose. During an interview and observation on 08/05/2025, at 11:44 A.M., the resident said the following:-The right bed rail was loose;-He/she was having difficulties using the bed rail to get up out of bed and to turn in bed;-He/she was lying in bed and wiggled the bed rail;-The resident said it was hard for him/her to use the rail;-When lightly touched the right bed rail wiggled and it appeared very loose and unstable;-The resident was observed struggling to use the rail to pull himself/herself up on the side of the bed;-He/she did not feel like the loose bed rail was safe;-The loose bed rail makes it difficult for him/her to turn in bed and pull himself/herself up in bed;-He/she told a couple of staff members including the maintenance man that the rail was loose, but no one had fixed it;-The resident would like to have the loose bed rail fixed. During an interview on 08/08/25, at 10:09 A.M., Licensed Practical Nurse (LPN) F said the following:-He/She had not noticed the resident's bed rail being loose;-The resident sets him/herself up when he/she wants to get out of bed;-If he/she noticed a side rail was loose, he/she would report it to maintenance;-Quarterly inspections/audits are completed by the nursing staff or the MDS Coordinator;-The Restorative Aide does weekly bed rail checks to make sure bed rails are still appropriate for the resident because residents move beds a lot;-The maintenance department does measurement checks on the bed rails. During an interview on 08/08/25, at 10:39 A.M., Certified Nurse Aide (CNA) I said the following:-He/She had not noticed the resident's bed rail being loose;-The resident never told him/her the side rail was loose;-If he/she was aware of a loose side rail, he/she would report it to a nurse or find someone in maintenance and let them know. During an interview on 08/08/25, at 11:53 A.M., the (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintenance Assistant said the following:-He/She was not aware of the resident's or any other resident's bed rails being loose;-The Maintenance Assistant thought the resident's loose bed rail could have been caused by a bolt being threaded wrong;-He/She had done some bed rail checks;-He/She was not sure who checks them to see if they are loose;-He/She had never checked any bed rails to see if they were loose;-When new beds arrive at the facility or he/she was told a resident needed bed rails, he/she put them on. During an interview on 08/08/25, at 11:56 A.M., CNA G said the following:-He/She works with the resident, but he/she did not notice the side rail was loose;-The resident had never told him/her the side rail was loose;-He/She believed maintenance or housekeeping completed bed rail checks;-He/She did not know how often bed rails are checked;-If he/she noticed that a side rail was loose, he/she would tell someone in maintenance.During an interview on 08/12/25, at 3:10 P.M., the Restorative Aide (RA) said the following:-On 02/28/24, he/she was asked to complete the weekly bed rail audits because it was a state thing;-He/she goes room to room weekly as his/her schedule allows to document who has bed rails;-He/she records the room number and if it is bed A or B, the resident's name, bed type such as vinyl, metal, hospice, etc., and the rail size that he/she observes on the bed;-The weekly bed rail audit documentation is turned into the DON and the MDS Coordinator when it is completed for the week;-He/She did not always have time to complete the weekly bed rail audits because he/she was pulled to the floor to work;-When he/she does not have time to complete the weekly bed rail audits they do not get completed. During an interview on 08/12/25, at 11:35 A.M., Housekeeper P said the following:-The last he/she recalled (unsure of date) completing the resident's bedrail paperwork, the resident's bed rails were fine;-He/She was not aware the resident's bedrail was loose;-The last maintenance person prior to the Maintenance Supervisor now did not want to do the bed rail measurements, so he/she was given that job;-He/She was expected to measure the rails quarterly;-He/She had paperwork to fill out for each bed when he/she completed the measurements;-He/She turned his/her measurement documents into the Housekeeping Supervisor, and the Housekeeping Supervisor turned the paperwork into the DON;-He/she wiggled the bed rails to see if they are loose when he/she completes the quarterly measurements;-Maintenance was responsible for tightening the bed rails;-If he/she were to find a loose bed rail he/she would fill out a work order and documents it;-He/She gave work orders to the Housekeeping Supervisor, or he/she put them in a box for maintenance. During an interview on 08/12/25, at 1:06 P.M., the Maintenance Supervisor said the following: -He/she was not aware of the resident's bed rail being loose until the resident stopped him/her in the hall last Friday, 08/08/25, and told him/her that the bed rail was loose, and it needed to be looked at;-His/her role with bed rails is that if he/she was handed a work order saying a bed rail needed to be checked and measured, he/she would do that;-Normally Housekeeper P did the bed rail measurements.During an interview on 08/08/25, at 9:40 A.M., the Housekeeping Supervisor and the DON said the following:-Maintenance was not involved with bed rail checks;-Housekeeper P does side rail measurements every three months;-The DON has the RA do a bed rail audit every week;-Bed rail assessments were done quarterly and involved nurses checking to make sure resident consent forms were signed and that bed rails were still appropriate for the resident;-They would both expect staff to tell maintenance if repairs need to be made to bed rails;-The DON said the facility/staff does not do any testing of the bed rails to see if they are loose;-Housekeeper P would make sure the bed rail goes up and down and he/she would know if the bed rail were loose;-Housekeeping makes sure the assessments and measurements were done;-The maintenance department puts the bed rails on, removes them, and makes any repairs. During an interview on 08/13/25, at 11:00 A.M., the DON said the following:-If the RA did not have time to complete the weekly bed rail audits, they do not get done, but there is no facility policy saying they have to be completed weekly, he/she just likes them completed weekly for his/her own record since residents are moved to different rooms often;-The weekly bed rail audit consists of the RA or the nurses documenting which residents have side rails and if they are half or quarter rails etc.;-The nurses complete the quarterly bed rail assessments in the resident's electronic (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health record;-The nursing staff completes the bed rail assessments in the electronic health record quarterly, but that does not include checking for loose bed rails. During an interview on 08/13/25, at 12:00 P.M., the Administrator said the following:-His expectation is for staff to complete side rail audit checks and assessments at least quarterly, but the staff is doing them monthly instead;-The RA, DON, nursing, housekeeping, and maintenance departments are involved in bed rail checks and maintenance;-He/She was not sure that staff had a time frame to check for loose bed rails. There is nothing scheduled for that;-Loose bed rails were taken care of as needed;-The expectation would be for staff, residents, and family to tell someone if a bed rail was loose;-The majority of the bed rails in the facility are half rails and residents like them because they need them to help them position in the bed.