STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47195 Based on record review and interview, the facility failed to thoroughly investigate an allegation of injury of unknown origin when one resident (Resident #1) was found to have bruising that spread across his/her abdomen, perineal area, and legs. The facility failed to implement the abuse and neglect policy and failed to provide documentation that all staff working were interviewed, failed to interview facility residents, and failed to provide complete and thorough documentation of the investigation. This affected one of four sampled residents. The facility census was 27. Review of facility policy, abuse and neglect, dated 1/1/23, showed: -It is the policy of the facility that all residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, and financial exploitation. -All allegations of abuse will be investigated and documented. -Abuse means willful indication of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Alleged incidents will be identified and investigated. Interventions will be implemented as needed to correct a situation and/or potential situation which may lead to abuse, neglect, or misappropriation of resident property. -The administrator and/or Director of nursing, and Social Services Designee shall conduct all investigations. -The investigation shall include interviews with staff, visitors, or residents who may have knowledge of the alleged incident. Written statements from involved parties should be requested. The documentation of the investigation will be held confidential and kept in the Administrator's office or Designee's office. -The medical record shall be reviewed to determine the resident's history and condition and its relevance to the alleged violation. -The Director of Nursing or Designee shall notify the resident's representative regarding the alleged violation and reassure the resident's representative that an investigation had bee initiated and appropriate action will be taken. The contact shall be documented. (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
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Director of Nursing or Designee shall notify the resident's physician. This contact shall be documented. 1. Review of Resident #1's annual minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/23/24, showed: -He/She had a Brief Interview Mental Status (BIMS) score of 99, a brief cognitive screening tool used to measure and track resident's cognitive decline or improvement in long-term care, showed resident was not able to be tested . -He/She had unclear speech with slurred or mumbled words; -He/She only sometimes understands others or is able to make self-understood; -He/She was dependent on a wheelchair for mobility; -He/She required partial to moderate assistance with eating, rolling left to right, and sitting to lying; -He/She required substantial/maximal assistance with oral hygiene, bathing, upper and lower body dressing, personal hygiene, and transitioning from lying to sitting on side of bed, sitting to standing, chair to bed transfers, and toilet/bath transfers; -He/She was dependent for toileting and putting on and taking off footwear; -Diagnoses included dementia (a condition characterized by impairment of at least two brain functions such as memory loss and judgement), myeloma in remission (a cancer of plasma cells that is no longer present), vitamin D deficiency, and gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of care plan, dated 6/19/23, showed: -He/She had impaired cognitive function and impaired thought processes due to dementia; -He/She had impaired cognitive visual function due to aging; -He/She had a communication problem due to disease process; -He/She will remain free of injuries or complications related to decreased mobility through refuse; -Monitor and document for risk of falls. Educate resident, family/caregivers on safety measures that need to be taken in order to reduce risk of falls. -He/She was at moderate risk for falls due to decreased functions related to disease process; -He/She had potential to demonstrate physical behaviors hitting, kicking, and trying to bite due to dementia; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had activities of daily living (ADL) self care performance deficit due to dementia; -He/She was totally dependent on staff for toilet use; -He/She required two staff participation to use toilet; -Bed mobility: He/She required 1 staff participation to reposition and turn in bed; -He/She required skin inspection every shift. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. -He/She required physical assistance with transferring; Review of medical record showed on 2/21/23 was last entry from physician that included no entries regarding bruising or assessments from physician or nurse practitioner. Review of electronic medical record showed: -On 3/2/24 at 3:59 P.M. Resident had bruising across his/her lower abdomen, a dark purple area in center umbilical area and lower, with light purple/green areas towards both sides of abdomen. The resident did not show signs of pain when touching the bruising. No known falls or rolling out of bed. -On 3/3/24 at 5:44 A.M., When two Certified Nurse Aides (CNA)'s were getting resident up for the morning the resident cried out when he/she put weight on his/her left leg. The resident had dark purple bruising at umbilical site on abdomen and less purple colored bruising going across low abdomen and downward. -On 3/3/24 at 1:15 P.M., Bruising noted to pubic area and left interior thigh. the resident grabbed his/her left leg and moaned in pain when he/she was moved or transferred. Director of Nursing (DON) was notified and he/she reported that he/she had already seen it. Review of medication administration record (MARS) showed: -Facility used MARS to document weekly skin assessment weekly on Friday: -On 3/1/24 showed scattered bruises and scratches; -On 3/8/24 showed leg bruise and abdomen and redness under breasts; -On 3/15/24 showed bruises abdomen and to thighs; -On 3/22/24 showed bruising the his/her abdomen and left thigh with scratches. Review of skin assessments showed: -Facility used a monthly shower log with area to write in skin issues; -On 3/4/24 notes showed red under breast; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 3/7/24 no skin issues documented; -On 3/11/24 no skin issues documented; -On 3/14/24 bruise on left thigh. Review of facility incident reports showed no incident report was completed on the injury of unknown origin discovered on 3/2/24. Review of facility abuse and neglect training showed: -3/5/24 facility provided a read and sign in-service on abuse and neglect: prevent, recognize, report and the facility abuse and neglect policy. Training was signed and dated by twenty-four employees. During an interview on 3/25/24 at 10:15 A.M., the DON said: -When a bruise of unknown origin occurs the social worker would do an investigation; -He/She was not aware of any recent investigations. During an interview on 3/25/24 at 11:15 A.M., Licensed Practical Nurse (LPN) A said: -He/She did not know anything about the resident's bruise; -Resident can be feisty at times; -When resident wants up, he/she will get up on his/her own; -If injury of unknown origin he/she would report concerns to DON, complete an incident report, chart for three days on every shift, notify family, notify physician, and if/when it was an emergency he/she would call 911. During an interview on 3/25/24 at 11:53 A.M., CNA A said: -He/She primarily worked as bath aide and first noted resident's bruise on his/her bath day which was Monday or Thursday; -Bruise he/she saw looked like it could have been a result of resident picking; -He/She sometimes documents skin observations on the shower sheet and sometimes he/she did not document skin concerns; -He/She was not sure who the facility investigator was but felt it may be Administrator or Business office manager; -He/She did not give a statement regarding resident's bruise; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would not expect the resident to have a bruise in lower abdomen and groin area. During an interview on 3/25/24 at 12:03 P.M., Administrator said: -He/She did not do formal investigation on resident's bruise of unknown origin; -He/She discussed with all staff at the stand up meetings held at shift changes for three days; -He/She had no staff who knew what had happened to resident to cause bruise; -He/She obtained no documentation from staff regarding the discovered bruise; -He/She spoke with all CNA's; -It was not facility's standard of practice to not document their investigations; -He/She was not sure if staff contacted resident's family regarding bruising; -If resident had a significant change he/she expected staff to contact the nurse practitioner or physician and document in the resident's hard chart. During an interview on 3/25/24 at 12:37 P.M., DON said: -He/She had talked to everyone who had worked; -Bruise was found on 3/1/24 at 5:06 A.M. by CNA and charted by the LPN; -A cause for the bruise was not determined; -There was medical cause or expectation to find bruise in that area of resident based on resident's medical history; -Resident was first admitted to facility with pelvis/abdomen fracture; -The nurse practitioner saw resident on 3/4/24 when he/she was in facility as he/she pulled him/her into the shower to look at resident's bruising; -The nurse practitioner did not make any documentation regarding the assessment or observation. During an interview on 3/25/24 at 1:13 P.M., CNA B said: -He/She heard about the resident's bruise on the last day of February but saw it on 3/1/24; -The bruise was in the peri area; -He/She had never seen bruises in resident's peri-area previously; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She observed the bruises grow day by day from inside of the legs and by the folds of skin around the urethra; -He/She observed no measurements taken of bruises; -He/She was not asked questions or asked to provide statement regarding the observed bruise; -He/She had not witnessed any staff being rough with resident; -He/She did not document the bruises as he/she's job was to notify the nurse, the nurse documents injury; -He/She knows every nurse looked at and saw the bruise; -He/She was aware that no staff had informed the family of the bruise. During an interview on 3/25/24 at 1:20 P.M., CNA C said: -He/She came to work at 2:00 A.M. on 3/1 and found bruise during his/her first bed check of resident; -He/She reported bruise to the nurse who went and looked at it; -He/She observed the bruise to be in abdominal area the size of a dime; -When the DON arrived to building he/she took him/her to the resident's room to look at the resident's bruise; -At that time the bruise covered the entire perineal area and was very dark purple in color. The bruising had progressed down the residents right leg; -He/She did not get interviewed or provide any statements regarding the bruise; -He/She did not document any of his/her observations of the skin. During an interview on 3/25/24 at 1:31 P.M., Administrator said: -Facility did not do abuse and neglect training with staff upon hire; -Staff just receive the normal CNA training; -Upon hire staff received orientation on exits, what to do during power failures, where water shut offs are located; -Facility did not provide specific training on resident care; -No measurements were documented of resident's bruise. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/24 at 1:43 P.M., DON said: -No staff took measurements of resident's bruising in notes; -He/She was aware that staff drew a line around bruise and the bruise spread over that line; -Bruising was purple oval shaped and as the days went on it spread out and went down the resident's legs; -He/She did not make a note of observation of bruise; -Nurse practitioner did see bruising but did not make documentation of observation; -Facility did discuss bruise as a group at morning meeting; -Social Services staff normally completes investigations. MO233069

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 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** 47195 Based on observation, record review and interviews, the facility failed to update and revise the care plan with fall interventions for four of four sampled residents (Resident #1, #2, #3, and #4) who had experienced falls. The facility census was 27. Review of facility fall policy and procedure, dated 7/29/13. showed: -Falls are the most common injury sustained by residents in the long term healthcare setting. They are a major cause of injury and death among the elderly and debilitated patients. Environmental, physical, and psychological factors contribute to patient falls and the ensuing injuries. The goal of the fall program is to identify the resident who is at risk to fall, institute proactive efforts to reduce the occurrence of fall related incidents, respond, and provide a safe environment. -All residents will be assessed on admission and continuing throughout the stay using the fall assessment guidelines. -Implement fall protocol as determined by the resident's assessed needs; -Post fall assessment is done by Registered Nurse (RN) or Licensed Practical Nurse (LPN) to include fall risk assessment, incident report to be completed by RN or LPN; -Notify physician and family/legal representative of fall as indicted; -Review and update care plan; -RN or LPN will continue to monitor status for minimum of 24 hours. Review of resident care plan policy and procedure, dated 4/19/23, showed: -The care plan shall be used in developing the resident's daily care routines and will be available to caregivers and other staff who have the responsibility for providing care or services to the resident. -Care plans for each resident will be developed upon admission and updated quarterly. -Certified Nurses Aides (CNA)'s are responsible for reporting to the charge nurse any change in the resident's condition and the care plan goals that have not been met. -Change in a resident's condition must be reported to the Director of Nursing/Assistant Director of Nursing so that a review of the resident's assessment and care plan can be made. -Documentation must be consistent with the resident's care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Information contained on the care plan, and other documents used by the caregiver and nursing staff, shall be maintained in a confidential manner in accordance with established facility policy. 1. Review of Resident #1's annual minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/23/24, showed: -He/She had a Brief Interview Mental Status (BIMS) score of 99, a brief cognitive screening tool used to measure and track resident's cognitive decline or improvement in long-term care, showed resident was not able to be tested . -He/She had one fall with injury since prior assessment on 11/24/23; -He/She had unclear speech with slurred or mumbled words; -He/She only sometimes understands others or is able to make self-understood; -He/She was dependent on a wheelchair for mobility; -He/She required partial to moderate assistance with eating, rolling left to right, and sitting to lying; -He/She required substantial/maximal assistance with oral hygiene, bathing, upper and lower body dressing, personal hygiene, and transitioning from lying to sitting on side of bed, sitting to standing, chair to bed transfers, and toilet/bath transfers; -He/She was dependent for toileting and putting on and taking off footwear; -Diagnoses included dementia (a condition characterized by impairment of at least two brain functions such as memory loss and judgement), myeloma in remission (a cancer of plasma cells that is no longer present), vitamin D deficiency, and gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of facility falls, from 1/1/24 to 3/25/24, showed he/she had experienced a fall on 1/26/24 and 3/16/24. Review of incident/accident reports showed: -On 1/11/24, Resident was heard saying oh and found on the floor. No interventions or steps taken to prevent reoccurrences were documented on the form. -On 1/26/24, Resident was found on the floor by his/her bed. His/Her head was bleeding from a laceration to the back and side of his/her head. No interventions or steps taken to prevent reoccurrences were documented on form. -On 3/16/24, Resident was found on the floor on his/her back the dining room. No interventions or steps taken to prevent reoccurrences were documented on form. Review of care plan, dated 6/19/23, 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
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was at moderate risk for falls due to decreased functions related to disease process. -Anticipate and meet needs; -Be sure call light is within reach and provide prompt response to all requests for assistance; -Ensure that he/she was wearing appropriate footwear when ambulating or mobilizing in wheelchair; -He/she need a safe environment with even floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, and the bed in low position at night. -Monitor and document for risk of falls. Educate resident, family/caregivers on safety measures that need to be taken in order to reduce risk of falls (if resident has a care plan for falls, refer to this). -No new interventions care planned after 1/11/24, 1/26/24, and 3/16/24 falls. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: -He/She had a BIMS score of 14, showed resident was cognitively intact; -He/She had two more falls with no injury since prior assessment on 11/20/23; -He/She had clear speech, was able to make self-understood and understand others; -He/She was dependent on a walker and wheelchair; -He/She was independent with eating, oral hygiene, toileting , putting on and taking off footwear, personal hygiene, rolling left and right, sit to lying, lying to sitting , sit to stand, chair to bed/chair transfer, and toilet transfers. -He/She required supervision or touching assistance with bathing, and walking 10 feet, 50 feet, and 150 feet. -He/She required set up or clean up assistance with upper and lower body dressing, shower transfers -Diagnosis included hydrocephalus (a condition causing fluid build-up in the cavities deep within the brain), high blood pressure, diabetes (a condition causing too much sugar in the blood), weakness, pain in hip, spinal stenosis (a condition where the space inside bones of spine get too small), generalized muscle weakness, and unsteadiness on feet. Review of facility falls, from 1/1/24 to 3/25/24, showed he/she had experienced a fall on 1/13/24 and 3/15/24. Review of incident/accident reports 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
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/13/24, Resident was using the toilet, when getting up from toilet he/she stated he/she lost his/her balance and sat down on the floor. No interventions or steps taken to prevent reoccurrences were documented on form. -On 3/15/24, Resident found sitting on the floor stating he/she slid out of his/her wheelchair. No interventions or steps taken to prevent reoccurrences were documented on form. Review of care plan, dated 12/6/23, showed: -He/She had an actual fall with no injury; -For no apparent acute injury, determine and address causative factors of the fall; -Monitor/document/report as needed for 72 hours to medical doctor for signs and symptoms of pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation; -Provide activities that promote exercise and strength building where possible. -Physical therapy consult for strength and mobility. -No new interventions care planned after 1/13/24 and 3/15/24 falls. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed: -He/She had a BIMS score of 15, he/she was cognitively intact; -He/She was dependent on wheelchair for mobility; -He/She had 2 or more falls without injury since last assessment on 11/5/23; -He/She required partial to moderate assistance with toileting, bathing upper and lower body dressing, putting on footwear, and personal hygiene; -He/She required supervision or touching assistance with rolling left and right, sit to lying, and lying to sitting; -He/She required partial to moderate assistance with sitting to standing, chair to bed transfers, toilet transfers, and tub transfers. -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (a group of lung disease that block airflow and make it difficult to breathe), difficulty in walking, unsteadiness on feet, weakness, osteoarthritis (a condition that causes flexible tissue at the end of bones to wear down), and stroke (damage to the brain from interruption of blood supply which can result in trouble walking, speaking or paralysis or numbness of face, arm, or leg). Review of facility falls, from 1/1/24 to 3/25/24, showed he/she had experienced a fall on 1/7/24, 1/24/24, and 2/8/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of incident/accident reports showed: -On 1/23/24, Resident was found with the call light engaged and on his/her knees on floor and upper body on bed. Resident stated he/she did not fall. Both knees found with abrasions and bruising. No interventions or steps taken to prevent reoccurrences were documented on form. Review of care plan, dated 8/16/18, showed: -He/She was at moderate risk for falls related to history of frequent falls when at home; -Be sure call light is within reach and encourage to use it for assistance as needed; -Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as exercise class. -Ensure the resident is wearing appropriate footwear nonskid soled shoes when ambulating; -Physical therapy to evaluate and treat as ordered or as needed. -Restorative aide program. -Review information on past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family/caretakers and interdisciplinary team to causes. -Resident uses an electric wheelchair for mobility. He/she needed assistance of two with ambulation and walker. -Use electric wheelchair, safety evaluation done yearly. He//She can clap own seatbelt, has had this chair when he/she was at home. -No new intervention strategies care planned after 1/23/24 fall. 4. Review of Resident #4's quarterly MDS, dated [DATE], showed: -He/She had a BIMS of 13, he/she was cognitively intact; -He/She was dependent on walker or wheelchair for mobility; -He/She had no falls since prior assessment on 10/6/23; -He/She required set up or clean up assistance with oral hygiene, personal hygiene, and toileting; -He/She required partial to moderate assistance with bathing, upper and lower body dressing, putting on and taking off footwear, sitting to standing and chair to bed transfers, toilet transfers, and shower transfers; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She required supervision or touching assistance with rolling left and right, sitting to lying, lying to sitting on bed mobility; -Diagnoses included stroke (damage to the brain from interruption of blood supply which can result in trouble walking, speaking or paralysis or numbness of face, arm, or leg), difficulty in walking, weakness, generalized muscle weakness, lack of coordination, and macular degeneration (a long-lasting eye disorder that causes blurred vision or a blind spot in the central vision). Review of facility falls, from 1/1/24 to 3/25/24, showed he/she had experienced a fall on 3/3/24. Review of incident/accident reports showed: -On 3/3/24, resident transferred self from toilet to wheelchair without assistance and did not engage the call light for help. No interventions or steps taken to prevent reoccurrence were documented on form. Review of care plan, dated 4/14/22, showed: -Resident had an actual fall with serious injury; -Check range of motion daily or as physical therapy/occupational therapy protocol; -Continue interventions on the at-risk plan; -Provide activities that promote exercise and strength building where possible; -Resident had limited physical mobility related to past cerebral infarction. -No new interventions care planned after 3/3/24 fall. 5. During an interview on 3/25/24 at 10:12 A.M., Administrator said: -Director of Nursing (DON) handled fall investigations to include interventions; -After a fall orders may be changed, items added to care plans, and possible medication changes may occur. During an interview on 3/25/24 at 10:15 A.M., DON said: -Process for fall investigations included looking at fall, determining reason for the fall that occurred; -If equipment caused fall would change something in his/her care plan; -Depended on resident and the situation on what interventions would be added to care plan; -If resident slept on edge of bed, he/she may have had bolsters added to his/her bed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Care plans are updated every three months and more often if needed. During an interview on 3/25/24 at 11:15 A.M., Administrator said: -The facility incident/accident report was being used as the facility's fall assessment form. During an interview on 3/25/24 at 11:15 A.M., LPN A said: -If resident fell he/she would leave resident in position until they were assessed and vitals were checked; -He/She would then report fall to DON, complete an incident/accident report, chart in medical record for three days during every shift after the fall, notify family and physician, and when it was an emergency would contact 911. During an interview on 3/25/24 at 12:03 P.M., Administrator said: -The quality assurance team discusses fall interventions; -Interventions would be added to care plan if they were needed; -Care plan should be updated 24-48 hours. During an interview on 3/25/24 at 1:13 P.M., CNA B said: -He/She looked at care plans; -Updates to the care plan are completed by the DON; -He/She was not notified of changes to resident's care plans. During an interview on 3/25/24 at 1:20 P.M., CNA C said: -He/She did not look at resident's care plan; -Social services director notifies staff of changes to care plans During an interview on 3/25/24 at 1:43 P.M., DON said: -He/She was responsible for updating care plans -Care plans should be updated if something comes up in between quarterly care plan meetings; -Facility did not document discussions of possible fall interventions. MO233069