STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265778	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Manor Health & Rehabilitation	2012 Nifong Boulevard Columbia, MO 65201

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 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42484

Based on interview and record review, facility staff failed to document residents' code status consistently, Do Not Resuscitate (DNR) or Full Code (Resuscitate refers to cardiopulmonary resuscitation-CPR) for two (Resident #39 and #137) of four sampled residents. The facility census was 37.

1. Review of the facility's Advance Directives policy, revised [DATE], showed staff are directed to:

-Inquire if the resident, his/her family members and/or his or her and/or his or her legal representative, about the existence of any written advance directives;

-Prominently display information about whether or not the resident has executed an advance directive in the resident's medical record;

-The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive;

-The resident's attending physician will clarify and present any relevant medical issues and decision to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the resident's wishes;

-Changes or revocations of a directive must be submitted in writing to the administrator. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan;

-The director of nursing (DON) services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care.

2. Review of Resident #39's medical record showed the resident admitted to the facility on [DATE] from the hospital.

Review of the resident's nurse's progress note, dated [DATE], showed staff documented the resident advanced directive as Full Code.

(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: 265778	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Columbia Manor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2012 Nifong Boulevard Columbia, MO 65201	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician Order Sheet (POS), dated [DATE], showed an active order of Full Code Status. Review of the resident's Baseline Care Plan, dated [DATE], directed staff the resident a Full Code. Review of the resident's Outside the Hospital Do Not Resuscitate (OHDNR), dated [DATE], showed the resident's guardian and attending physician authorized the resident as a DNR code status. During an interview on [DATE] at 11:19 A.M., the Director of Nursing (DON) said the orders for the DNR status were not entered into the system, and must have been overlooked after the forms were signed. 3. Review of Resident #143's Admission MDS, dated [DATE], showed the resident admitted on [DATE]. Staff assessed the resident as severe cognitive impairment. Review of the resident's POS, dated [DATE], showed an order on [DATE] for Full Code. Review of the resident's baseline care plan, dated [DATE], showed Do Not Resuscitate. Review of the resident's comprehensive care plan, dated [DATE], showed the care plan did not contain direction for advanced directives. During an interview on [DATE] at 10:27 A.M., the Social Service Designee said he/she was not aware of the discrepancy, but believes the resident is a DNR. 4. During an interview on [DATE] at 09:21 P.M., Registered Nurse (RN) K said the charge nurse is responsible for entering the code status for the resident in the electronic medical record. Social Services is responsible for the review of the advance directive. RN K said all documents and orders should be consistent. During an interview on [DATE] at 10:27 A.M., the Social Service Designee said when a resident comes from the hospital, they often come with a signed DNR or advanced directive. If the resident does not come with one, then it is completed with social services during the admission process. Social Services will update the electronic health record, update the code status book at the nurse station, and then the nurses will mark it in the computer and obtain an order. He/She said if the resident changes code status during his/her stay at the facility, the Social Service designee is responsible to update the record. During an interview on [DATE] at 11:19 A.M., the DON said when residents are admitted from the hospital the charge nurse enters the code status on the hospital discharge paperwork. The social worker is then to verify the code status, and the facility will treat the resident as a full code if the code status is unclear. If the resident has a DNR code status, the DNR form should be filled out with a physician signature and the resident or health Power of Attorney (POA) signature; the DNR orders should be entered and the physician should cosign the order. A discrepancy in the process places a risk that the resident's wishes would not be met. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:55 A.M., the administrator said when a resident is admitted from the hospital, paperwork for the code status should be started and social services and nursing should coordinate and assure everything is consistent and an order entered into the medical record. Discrepancies should be caught during daily communication or when the chart is scrubbed weekly. Social services is in charge to start the code status process and nursing is responsible to follow through in taking care of the physician order 43327

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NAME OF PROVIDER OR SUPPLIER: Columbia Manor Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2012 Nifong Boulevard Columbia, MO 65201	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interviews, and record review, facility staff failed to maintain a clean comfortable, and maintained homelike environment. The facility census was 37. 1. Review of the facility's Work Orders, Maintenance policy, dated April 2010, showed maintenance work orders shall be completed in order to establish a priority of maintenance, work orders must be filled out and forwarded to the maintenance director and emergency requests will be given priority in making necessary repairs. Review of the facility's Cleaning and Disinfection of Environmental Surfaces, dated August 2019, showed environmental surfaces will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration (OSHA) bloodborne pathogens standard. 2. Observation on 05/28/24 at 10:30 A.M., showed the occupied room [ROOM NUMBER] with build up of a dark substance on the room floor tile grout lines. Observation on 05/30/24 at 10:30 A.M., showed the occupied room [ROOM NUMBER] with build up of a dark substance on the room floor tile grout lines. 3. Observation on 05/28/24 at 10:40 A.M., showed the occupied room [ROOM NUMBER]'s bathroom floor with multiple areas of gouges. Observation showed bathroom wall tile around the toilet with a dark dried smear. Observation on 05/30/24 at 11:05 A.M., showed the occupied room [ROOM NUMBER]'s bathroom floor with multiple areas of gouges. Observation showed bathroom wall tile around the toilet with a dark dried smear. 4. Observation on 05/28/24 at 10:45 A.M., showed the occupied room [ROOM NUMBER] bathroom door with large gouges and rough edges. Observation on 05/30/24 at 11:45 A.M., showed the occupied room [ROOM NUMBER] bathroom door with large gouges and rough edges. 5. Observation on 05/28/24 at 10:58 A.M., showed the occupied room [ROOM NUMBER] with a large black build up between the room floor tile. Observation showed the bathroom door frame rusted. Observation on 05/30/24 at 1:58 P.M., showed the occupied room [ROOM NUMBER] with a large black build up between the room floor tile. Observation showed the bathroom door frame was rusted. 6. Observation on 05/28/24 at 11:05 A.M., showed the occupied room [ROOM NUMBER] contained a sink counter top that was cracked with rough edges down the side. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 05/30/24 at 1:46 P.M., Certified Nurse Aid (CNA) L said staff are to tell the Maintenance Director when they find damaged areas in the resident rooms. Housekeeping are told about dirty areas or we clean then ourselves. During an interview on 05/30/24 at 2:00 P.M., Nurse Aid (NA) E said the maintenance department is informed about broken items in resident rooms and housekeeping is responsible for cleaning the resident rooms. During an interview on 05/30/24 at 2:40 P.M., The Maintenance Director said he/she was aware of some of the damage in the resident rooms. He/She said they attempt to patch damage like the counter tops, but the corporate office has to provide payment for the materials needed. He/She said the facility uses a computer based system to track repair request of staff tell them directly. During an interview on 05/31/24 at 10:38 A.M., Housekeeper N said he/she cleans all of the resident rooms daily. He/She said something like a smear on a toilet wall should be cleaned immediately. During an interview on 05/31/224 at 11:21 A.M., the Director of Nursing said damage in the resident rooms is the responsibility of the maintenance department and approval from the corporate office would be needed for the expense of making the repairs. He/She said housekeeping cleans the rooms daily and there should be no areas left uncleaned.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on observation, interview and record review, facility staff failed to develop and implement a comprehensive person-centered care plan for three (Resident #9, #33 and #143) out of ten sampled residents The facility census was 37. 1. Review of the facility's Care Plans, Comprehensive Person-Centered policy, dated December 2016 showed: -The care plan interventions are derived from a thorough analysis of information gathered as part of the comprehensive assessment; -The care planning process will include an assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing the goals of care; -The comprehensive, person centered care plan will: include measurable, objectives and timeframe's, describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, psychosocial well-being, describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his/her right, including the right to refuse treatment, incorporate identified problem areas and risk factors associated with identified problems, build on the resident's strengths, reflect the residents expressed wishes regarding care and treatment goals, reflect treatment goals, timetables, and objectives in measurable outcomes, identify the professional services that are responsible for each element of care, aid in preventing or reducing the decline in the resident's functional status and/or functional levels, enhance the optimal functioning of the resident by focusing on a rehabilitative program and reflect currently recognized standards of practice for problem areas and conditions; -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change. 2. Review of Resident #9's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/25/24 showed staff assessed the resident as: -Cognitively intact; -No behaviors or rejection of care; -Had pain; -Use an antidepressant, antipsychotic, antianxiety, antiplatelet, anticoagulant and opiod medication; -Diagnosis of stroke, dementia and anxiety. Review of the residents Physician Order Set (POS), dated May 2024, showed physician orders for: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lithium 300 milligrams (mg) (used to reduce mania and manic episodes) daily for psychosis; -Lithium 150 mg at bedtime for psychosis; -Abilify (an antipsychotic) 20 mg tablet, give 0.5 tablet twice daily for depression, anxiety and obsessive compulsive disorder (OCD); -Buspirone (an antianxiety) 7.5 mg three times a day for anxiety; -Plavix (stop blood cells from sticking together) 75 mg daily for blood clot prevention; -Cymbalta (antidepressant and pain medication) 30 mg daily for depression; -Eliquis (blood thinner) 5 mg twice a day for hypertension; -Hydrocodone/acetaminophen (used to decrease pain) 5/325 1-2 tablets every 6 hours as needed for pain; -Lorazepam (antianxiety) 0.5 mg three times a day for anxiety; -Trazodone (antidepressant and sedative) 50 mg daily at bedtime for sleep related to anxiety; -Methylphenidate (stimulates brain involved with concentration) 5 mg tablet, give 0.5 mg daily for anxiety; -Namenda (reduces chemicals in brain that contribute to symptoms of Alzheimer's disease) 28 mg daily for depression, anxiety and OCD; -Banophen (used to temporarily relieve pain caused by minor cuts/burns/scrapes, insect bites, or skin irritations) 25 mg tablet, give 0.5 tablet every 24 hours for pain; -Myrbetriq (used for urinary incontinence and overactive bladder) 25 mg daily for spastic hemiplegia; -Sumatriptan (treatment for headaches) 25 mg every 6 hours as needed for headache. Review of the residents care plan, dated 1/25/24, showed the care plan did not contain interventions for dementia care, resident centered behaviors/behavior management, pain management, or risk of bleeding for anticoagulant and antiplatelet use. During an interview on 5/31/24 at 08:17 A.M., the MDS Coordinator said the resident does not have any behaviors except for some reported depression and anxiety so it is not included in the care plan. He/She said the resident does not show signs of dementia. 3. Review of Resident #33's Admission MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No behaviors or rejection of care; -All activities were somewhat important to the resident; -Diagnoses of pneumonia, septicemia (a body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death), dementia, and respiratory disease. Review of the Care plan dated 1/25/24 showed the care plan did not address social, cognitive, or activity needs of the resident. 4. Review of Resident #143's admission MDS, dated [DATE] showed staff assessed the resident as: -Severe cognitive impairment; -Smokes; -History of falls prior to admission with a fracture; -Felt it was very important to have books, newspapers, and magazines to read, listen to music he/she liked, be around animals such as pets, keep up with the news, do things with groups of people, do favorite activities, go outside to get fresh air when the weather is good, and participate in religious services or practices. Review of the resident's smoking assessment, dated 5/13/24, showed the resident smokes two to three times a day with supervision. Review of the resident's nurse notes dated 5/9/2024 at 11:00 P.M., showed the resident on the floor in his/her room. Review of the resident's care plan, dated 5/28/24, showed the care plan did not contain activity preferences, smoking safety and use of cigarettes, or fall interventions for the fall on 5/8/24. During an interview on 5/31/24 at 08:17 A.M., the MDS Coordinator said the resident only participates in occasional smoke breaks and is a passive observer to other activities. The resident was hospitalized after the fall on 5/8/24 and is receiving therapy. He/She said the resident is still new to the facility and actively working on his/her care plan. 5. During an interview on 5/31/24 at 08:17 A.M., the MDS Coordinator said care plans should include resident specific behaviors and how to manage them, how a resident transfers, diet, goals of care, interventions for falls, if a resident is on hospice, side rail use, activity preferences and other triggers from the MDS assessment including psychotropic medication use. He/She said it is his/her responsibility to update the care plans when there are changes in the resident conditions, on admission and at least quarterly. He/She said the Director of Nursing adds new interventions for falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/31/24 at 10:16 A.M., Registered Nurse (RN) M said care plans should include things that trigger in the MDS assessment such as behaviors and should be updated on admission, quarterly and with changes in condition. Other things that the care plan should include are behavior problems, dementia care, anticoagulant medication use, smoking and activity preferences. He/She said the MDS nurse updates the care plans with changes in the residents care. During an interview on 5/31/24 at 11:13 A.M., the Director of Nursing (DON) said care plans should include triggers from the MDS such as code status, diet, mobility, transfers, activity of daily living, assistive devices, activity preferences and medication use. He/She said the managers and MDS coordinator update the care plans. The DON said all the nursing staff have access to care plans. He/She said if a resident has dementia there should be a goal and interventions specific to the person in the care plan and updated accordingly. 43327 50753

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on interview and record review, facility staff failed to meet professional standards of care when nursing staff failed to obtain and document weights for five (Resident #1, #12, #17, #33 and #142) of nine sampled residents and failed to follow up on dietician recommendations for one (Resident #142) of one sampled residents with a weight loss. The facility census was 37. 1. Review of the facility's Weighing and Measuring the Resident policy, dated March 2011, showed: -The purpose to determine the weight, to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident; -Weight is measured on admission and monthly during the resident's stay; -The following should be recorded in the resident's record: date and time the procedure was performed, name and title of person who performed the procedure, signature and title of person recording the data; -Notify the nurse supervisor if the resident refuses the procedure. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 5/16/24, showed staff assessed the resident as: -Cognitively intact; -Did not lose or gain weight or unknown; -Weight 120 pounds; -Diagnosis of anemia, kidney disease and lung disease. Review of the resident's Physician Order Sheet (POS), dated May 2024, showed an order with a start date of 9/2/23 to weigh the resident monthly on the second. Review of the resident's Treatment Administration Record (TAR) showed staff did not document the residents weight for the months of 01/2024 through 05/2024: Review of the resident's nurse notes, dated January 2024 through May 30, 2024, showed the nurses notes did contain the residents weights. 3. Review of Resident #12's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Did not have cognitive assessment; -Did not lose weight or unknown; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Weight of 150; -Diagnosis of thyroid disorder, arthritis, dementia, and anxiety disorder. Review of the resident's POS, dated 05/21/24, showed an order to weight the resident weekly after the admitted for four weeks, and then weigh the resident once monthly. Review of the resident's TAR, dated 03/2024, showed staff documented the residents weight on 03/06/24. Review showed the TAR did not contain documentation staff weighed the resident for the additional three weekly weights and did not document the resident's weight for April 2024. Review of the resident's medical record showed the record did not contain weekly weights after admission or monthly weights for April 2024. 4. Review of Resident #17's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Did not lose or gain weight or unknown; -Weight 98 pounds; -Diagnosis of Alzheimer dementia. Review of the resident's POS, dated May 2024, showed the POS did not contain an order for weights. Review of the resident's medical record, showed the record did not contain a documented weight for April or May 2024. 5. Review of Resident #33's Admission MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Did not lose or gain weight or unknown; -Weight 132 pounds; -Diagnosis of pneumonia, septicemia (a body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death), dementia, and respiratory disease. Review of the resident's POS, dated 02/02/24, showed an order to weigh the resident monthly. Review of the resident's medical record did not contain documentation of the residents mothly weights for March, April or May 2024. 6. Review of Resident #142's Admission MDS, dated [DATE], showed staff assessed the resident as: -admitted on [DATE]; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognition intact; -Presence of a diabetic foot ulcer; -Did not lose or gain weight or unknown; -Weight 221 pounds; -Diagnosis of anemia, heart failure, diabetes and kidney failure. Review of the resident's census sheet showed the resident: -admitted to the faciity on 04/22/24; -hospitalized [DATE]; -readmitted to the facility 05/08/24. Review of the resident's POS, dated May 2024, showed an order with a start date of 05/08/24, to weigh the resident weekly after the admitted for four weeks, and then weigh the resident once monthly on the fifth. Review of the resident's medical record showed staff did not documented the resident weight on 5/9/24 and 5/13/24. Review of the residents nurse notes, dated April through May 2024, showed dietician documented recommendation as follows: -On 4/26/24, recommendation of multivitamin with minerals daily and one scoop of protein powder twice a day or 30 milliliters of protein liquid; -On 5/21/24, start house supplement 120 milliliters twice a day and monitor weight and intake. Review of the residents medical record, showed, the record did not contain follow up documentation to the dietician recommendations. 7. During an interview on 05/29/24 at 2:24 P.M., the DON said if the weights are not recorded in the electronic medical record, then they are not completed. He/She said it has been a struggle getting the weights as ordered but feels it is getting better in the past couple of weeks. The dietician comes in monthly and his/her assistant either comes in person or reviews the residents remotely. The registered dietician recommendations should be followed up on within 24 hours by the DON or the charge nurse. He/She was not aware of any dietician recommendations until 5/29/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/30/24 at 1:52 P.M., the Registered Dietician said he/she comes to the facility monthly and would like to have the weights during each visit so he/she could determine if there are nutritional issues with the residents. He/She said the weights are not always done for his/her visits. He/She would expect the facility staff to follow up on recommendations, especially those residents with wounds or other significant issues. He/She did not have an expectation of a timeframe when the recommendations should be followed up on. During an interview on 05/31/24 at 8:17 A.M., Licensed Practical Nurse (LPN) M said weights are the responsibility of the nursing staff but is not sure if they are up to date. He/She said if the weights are not done, then there is an opportunity to miss a potential problem. The dietary recommendations go to the DON for review and if an order or other follow up is needed, the DON will give them to the nurse working. He/She is not sure why the recommendations were not followed up on, but would expect they should have been. During an interview on 05/31/24 at 8:33 A.M., Nurse Aide (NA) J said weights are completed monthly as assigned by the DON. He/She said he/she does not know if they are up to date. 42484 43327

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 40424 Based on observation, interview, and record review, facility staff failed to safely propel two (Resident #17 and #8) out of 15 sampled residents while in a wheelchair. The facility census was 37. 1. Review of the facility's polices showed staff did not provide a wheelchair propulsion policy. 2. Review of Resident #17's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/28/24, showed staff assessed the resident as follows: -Cognition not assessed; -Uses a wheelchair for mobility; -Diagnosis of Alzheimers, and Parkinson disease. Observation on 05/30/24 at 11:40 A.M., showed Certified Nurse Aid (CNA) L propelled the resident from the hall to the dinning area without the resident's foot pedals. Observation showed the residents feet made contact on the floor. During an interview on 05/30/24 at 11:42 A.M., CNA L said he/she should have put the residents feet in the footrests but did not because the resident has contractor in both legs. 3. Review of Resident #8's annual MDS, dated [DATE], showed staff assessed the resident as follows: -Cognition not assessed; -Dependent for wheelchair mobility; -Diagnosis of stroke, dementia, aphasia, seizures, depression, and respiratory failure. Observation on 05/31/24 at 11:25 A.M., showed CNA K propelled the resident from the hall towards the dinning area without footrests on the wheelchair. The residents feet glided across the floor. During an interview on 05/31/24 at 11:27 A.M., CNA K said he/she should not push the resident in a wheelchair without footrest but forgot to put the footrests on because they were not with the wheelchair. 4. During an interview on 05/31/24 at 8:06 A.M., Licensed Practical Nurse (LPN) M said staff should use footrests to push residents in wheelchair. The resident might fall out and be injured if the staff don't. The staff are educated on this often. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/31/24 at 11:18 A.M., the Director of Nursing (DON) said staff should use footrests when propelling a resident and make sure the resident is secure. Staff have been educated on the risks of not doing so. He/She said staff and the administrator are responsible for resident safety. During an interview on 05/31/24 at 11:45 A.M., the administrator said staff should use footpedals when propelling a resident. Injury is a risk to any resident when pushed in a wheelchair without footpedals. He/She said the DON and themselves along with all nurses are responsible for oversight.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50753 Based on interview and record review, facility staff failed to ensure one (Resident #141) out of one sampled resident received care and services for the provision of hemodialysis (the clinical cleansing of blood by dialysis, as a substitute for the normal function of the kidney) when staff failed to provide ongoing assessments of the resident's condition, monitoring for complications before and after dialysis treatments, and provide ongoing communication and collaboration with the dialysis clinic. The facility census was 37. 1. Review of the facility's policy End-Stage Renal Disease, Care of a Resident with, dated 09/2010, showed the policy did not contain direction on pre and post dialysis assessments or collaboration with the dialysis clinic. 2. Review of Resident #141's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/22/2024, showed staff assess the resident as follows: -admitted [DATE]; -Diagnosis of chronic kidney disease; -Did not receive dialysis as a resident. Review of the resident's Physician's Order Sheets (POS), dated 05/16/2024, showed the POS did not contain an order for hemodialysis treatments. Review of the resident's care plan, dated 05/28/24, showed the plan did not contain documentation the resident received hemodialysis treatments. Review of the resident's medical record showed the record did not contain documentation of collaboration between the facility staff and dialysis staff of ongoing assessment or a pre and post hemodialysis treatment assessments for 05/27/24 or 05/29/24. Review of the resident's Treatment Administration Record (TAR), dated May 2024, showed the TAR did not contain an order for staff to complete dialysis pre and post assessments. During an interview on 05/29/2024 at 10:15 A.M., Licensed Practical Nurse (LPN) M said it was the responsibility of resident's nurse to do pre and post hemodialysis treatment assessments. The Treatment Administration Record (TAR) would show if pre and post assessments were done. There is no regular communication between the facility and dialysis clinic, regarding the resident's assessments, on treatment days. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/2024 at 02:06 P.M., the MDS Coordinator said it is his/her duty to list hemodialysis on the MDS. He/She said if hemodialysis was not listed on the initial MDS, it was his/her over-sight. It is the responsibility of the MDS Coordinator to do the care plans. Care plans are due 14 days after admission. If the care plan did not include Hemodialysis, it was because she did not complete the care plan. He/She obtains data for the MDS from the hospital paperwork, the nurses, the doctors, and from administration. During an interview on 05/31/2024 at 10:53 A.M., the Director of Nursing (DON) said he/she is aware the resident received hemodialysis. The DON said he/she did not know why hemodialysis treatment was not listed on the MDS or the Care Plan. He/She said the MDS and Care Plan were the responsibility of the MDS Coordinator. The DON said he/she did not know why assessments before and after hemodialysis were stopped. He/she said he/she would expect them to be done every treatment. The DON said the responsibility of assessing the patient pre and post dialysis and communicating with the clinic regarding the patient's condition was the responsibility of the nurse. During an interview on 05/31/24 at 12:11 P.M., the administrator said she did not know why hemodialysis treatment was not listed on the MDS or the care plan. She said the MDS, and care plan, were the responsibility of the MDS Coordinator. The administrator said that she did not know why assessments before and after hemodialysis were stopped. She said that she would expect them to be done every treatment. The DON said the responsibility of assessing the patient pre and post dialysis and communicating with the clinic regarding the patient's condition was the responsibility of the nurse.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on observation, interview and record review, facility staff failed to obtain a consent for the use of side rails for six of six sampled residents (Resident #3, #9, #10, #13, and #141). The facility census was 37. 1. Review of the facility's Proper Use of Side Rails Policy, dated December 2016, showed staff are to obtain consent for side rail use from the resident or legal representative 2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 03/28/24, showed staff assessed the resident as follows: -Required moderate assistance with bed mobility; -Totally dependent for assistance with transfers, and toileting; -Impairment in all four extremities. Review of the resident's medical record showed the record did not contain a signed consent for the use of side rails. Observation on 05/28/24 at 11:04 A.M., showed the resident in bed with a right quarter sized side rail in the upright position. Observation on 05/29/24 at 8:54 A.M., showed the resident in bed with a right quarter sized side rail in the upright position. Observation on 05/30/24 at 7:57 A.M., showed the resident in bed with a right quarter sized side rail in the upright position. During an interview on 05/29/24 at 10:20 A.M., the resident said the bed bar helps a great deal with mobility in bed. 3. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Required supervision or touch assistance for chair/bed to chair transfers, sit to stand, lying to sitting on the side of the bed, sit to lying, and to roll left and right; -Diagnoses of stroke. Review of the resident's medical record showed the record did not contain a signed consent for the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/28/24 at 10:57 A.M., showed the resident in bed with a grab bar in the raised position on both sides of the bed. Observation on 05/29/24 at 09:57 A.M., showed the resident in bed with a grab bar in the raised position on both sides of the bed. Observation on 05/31/24 at 08:09 A.M., showed the resident in bed with a grab bar in the raised position on both sides of the bed. During an interview on 05/28/24 at 10:57 A.M., the resident said the grab bar helps him/her get out of bed and turn over at night. During an interview on 5/31/24 at 08:17 A.M., the MDS Coordinator said he/she is unaware if there is a consent for the resident. 4. Review of Resident #10's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Required maximal assistance with bed mobility; -Required total assistance with transfers, and toileting. Review of the resident's medical record showed the record did not contain a signed consent for the use of side rails. Observation on 05/28/24 at 11:06 A.M., showed the resident in bed with the quarter sized side rail in the raised position. Observation on 05/29/24 at 8:54 A.M., showed the resident in bed with the quarter sized side rail in the raised position. Observation on 05/30/24 at 7:57 A.M., showed the resident in bed with the quarter sized side rail in the raised position. During an interview on 05/28/24 at 11:06 A.M., the resident said the bed bar assists with stability while in the bed. 5. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as independent for bed mobility, transfers, and toileting. Review of the resident's medical record showed the record did not contain a signed consent for the use of side rails. Observation on 05/28/24 at 10:46 A.M., showed the resident sat on the side of the bed with a raised side rail. Observation on 05/28/24 at 2:43 P.M., the resident sat on the side of the bed with a hand on the raised bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/30/24 at 7:59 A.M., showed the resident held the raised side rail when he/she sat down on the bed. During an interview on 05/28/24 at 2:43 P.M., the resident said the side rail helps him/her get up and down from the bed. 6. Review of Resident #141's Admission MDS, dated [DATE], showed staff assessed the resident as: -Assistance required to get in and out of bed; -Incontinence; -Bilateral knee contractures. Review of the resident's medical record showed the record did not contain a signed consent for the use of side rails. Observation on 05/30/24 at 3;45 A.M., showed the resident sitting on the side of the bed with the quarter sized side rail in the raised position During an interview on 05/29/24 at 2:19 P.M. the resident said he/she uses the side rails to transfer to and from bed and to turn when being changed. During an interview on 05/31/24 10:01 A.M., Nurse Aid (NA) A said the resident uses the side rails to turn himself/herself when he/she is being changed. 7. During an interview on 05/31/24 at 08:17 A.M., the MDS Coordinator said if a resident requires or request side rails, therapy will evaluate the resident for safety and need. He/She said if the resident qualifys then the information is given to the Director of Nursing (DON) who will obtain a signed form that is uploaded into the computer, but is not sure what is on the form. During an interview on 05/31/24 at 10:53 A.M., the DON said she was not aware that consents were required for bed side rails. During an interview on 05/31/24 at 12:11 A.M., the administrator said a consent for use of bed side rails should be collected upon admission. She was not aware consents are not being used. The MDS Coordinator and Maintenance are responsible for getting signed consents. 43327 50753

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 43327 Based on interview and record review, facility staff failed to ensure ten out of ten nurse aides ((NA) NA A, NA B, NA C, NA D, NA E, NA F, NA G, NA H, NA I, and NA J) out of ten sampled NA , completed the nurse aide training program within four months of their employment in the facility. The facility census was 37. 1. Review of the facility's Nurse Aide Qualifications and Training Requirements, dated May 2019, showed the facility will not employ any individual as a nurse aide for more than four months full-time, temporary, per diem, or otherwise, unless: -That individual is competent to provide designated nursing care and nursing related services; and -That individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; or that individual has been deemed competent as provided in the requirements of participation; -Nurse assistants failing to successfully complete the required training program within the first four months of their employment may be terminated from the employment or may be reassigned to non-nursing related duties. Review of the facility's Facility Assessment Tool dated April 2024, showed all nurse aides must be certified within 120 days. 2. Review of the facility's Active Employee list, printed 5/29/24 at 10:33 A.M. showed: -NA A hired 01/05/23; -NA B hired 02/15/23; -NA C hired 03/14/23; -NA D hired 10/26/23; -NA E hired 04/18/23; -NA F hired 04/25/23; -NA G hired 04/26/23; -NA H hired 08/17/23; -NA I hired 08/17/23; -NA J hired 04/25/23; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NA A through J are listed as Certified Nurse Aide (CNA) in training. During an interview on 05/29/24 at 1:50 P.M., NA I said he/she did not know why it has taken so long to complete his/her training but is getting close to being completed now. He/She said he/she goes to class twice a week. During an interview on 05/29/24 at 2:24 P.M., the Director of Nursing (DON) said CNA training has been a struggle to get done because of the distance of the testing centers to the facility. He/She said the NA's do not want to travel to another city to test. The DON said he/she is aware of the four month requirement but the testing centers that are close by fill up quickly. During an interview on 05/31/24 at 8:33 A.M., NA J said he/she had been at the facility over a year and has been getting the run around on why he/she has not completed the training sooner including change of ownership and test center problems. He/She said it is frustrating but does have a test date set in the upcoming two weeks. During an interview on 05/31/24 at 11:53 A.M., the administrator said he/she is aware the NA's are over the four month requirement to become a CNA but the testing sites fill up quickly. He/She has offered to take the NA's to alternate cites but it has not worked out.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on interview and record review, facility staff failed to ensure residents with psychotropic and anti-psychotic medications were monitored for adverse reactions or efficacy of these medications for five of seven sampled residents (Resident #1, #9, #13, #23 and #143) and failed to obtain and document an appropriate diagnosis for medication use for three of five sampled residents. (Resident #1, #9, #143). The facility census was 37. 1. Review of the facility's Antipsychotic Medication use policy, dated December 2016 showed: -Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; -The physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others; -The physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications; -Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use; -The Interdisciplinary team (IDT) will re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks to consider whether or not the medication can be reduced, tapered, or discontinued; -Antipsychotic medications shall generally be used only for the following conditions/diagnosis as documented in the record: schizophrenia, schizoaffective (combination of Schizophrenia and mood disorder) disorder, schizophreniform (like schizophrenia with a shorter duration) disorder, delusional disorder, mood disorders (bipolar, depression with psychotic features, and refractory depression), psychosis in the absence of dementia, medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania; Tourette's disorder, Huntington's Disease, Hiccups, or nausea and vomiting associated with cancer or chemotherapy; -Diagnosis alone do not warrant the use of antipsychotic medication. In addition, will only be considered if the following conditions are also met: behavioral symptoms identified as being a danger to the resident or others; -The staff will observe, document and report to the physician information regarding the effectiveness of any interventions, including antipsychotic medications; -Nursing staff will monitor for and report side effects and adverse consequences of antipsychotic medications to the attending physician; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The physician will change or stop problematic doses or medications or clearly document why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/16/24, showed staff assessed the resident as: -Cognitively intact; -No behaviors, rejection of care, or signs and symptoms of delirium; -Diagnosis of depression. Review of the resident's Physician Order Set (POS), dated 05/2024, showed the following orders: -Citalopram (an antidepressant) 20 milligrams (mg) daily for admission; -Mirtazepine (an antidepressant and used to increase appetite) 7.5 mg at bedtime for decreased appetite related to depression; -Seroquel (an antipsychotic) 25 mg, give 0.5 tablet at bedtime for depression; -Trazodone (antidepressant and sedative) 50 mg at bedtime for insomnia; -Did not contain an appropriate diagnosis for Citalopram. Review of the resident's care plan, dated 05/28/24, showed: -Monitor/document side effects and effectiveness; -Monitor/document/report as needed adverse reactions to antidepressant therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth and dry eyes; -Monitor/document/report as needed any adverse reactions to psychotropic medications such as: unsteady gait, tardive dyskinesia, extrapyramidal symptoms (EPS - shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person; -Administer sedative/hypnotic medications as ordered by the physician; monitor for side effects and effectiveness; -Monitor/report/document as needed for following adverse effects of sedative/hypnotic therapy; day time drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, and dizziness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed the record did not contain documentation staff monitored the effectiveness or side effects of the residents antipsychotic, antidepressant or sedative/hypnotic medication. 3. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -No behaviors or rejection of care; -Used an antidepressant, antipsychotic, and antianxiety medication; -Diagnosis of stroke, dementia and anxiety. Review of the resident's POS, dated 05/2024, showed physicain orders: -Lithium 300 mg (used to reduce mania and manic episodes) daily for psychosis; -Lithium 150 mg at bedtime for psychosis; -Abilify (an antipsychotic) 20 mg tablet, give 0.5 tablet twice daily for depression, anxiety and obsessive compulsive disorder (OCD); -Buspirone (an antianxiety) 7.5 mg three times a day for anxiety; -Cymbalta (antidepressant and pain medication) 30 mg daily for depression; -Lorazepam (antianxiety) 0.5 mg three times a day for anxiety; -Trazodone 50 mg daily at bedtime for sleep related to anxiety. Review of the resident's care plan, dated 01/25/24, showed: -Resident will be free of discomfort or adverse reactions related to antidepressant, antianxiety and antipsychotic therapy; -Monitor/document/report as needed adverse reactions to medication therapy, change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in activities of daily living (ADL) ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth and/or dry eyes. Review of the resident's medical record showed, the record did not contain documentation staff monitored the effectiveness or side effects of the residents antipsychotic, antidepressant or antianxiety medication. 4. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Manor Health & Rehabilitation	2012 Nifong Boulevard Columbia, MO 65201

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -No behaviors, rejection of care, or signs and symptoms of delirium; -Diagnoses of anxiety, depression, and schizophrenia. Review of the resident's POS, dated 05/2024, showed the physician ordered: -Abilify 15 mg daily; -Bupropion (an antidepressant medication used to treat adult depression, seasonal affective disorder, and smoking cessation), 150 mg daily; -Bupropion, 300 mg daily; -Lorazepam 0.5 mg daily; -Trazodone 50 mg at bedtime; -Quetiapine (an antipsychotic medication used to treat schizophrenia and bipolar disorder), 25 mg two times a day; Review of the resident's care plan, dated 04/14/24, showed the following : -Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness. -Monitor/document/report as needed adverse reactions to antidepressant therapy, change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea or vomiting, dry mouth, dry eyes; -Resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment; -Monitor/document/report as needed any adverse reactions of psychotropic medications unsteady gait, tardive dyskinesia, drug induced movement disorders (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. -Resident has depression and anxiety. Resident will remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood; -Administer medications as ordered; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor/document for side effects and effectiveness. Review of the resident's medical record, showed the record did not contain documentation staff monitored the effectiveness or side effects of the resident's antipsychotic, antidepressant or sedative/hypnotic medication. 5. Review of Resident #23's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Rejection of care 4-6 times in a week but not daily, delusions and delirium; -No wandering, hallucinations, verbal or physical behaviors directed towards others; -Diagnoses of dementia and post-traumatic stress disorder (PTSD). Review of the resident's POS, dated 05/2024, showed the physicain ordered: -Wellbutrin (an antidepressant medication used to treat adult depression, seasonal affective disorder, and smoking cessation) 150 mg daily; -Prozac (an antidepressant used to treat depression, OCD, bulimia nervosa, and panic disorder) 20 mg daily. Review of the resident's care plan, dated 05/08/24, showed: -Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness when needed; -Monitor/document/report as needed adverse reactions to antidepressant therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in activities of daily living ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea, vomiting, dry mouth, dry eyes. Review of the resident's medical record, showed the record did not contain documentation staff monitored the effectiveness or side effects of the resident's antipsychotic, antidepressant or sedative/hypnotic medication. 6. Review of Resident #143's Admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Daily verbal behaviors directed toward others; -Daily rejection of care; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Inattention that fluctuates; -Received an antidepressant and antipsychotic medication; -Diagnosis of stroke, dementia and anxiety. Review of the resident's POS, dated 05/2024, showed the physician ordered: -Clonazepam (used to slow down the nervous system) 0.5 mg at bedtime for admission; -Hydroxyzine (treats anxiety, nausea, vomiting and allergies) 25 mg four times a day for admission; -Seroquel 400 mg at bedtime for admission; -Trazodone 300 mg at bedtime for admission; -Did not contain an appropriate diagnosis for Clonazepam, Hydroxyzine, Seroquel or Trazodone. Review of the resident's comprehensive care plan, dated 05/28/24, showed the care plan did not contain direction for use of any medications. Review of the resident's medical record, showed the record did not contain documentation staff monitored the effectiveness or side effects of the residents antipsychotic and antidepressant medication. 7. During an interview on 05/31/24 at 10:16 A.M., Registered Nurse (RN) K said charge nurses only document and monitor for unwanted or behaviors out of the normal. The care plan should contain resident specific behaviors and what to watch for in regard to adverse effects. He/She said non-pharmacological interventions should also be care planned and tried before medication use. Diagnosis should be appropriate for all medications and not just antipsychotic's and was not aware some of them were not appropriate. The admitting nurse or the nurse receiving the order is responsible to get the diagnosis and document it. During an interview on 05/31/24 at 11:13 A.M., the Director of Nursing (DON) said medications, especially psychotropics should have an appropriate diagnosis for use. The care plans should include behavior management and interventions specific to the resident and documentation should include side effects and monitoring if the medications are effective so that appropriate Gradual Dose Reductions (GDR)'s can be completed by the pharmacist and physician if needed. 43327

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 43327 Based on interview, and record review, facility staff failed to comply with federal, state,and local laws and professional standards by not providing financial payment for Certified Nurse Aid (CNA) training and certification expenses for two Nurse Aids (NA) out of two sampled staff. The facility census was 37. 1. Review of the Missouri Department of Health and Senior Services On Site Visit Evaluation Instrument for Nurse Aid Training form (DA-603), dated 05/30/24, showed the facility charged Nurse Aids (NA) 850.00 dollars by paycheck deduction to complete a CNA training course and certification test. 2. Review of the facility's Sponsorship Plan Reimbursement Agreement, undated, showed NA staff were required to sign an agreement to pay for half of the cost of CNA training through payroll deduction. During an interview on 05/29/24 at 10:45 A.M., Nurse Aide (NA) J said when he/she applied to work at the facility he/she was told he/she would be required to pay for CNA training and certification. The payment is deducted from the NA's paycheck. During and interview on 05/29/24 at 11:30 A.M., NA A said the facility required him/her to pay for training and CNA certification. He/She said has not been reimbursed by the facility and they are still not a CNA. During an interview on 05/31/24 at 11:26 A.M., the Director of Nursing (DON) said he/she was aware the facility charged NA's to complete training. He/She said previously under different ownership the facility paid for the training and then were refunded by the state. During an interview on 05/31/24 at 12:01 P.M., the administrator said they were aware of charging NA's for the cost of training and certification as required by the new owners of the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 45564 Based on observation, interview and record review, the facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD- a serious type of pneumonia (lung infection) caused by Legionella bacteria. Facility staff failure to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems has the potential for the failure of staff to identify and mitigate the presence of waterborne pathogens, which places all residents of the facility at risk of exposure which could lead to illness. The facility census was 37 with a capacity of 52. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17; showed: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Centers for Disease Control and Prevention (CDC) and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; -Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Legionella Water management program, reviewed April 2024, showed facility staff identified ice machines and hot water storage less than 140 degrees Fahrenheit (F) as potential risk areas for the growth of Legionella. Review showed control measures included weekly visual inspections of ice machines, weekly temperature checks of water temperatures and monthly inspection and flushing of hot water storage tanks. Review showed the program instructed staff to document how the program status is monitored and when staff are to take corrective action. Review of the water management program records showed the records did not contain documentation of monthly water heater flushing. Observation on 05/29/24 during the Life Safety Code tour showed the facility contained two ice machines for resident use. Observation showed the dining room ice machine contained a black drainage tube which was inserted into a white plastic drain. The ice machine drain did not contain an air gap. Observation showed the ice machine filter was dated 12/21/22 and contained a label which directed the user to replace the cartridge no later than six months from installation date. Observation on 05/29/24 showed the facility contained two water heaters which provided hot water throughout the facility. During an interview on 05/30/24 at 9:05 A.M., the maintenance director said he/she should change the ice machine filter every three or four months and he/she did not know why the dining room filter was not changed. The maintenance director said he/she did not know about the requirement to have an air gap in the ice machine drain. The maintenance director said he/she kept the water temperature between 105 and 120 degrees F. The maintenance director said he/she released pressure from the water heaters for about 15 seconds every month, but he/she never flushed the water heater tanks. The maintenance director said he/she did not know about flushing the water heaters as a Legionella control measure. During an interview on 05/30/24 at 11:05 A.M., the administrator said the maintenance director was responsible for the ice machines and water heaters. The administrator said the maintenance director inspected the ice machines weekly but was not sure if the inspection included looking for an air gap in the drain. The administrator said he/she would expect the ice machine filter to be changed according to manufacturer's instructions. The administrator said he/she was not sure exactly what the water heater flush was so he/she relied on the maintenance director for expertise.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 43327 Based on interview and record review, facility staff failed to document the administration or refusal of the pneumococcal (lung inflammation caused by bacterial or viral infection) vaccine for three (Resident #1, #142 and #143) out of seven sampled residents. The facility census was 37. 1. Review of the facility's Pneumococcal Vaccine Policy, dated August 2016, showed: -Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated; -Assessments of pneumococcal vaccine status will be conducted within 5 working days of the resident's admission if not conducted prior to admission; -If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccine; -For residents who receive the vaccine, the date of the vaccine, lot number, expiration data, person administering and the site of the vaccine will be documented in the resident's medical record; -Administration of the pneumococcal vaccine or revaccination's will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 2. Review of Resident #1's medical record showed: -Age 88 -admitted to facility on 05/26/23; -The record did not contain documentation the resident received or refused the pneumococcal vaccine. 3. Review of resident #142's medical record showed: -Age 81; -admitted to facility on 04/22/24; -The record did not contain documentation the resident received or refused the pneumococcal vaccine. 4. Review of resident #143's medical record showed: -Age 73; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted to facility on 05/01/24; -The record did not contain documentation the resident received or refused the pneumococcal vaccine. 5. During an interview on 05/29/24 at 2:24 P.M., the Director of Nursing said it has been a struggle keeping up on the vaccines. The care plan nurse is responsible to review if a resident has had their vaccine when the Minimum Data Set (MDS), a federally mandated assessment tool, is completed on the residents after admission. If needed, the care plan nurse will have the charge nurse obtain an order and consent for the administration of the vaccine. If refused, then the care plan nurse or the DON will document the refusal in the progress notes or on a form for declination. He/She said he/she is not sure what is going on with the residents mentioned but would research it. During an interview on 05/29/24 at 3:36 P.M., the DON said he/she could not find documentation of the refusal or administration of the three residents pneumococcal vaccines. During an interview on 05/31/24 at 10:16 P.M., the care plan nurse said he/she tries to obtain the vaccine information from the hospital during the admission process and initial assessment and enter the data in the medical record under immunizations. He/She said sometimes it is hard to get the information from the hospital and have to go back to some of them multiple times which takes longer than what is ideal but should not take that long.