

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Independence Care Center of Perry County		STREET ADDRESS, CITY, STATE, ZIP CODE 800 South Kingshighway Perryville, MO 63775	
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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to electronically transmit Minimum Data Set assessments (MDS, a federally mandated assessment completed by the facility) in a timely manner and in accordance with guidelines for five residents (Resident #1, #2, #3, #33, and #36) of 18 sampled residents and one resident (Resident #8) outside the sample. The facility census was 76. Review of the facility's policy, MDS Assessments, revised March 2024, showed:- The facility will ensure accurate, timely, and compliant completion and electronic transmission of MDS in accordance with Center for Medicare and Medicaid Services (CMS) regulations, supporting resident care planning, quality outcomes, and reimbursement accuracy;- MDS assessments are scheduled according to the CMS-required timeframes, including admission, quarterly, annual, and significant change;- Assessment Reference Dates (ARDs) are selected to reflect the resident's most accurate clinical status;- Routine internal audits are conducted to monitor MDS accuracy, documentation support, and timeliness of completion and transmission;- Audit findings are reported to Quality Assurance and Performance Improvement (QAPI). Review of the Resident Assessment Instrument (RAI) Manual for assessment transmission showed the following:- Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date;- All other MDS assessments must be submitted within 14 days of the MDS completion date.1. Review of Resident #1's medical record showed:- An annual MDS assessment with a care plan completion date of 02/19/25;- The annual MDS assessment transmitted and accepted on 03/24/25 (19 days late);- A quarterly MDS assessment with a completion date of 05/22/25;- The quarterly MDS assessment transmitted and accepted on 07/11/25 (36 days late);- A quarterly MDS assessment with a completion date of 08/22/25;- The quarterly MDS assessment transmitted and accepted on 09/12/25 (seven days late);- The facility failed to ensure the MDS assessments were transmitted electronically within 14 days of the completion date.2. Review of Resident #2's medical record showed:- A quarterly MDS assessment completion date of 03/07/25;- The quarterly MDS assessment transmitted and accepted on 04/11/25 (21 days late);- A quarterly MDS assessment with a completion date of 06/06/25;- The quarterly MDS assessment transmitted and accepted on 07/25/25 (35 days late);- A significant change MDS assessment with a care plan completion date of 10/14/25;- The significant change MDS assessment transmitted and accepted on 11/03/25 (six days late);- The facility failed to ensure the MDS assessments were transmitted electronically within 14 days of the completion date.3. Review of Resident #3's medical record showed:- A quarterly MDS assessment with a completion date of 03/05/25;- The quarterly MDS assessment transmitted and accepted on 04/11/25 (23 days late);- A quarterly MDS assessment with a completion date of 06/05/25;- The quarterly MDS assessment transmitted and accepted on 07/25/25 (36 days late);- An annual MDS assessment with a care plan completion date of 09/03/25;- The annual MDS assessment transmitted and accepted on 09/18/25 (one day late);- The facility failed to ensure the MDS assessments were transmitted electronically within 14 days of the completion date.4. Review of Resident #8's medical record showed:- An annual MDS assessment with a care plan completion date of 04/23/25;- The annual MDS assessment transmitted and accepted on 06/06/25 (30 days late);- A quarterly MDS assessment with a (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completion date of 07/24/25;- The quarterly MDS assessment transmitted and accepted on 08/15/25 (eight days late);- The facility failed to ensure the MDS assessments were transmitted electronically within 14 days of the completion date.5. Review of Resident #33's medical record showed:- A quarterly MDS assessment with a completion date of 08/07/25;- The quarterly MDS assessment transmitted and accepted on 08/22/25 (one day late);- A significant change MDS assessment with a care plan completion date of 09/16/25;- The significant change MDS assessment transmitted and accepted on 10/17/25 (17 days late);- The facility failed to ensure the MDS assessments were transmitted electronically within 14 days of the completion date.6. Review of Resident #36's medical record showed:- A quarterly MDS assessment with a completion date of 02/19/25;- The quarterly MDS assessment transmitted and accepted on 03/12/25 (seven days late);- A quarterly MDS assessment with a completion date of 05/22/25;- The quarterly MDS assessment transmitted and accepted on 07/11/25 (36 days late);- A quarterly MDS assessment with a completion date of 08/22/25;- The quarterly MDS assessment transmitted and accepted on 09/12/25 (seven days late);- An annual MDS assessment with a care plan completion date of 11/19/25;- The annual MDS assessment transmitted and accepted on 12/15/25 (12 days late);- The facility failed to ensure the MDS assessments were transmitted electronically within 14 days of the completion date.During an interview on 01/09/26 at 4:05 P.M., the Administrator and MDS Coordinator said they would expect MDS assessments to be completed per the RAI Manual timeframes.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility) within the required timeframes for two residents (Resident #3 and #33) out of 18 sampled residents. The facility's census was 76. Review of the facility's policy, MDS Assessments, revised March 2024, showed:- The facility will ensure accurate, timely, and compliant completion and electronic transmission of MDS in accordance with Center for Medicare and Medicaid Services (CMS) regulations, supporting resident care planning, quality outcomes, and reimbursement accuracy;- MDS assessments are scheduled according to the CMS-required timeframes, including admission, quarterly, annual, and significant change;- Assessment Reference Dates (ARDs) are selected to reflect the resident's most accurate clinical status;- Routine internal audits are conducted to monitor MDS accuracy, documentation support, and timeliness of completion and transmission;- Audit findings are reported to Quality Assurance and Performance Improvement (QAPI). Review of the Resident Assessment Instrument (RAI) Manual showed:- The Assessment Reference Date (ARD) of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent Omnibus Budget Reconciliation Act (OBRA - Nursing Home Reform Act of 1987, which improved the quality of care in nursing homes over the last twenty years by setting federal standards of how care should be provided to residents) assessment (ARD of previous OBRA assessment (Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment) + 92 calendar days);- The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD must be not more than 92 days after the ARD of the most recent OBRA assessment of any type;- The MDS completion date is the ARD + 14 calendar days. 1. Review of Resident #3's medical record showed:- admitted on [DATE];- An annual MDS assessment with an ARD of 08/20/25 and completed on 09/03/25;- A quarterly MDS assessment, dated 11/20/25, incomplete and unsubmitted;- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment. 2. Review of Resident #33's medical record showed:- admitted on [DATE];- A significant change MDS assessment with an ARD of 09/05/25 and completed on 09/16/25;- A quarterly MDS, dated [DATE], incomplete and unsubmitted;- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment. During an interview on 01/09/26 at 4:05 P.M., the Administrator and MDS Coordinator said they would expect MDS assessments to be completed per the RAI Manual timeframes.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS-a federally mandated assessment completed by the facility staff) for eight residents (Resident #1, #2, #4, #5, #6, #33, #36, and #52) out of 18 sampled residents and one resident (Resident #25) outside the sample. The facility's census was 76. Review of the facility's policy, MDS Assessments, revised March 2024, showed: - The facility will ensure accurate, timely, and compliant completion and electronic transmission of MDS in accordance with Center for Medicare and Medicaid Services (CMS) regulations, supporting resident care planning, quality outcomes, and reimbursement accuracy; - MDS assessments are scheduled according to the CMS-required timeframes, including admission, quarterly, annual, and significant change; - Assessment Reference Dates (ARDs) are selected to reflect the resident's most accurate clinical status; - All MDS responses must be supported by nursing notes, therapy documentation, physician orders, care plans, flow sheets, and assessments; - Discrepancies between documentation and MDS responses are resolved prior to completion; - A comprehensive review is conducted to ensure internal consistency, logical coding, and alignment with clinical documentation; - Errors or omissions are corrected prior to locking the assessment; - Corrections are made following CMS correction and modification guidelines; - Routine internal audits are conducted to monitor MDS accuracy, documentation support, and timeliness of completion and transmission; - Audit findings are reported to Quality Assurance and Performance Improvement (QAPI). 1. Review of Resident #1's medical record showed: - admitted on [DATE]; - Diagnoses of muscle weakness, unsteadiness on feet, history of falling, difficulty in walking, and pain in low back. - Side rail assessment, dated 09/11/25, showed use of one side rail to keep resident as independent as possible with bed mobility. Observation of the resident's bed on 01/07/26 at 10:49 A.M., showed one half rail on the right side and one grab bar on the left side of the bed in upright positions. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly MDS assessment, dated 11/25/25, showed: - Section P0100 Physical Restraints coded for daily use of bed rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 2. Review of Resident #2's medical record showed: - admitted on [DATE]; - Diagnoses of muscle weakness, repeated falls, Alzheimer's dementia (a progressive brain disorder that destroys memory, thinking and the ability to perform simple tasks) and hemiplegia (paralysis of one entire side of the body). - Side rail assessment, dated 10/27/25, showed use of one side rail to keep resident as independent as possible with bed mobility. Observations of the resident showed: - On 01/06/2026 at 10:55 A.M., the resident lay in bed with left side half rail in the upright position; - On 01/09/2026 at 2:27 P.M., the resident lay in bed with left side half rail in the upright position. Review of the resident's significant change MDS assessment, dated 10/01/25, showed: - Section P0100 Physical Restraints coded for daily use of bed rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 3. Review of Resident #4's medical record showed: - admitted on [DATE]; - Diagnoses of muscle weakness, need for assistance with personal care, lack of coordination, left humerus (upper arm bone) fracture, and left femur (upper leg bone) fracture. - Side rail assessment, dated 11/03/25, documented side rails/grab bar a medical necessity due to left humeral fracture, left hip fracture and to improve bed mobility; Observations of the resident's bed showed: - On 01/06/26 at 10:32 A.M., an enabler bar on the right side of the bed in the upright position; - On 01/07/26 at 1:45 P.M., an enabler bar on the right side of the bed in the upright position; Review of the resident's admission MDS assessment, dated 11/09/25, showed: - Section P0100 Physical Restraints coded for daily use of bed rails; (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 4. Review of Resident #5's medical record showed: - admitted on [DATE]; - Diagnoses of muscle weakness, difficulty in walking, unsteadiness on feet, and abnormalities of gait and mobility. - Side rail assessment, dated 12/03/25, showed use of one side rail to keep resident as independent as possible with bed mobility. Observation of the resident on 01/08/26 at 10:31 A.M., showed the resident sat in a wheelchair next to his/her bed with left side half rail in the upright position. Review of the resident's quarterly MDS assessment, dated 11/25/25, showed: - Section P0100 Physical Restraints coded for daily use of bed rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 5. Review of Resident #6's medical record showed: - admitted on [DATE]; - Diagnoses of pain, muscle weakness, difficulty in walking, unsteadiness on feet, and lack of coordination. - Side rail assessment, dated 11/05/25, showed use of one grab assist bar to keep resident as independent as possible with bed mobility. Observation of the resident on 01/06/26 at 11:20 A.M., showed the resident sat in a wheelchair next to his/her bed with right side grab assist bar in the upright position. Review of the resident's quarterly MDS assessment, dated 11/07/25, showed: - Section P0100 Physical Restraints coded for daily use of bed rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 6. Review of Resident #25's medical record showed: - admitted on [DATE]; - Diagnoses of congestive heart failure (CHF-chronic condition in which heart muscles no longer pump blood effectively, causing fluid to build up in the lungs and other parts of the body), muscle weakness, and low back pain; - Side rail assessment, dated 10/15/25, grab assist bar to keep resident as independent as possible (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with bed mobility. Observation on 01/06/26 at 11:00 A.M., showed grab bar raised on left side of bed. Review of the resident's quarterly MDS assessment, dated 10/15/25, showed: - Section P0100, Physical Restraints, coded for daily use of side rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 7. Resident #33's medical record showed: - admitted on [DATE]; - Diagnoses of chronic obstructive pulmonary disease (COPD-a lung condition that blocks airflow, making it hard to breathe), muscle weakness and lack of coordination; - Side rail assessment, dated 12/03/25, showed grab assist bar in place to keep resident as independent as possible with bed mobility and transfers. Observations of the resident's bed showed: - On 01/06/26 at 11:20 A.M., the resident sat in recliner with a grab bar up on the left side of the bed; - On 01/08/26 at 10:06 A.M., the resident sat in recliner with his/her eyes closed with a grab bar up on the left side of the bed; Review of the resident's MDS assessments showed: - A quarterly MDS assessment, dated 07/24/25, with Section P0100, Physical Restraints, coded for daily use of side rails; - A significant change MDS assessment, dated 09/05/25, with Section P0100, Physical Restraints, coded for daily use of side rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. 8. Review of Resident #36's medical record showed: - admitted on [DATE]; - Diagnoses of Alzheimer's disease, pain, muscle weakness, and unsteadiness on feet. Review of the resident's Physician Order Sheet (POS), dated January 2026, showed: - An order for Seroquel (an antipsychotic (works by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking) 25 milligrams (mg), one tablet orally twice a day, dated 06/18/25 and discontinued 10/28/25; (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Seroquel 25 mg one tablet orally at bedtime, dated 10/28/25. Review of the Note from the Pharmacist to Attending Physician/Prescriber, dated 10/28/25, showed: - The resident had an order for Seroquel 25 mg one tablet orally twice a day; - The physician agreed with the dose reduction and decreased the Seroquel dose to 25 mg at bedtime, signed by the physician on 10/28/25. Review of the resident's annual MDS assessment, dated 11/06/25, showed: - N0415A1 marked the resident received antipsychotic medication in the seven-day lookback period; - N0450A marked the resident received antipsychotic medication on a routine basis only; - N0450B marked no gradual dose reduction (GDR) had been attempted; - N0450D marked the physician documented GDR as clinically contraindicated; - N0450E marked 10/28/25 as the date the physician documented GDR as clinically contraindicated; - The facility failed to capture the GDR from 10/28/25 on the MDS. 9. Review of Resident #52's medical record showed: - admitted on [DATE]; - Diagnoses of pain in leg, muscle spasm, pain in right shoulder, muscle weakness, and lack of coordination. -Side rail assessment, dated 10/20/25, grab/assist bar times two to keep resident as independent as possible with bed mobility; Observations of the resident's bed showed: - On 01/06/26 at 10:35 A.M., right and left upper enabler bars in the upright position; - On 01/07/26 at 1:55 P.M., an enabler bar on the left side of the bed in the upright position; Review of the resident's quarterly MDS assessment, dated 09/02/25, showed: - Section P0100 Physical Restraints coded for daily use of bed rails; - The facility failed to accurately code the MDS assessment by coding side rail use as a restraint. During an interview on 01/09/26 at 9:50 A.M., the Administrator said there were no restraints in the building besides side rails and half rails, but she felt like none of those were restraints. During an interview on 01/09/26 at 4:05 P.M., the Administrator and the MDS Coordinator said they would expect the MDS assessments to be coded accurately.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, facility staff failed to serve food in a manner to reduce the risk of cross contamination and food borne illness by touching the residents' items and food with bare hands. The facility census was 76. Review of the policy, Infection Control with Meals, undated, showed:- The facility maintains strict infection control practices during all aspects of meal service to protect residents, staff, and visitors. Proper hand hygiene, personal protective equipment (PPE), food handling techniques, and environmental sanitation shall be followed in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS) regulations;- Hand hygiene must be performed before handling food or meal trays; before and after assisting a resident with eating; after contact with bodily fluids or contaminated surfaces; and after removing gloves;- Alcohol-based hand sanitizer may be used unless hands are visibly soiled, in which case soap and water are required;- Gloves are worn when directly handling food; contact with bodily fluids is anticipated;- Gloves are changed between residents and tasks.Review of the facility's policy, Handwashing, revised 03/29/23, showed:- Soap and water are required for hand hygiene when: hands are visibly soiled, and/or after caring for a resident with diarrheal infection such as (C. Diff- Clostridium Difficile, a contagious bacteria that causes diarrhea and inflammation of the colon and is spread by spores found in feces), after potential exposure to body fluid, before and after eating or handling food and or after the personal use of the toilet;- Alcohol-based hand rub may be used for all other hand hygiene opportunities;- Hand hygiene is to be performed (including but not limited to): prior to caring for a resident, after caring for a resident including after removing gloves, before and after assisting a resident with meals, and after contact with a resident's mucous membranes and body fluids or excretions. Observation on 01/06/26 of the noon meal in the Creative Care Unit showed:- At 12:43 P.M., without performing hand hygiene, Nurse Aide (NA) F served Resident #45, and touched both straws with bare hands on the drinking end as he/she put them in the resident's cup; - At 12:55 P.M., NA F and NA G removed Resident #42's and Resident #8's plates and cups from table and did not perform hand hygiene; - At 12:57 P.M., without performing hand hygiene, NA G took Resident #66's straw from the resident's hand, touched the drinking end of the straw with his/her bare hands, and put it back in the resident's cup; - At 1:00 P.M., without performing hand hygiene, NA F took the wrapped silverware from Resident #19's tray, removed a fork and handed it to Resident #13, then put the spoon and napkin back on Resident #19's tray; - At 1:04 P.M., without performing hand hygiene, NA F obtained a new straw for Resident #8, opened it and touched the drinking end of the straw, put the straw in the resident's cup, then went back to Resident #29 and cut a bite of meatball sandwich for the resident, touching the bun with his/her bare left hand as he/she cut with his/her right hand on the resident's fork. NA F, without performing hand hygiene, then walked around the table to Resident #45, moved the resident's plate back and touched all the resident's cups and moved them in front of the resident; - At 1:08 P.M., without performing hand hygiene, NA F picked up Resident #69's napkin, picked up tater tots from the table with the napkin and put them in the resident's plate, then left the napkin on the table near the resident. NA F picked up the resident's fork, speared a tater tot and handed the fork to the resident; - At 1:11 P.M., without performing hand hygiene, NA F walked over to Resident #13, picked up a tater tot off the table with his/her bare hand and put it back on the resident's tray; - At 1:13 P.M., without performing hand hygiene, NA F picked up Resident #45's cup and handed it to the resident. NA G, without performing hand hygiene, placed all of Resident #36's used plates and utensils on a tray and took it to the rack; - At 1:15 P.M., NA G asked to see Resident #45's painted fingernails and held both the resident's hands in his/her bare hands. NA G, without performing hand hygiene, took Resident #69's used straw, obtained a new one, opened it, touched the drinking end of the straw, and put it in the resident's cup with bare hands. NA F picked up Resident #56's used tray, put it on the rack and did not perform hand hygiene; - At 1:28 P.M., without (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing hand hygiene, NA F obtained a paper towel, wet it, and wiped Resident #13's hands. NA F, without performing hand hygiene, obtained a paper towel for Resident #19, wet it, and wiped Resident #19's hands. NA F obtained a paper towel to dry Resident #19's hands. NA F then washed his/her own hands. Observation on 01/08/26 of the noon meal in the Creative Care Unit showed:- At 12:35 P.M., without performing hand hygiene, NA F opened a creamer packet and used his/her bare fingers on the inside to push the sides of the packet open for Resident #13, who then put the creamer in his/her coffee;- At 12:36 P.M., Certified Nurse Aide (CNA) J, without performing hand hygiene, assisted Resident #56 with lunch; - At 12:50 P.M., CNA I assisted Resident #19 with eating and, without performing hand hygiene, assisted Resident #61 with eating. During an interview on 01/08/26 at 1:00 P.M., NA F and NA G said they learn skills, including feeding, before they came here for clinicals. They started CNA classes in December and they end in April. They learned about infection control. There was some stuff about infection control in the textbook. They should wash hands every time they do resident care. When serving lunch, before they start and after they're done, was what they do. They should not touch bare food or the drinking end of straws. They should sanitize/wash hands after feeding one person and before they feed another. They didn't really touch any of the residents' food, they just took the foil and plastic wrap off. They should not put food on a tray from the table with bare hands. During an interview on 01/08/26 at 1:15 P.M., Registered Nurse (RN) H said before the aides came and did clinicals, they learn over 60 skills. They did go through infection control. That was one of the requirements before they came into the clinical setting. They should be performing hand hygiene before they start, in between residents, and after they were finished. They should not touch food with bare hands, or the drinking ends of straws. During an interview on 01/09/26 at 12:08 P.M., the Infection Preventionist (IP) said the nurse on 200 hall was responsible for students in the unit. When asked who would be responsible when there was no nurse on the unit, he/she said the students were assigned to CNAs, but it depended on the rotation. He/She wasn't 100% certain how that went. He/She would expect students to follow the facility's infection control policy, including performing hand hygiene. During an interview on 01/09/26 at 4:05 P.M., the Administrator and the Director of Nursing said they would expect employees and students to perform hand hygiene prior to serving residents, anytime they were touching a food, after tasks, if hands were soiled, touching trash, sneezing, and coughing. Staff should not touch food with bare hands, nor should they touch the drinking end of the straw with bare hands.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Independence Care Center of Perry County		STREET ADDRESS, CITY, STATE, ZIP CODE 800 South Kingshighway Perryville, MO 63775	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during medication administration for four residents (Resident #2, #4, #15 and #16) out of nine sampled residents. The facility's census was 76. Review of the facility's policy, Glove-Technique-non-sterile, undated, showed:- The facility will use glove technique to prevent the transmission of infectious organisms, provide personal protection and adhere to Occupational Safety and Health Administration (OSHA) regulations dictating staff safety. Review of the facility's policy, Handwashing, revised 03/29/23, showed:- Soap and water are required for hand hygiene when: hands are visibly soiled, and/or after caring for a resident with diarrheal infection such as (C. Diff - Clostridium Difficile - a contagious bacteria that causes diarrhea and inflammation of the colon and is spread by spores found in feces), after potential exposure to body fluid, before and after eating or handling food and or after the personal use of the toilet;- Alcohol-based hand rub may be used for all other hand hygiene opportunities;- Hand hygiene is to be performed (including but not limited to): prior to caring for a resident; prior to performing a procedure such as blood glucose monitoring; for catheter care; when moving from a contaminated body site to a clean body site, such as when changing a brief or wound dressing; after caring for a resident including after removing gloves; before and after entering isolation precaution settings; and before and after assisting a resident with meals; before and after assisting a resident with personal care; and after contact with a resident's mucous membranes and body fluids or excretions; and after handling soiled or used linens, bedpans catheters, and urinals. Review of the facility's policy, Infection Control-Medication Administration, dated 04/17/23, showed:- It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines;- Hand hygiene is performed prior to handling any medication;- Verify the resident's identity, verify medication name, order, dosage, route, time;- Document medication taken or refused;- Expired medications are to be properly discarded. Review of the facility's policy, Crushed Medication, dated May 2007, showed:- The facility will ensure medications are crushed safely and appropriately for residents who have difficulty swallowing, while maintaining medication effectiveness, resident safety, and regulatory compliance;- Medications may only be crushed when: a prescriber order authorizes or the resident has a documented swallowing difficulty and pharmacy has verified crushability;- Orders must specify the method of administration (e.g., applesauce, pudding);- Perform hand hygiene and don gloves as appropriate;- Mix crushed medications with the ordered food or liquid vehicle;- Administer immediately after preparation;- Document medication administration per medication administration record (MAR). 1. Observation on 01/08/26 at 10:55 A.M., showed:- Certified Medication Technician (CMT) A sanitized his/her hands;- CMT A retrieved eye drops from the medication cart;- CMT A entered Resident #4's room and administered one eye drop to the left eye;- CMT A failed to don gloves prior to eye drop administration. 2. Observation on 01/08/26 at 11:12 A.M., showed:- CMT A sanitized his/her hands;- CMT A popped two medications out of the medication cards into a small pill cup, then poured two capsules into the same pill cup;- CMT A placed an ungloved finger into the pill cup trying to separate the medications;- CMT A picked up the two capsules from the pill cup with ungloved hands and emptied the contents of the capsules into another pill cup;- CMT A crushed the other two medications and placed the contents in the same pill cup as the contents of the capsules and mixed with pudding;- CMT A administered the medication to Resident #2;- CMT A sanitized his/her hands. 3. Observation on 01/08/26 at 11:20 A.M., showed:- CMT A washed his/her hands;- CMT A retrieved eye drops from the medication cart;- CMT A entered Resident #15's room and administered eye drops to the left and right eyes;- CMT A obtained a tissue and blotted the left eye and then blotted the right eye with the same tissue;- CMT A failed to don gloves prior to eye drop administration. During an interview on 01/08/26 at 2:58 P.M., CMT A said he/she should probably wear gloves when administering eye drops and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Independence Care Center of Perry County		STREET ADDRESS, CITY, STATE, ZIP CODE 800 South Kingshighway Perryville, MO 63775	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought that it was ok to use the same tissue when blotting left and right eyes after eye drop administration and that no one had ever told him/her different. He/She guessed that gloves should be worn when touching medications and when emptying out capsules.4. Observation on 01/08/26 at 11:35 A.M., showed:- Licensed Practical Nurse (LPN) B obtained supplies for blood sugar checks;- LPN B sanitized his/her hands;- LPN B answered the telephone at the nurse's station;- LPN B did not sanitize his/her hands and donned gloves;- LPN B obtained a finger stick blood sugar (FSBS) on Resident #16; - LPN B removed gloves and did not sanitize or wash his/her hands.5. Observation on 01/08/26 at 11:38 A.M., showed:- LPN B did not wash or sanitize his/her hands and obtained a reading from Resident #2's Dexcom (a continuous blood sugar monitoring system that helps track blood sugar levels in real time without routine finger pricks);- LPN B donned gloves, wiped the tip of the insulin pen with an alcohol wipe, and primed the insulin pen;- LPN B administered the prescribed amount of insulin to Resident #2;- LPN B removed gloves and did not sanitize or wash his/her hands.During an interview on 01/08/26 at 2:52 P.M., LPN B said he/she should sanitize his/her hands before and after checking blood sugars and in between residents. He/She typically liked to keep hand sanitizer on the cart, but there was none on there today. During an interview on 01/09/26 at 4:05 P.M., the Administrator, Director of Nursing, and the Minimum Data Set (MDS-a federally mandated assessment completed by the facility) Coordinator said that they would expect staff to wear gloves during eye drop administration, and for staff to use a separate tissue to blot each eye separately after eye drops were administered, and for staff to sanitize hands between glove changes and in between residents receiving blood sugar checks and insulin administration.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, and record review, facility staff failed to conduct regular inspections of all bed frames, mattresses, side rails, and enabler bars as part of a regular maintenance program for three residents (Residents #2, #4, and #5) out of 7 sampled residents. The facility's census was 76. Review of the facility's policy, Bed Rails, reviewed 06/21/21, showed:- It is the policy to prevent entrapment and other safety hazards associated with bed rail use;- Assess the resident for risk of entrapment from bed rails prior to installation;- When installing or maintaining bed rails, the maintenance department staff will follow the manufacturer's recommendations and specifications or provide another bed or appropriate alternative in accordance with individual bed inspections;- The maintenance department will conduct regular inspection of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment.1. Review of Resident #2's medical record showed a maintenance inspection for the side rail completed on 01/09/26, more than six months after application of the side rail.Observations of the resident showed:- On 01/06/2026 at 10:55 A.M., the resident lay in bed with left side half rail in the upright position;- On 01/09/2026 at 2:27 P.M., the resident lay in bed with left side half rail in the upright position.2. Review of Resident #4's medical record showed a maintenance inspection for the side rail completed on 01/09/26, more than a year after application of the side rail.Observations of the resident showed:- On 01/06/26 at 10:32 A.M., the resident sat in a wheelchair next to his/her bed with right enabler bar in the upright position;- On 01/07/26 at 1:45 P.M., the resident sat in a wheelchair next to his/her bed with right enabler bar in the upright position.3. Review of Resident #5's medical record showed no maintenance inspection for the side rails.Observation of the resident on 01/08/26 at 10:31 A.M. showed the resident sat in a wheelchair next to his/her bed with left side half rail in the upright position.During an interview on 01/09/26 at 10:31 A.M., the Administrator said entrapment assessments should have been completed at the time of installation and regular inspections were being completed by the Minimum Data Set (MDS-a federally mandated assessment completed by the facility) Coordinator, but the logs were not kept.During an interview on 01/09/26 at 2:33 P.M., Registered Nurse (RN) C said certain nurses were trained to do entrapment assessments at the time of installation, and if a rail was reported loose, he/she would fill out a maintenance requisition.During an interview on 01/09/26 at 3:52 P.M., Maintenance Technician D said the maintenance department did not perform regular inspections of bed rails or entrapment assessments.During an interview on 01/09/26 at 3:55 P.M., the Maintenance Director said maintenance did not perform entrapment assessments or routine inspections for bed rails.During an interview on 01/09/26 at 4:05 P.M., the Administrator said that bed rail entrapment assessments should be completed when bed rails were installed, and when there was any change in the resident or changes to the bed. The Administrator said that he/she would expect maintenance to check the bed rails when there was an issue. The MDS Coordinator did the maintenance assessments and tried to do them quarterly, but had been throwing them away after they were completed. There were no routine checks done by maintenance, only work orders, and nursing staff fill out the work orders and send to maintenance.		