

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  Heisinger Bluffs Healthcare Western Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 West Main Street Jefferson City, MO 65109	
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>40424</p> <p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, interviews, and record review facility staff failed to protect resident's private medical information by not closing the computers screens on two medication carts and one nurse desk. The facility census was 58.</p> <p>1. Review of the facility's Resident Rights, dated 11/22/24, showed residents have the right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>2. Observation on 10/15/24 at 1:15 P.M., showed Licensed Practical Nurse (LPN) A left a medication cart on 200 hall unattended to administer medications. The computer screen on the medication cart open and visible to the public with residents medical information.</p> <p>During an interview on 10/15/24 at 1:30 P.M., LPN A said he/she should not have left the screen open on the computer. He/She staff are required to close the screen or lock it to protect resident's private medical information.</p> <p>3. Observation on 10/16/24 at 10:41 A. M., showed a computer screen at the nurse's desk open and visible to the public with private resident medical information displayed.</p> <p>4. Observation on 10/18/24 at 8:17 A.M., showed Registered Nurse (RN) D stepped away from a medication cart on 300 hall with the computer screen open and showed a medication for a resident. Observation showed four resident in proximity of the cart and a staff member walked by the cart.</p> <p>During an interview on 10/18/24 at 8:27 A.M., RN D said computer screens should be closed when stepping away from them to protect the residents information. He/She should have at least minimized it for resident privacy but was just going down the hall for a second.</p> <p>5. During an interview on 10/18/24 at 9:18 A.M., the Director of Nursing (DON) said hall screens or medication cart screens should be closed or minimized to protect the privacy of residents medical information. Staff are educated monthly on privacy.</p> <p>During an interview on 10/18/24 at 9:42 A.M., the Administrator said computer screens should be closed if unattended. Doing so protects the residents private medical records. The DON is responsible to ensure staff are educated to protect the privacy of residents. I would not expect staff to leave the screens open.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265837
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F 0583  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	43327		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327</b></p> <p>Based on observations and interviews, facility staff failed to maintain a professional standard of care when staff left medications at the dining room table and failed to ensure the resident took the medications for three residents (Resident #7, #19 and #26) of 17 residents. The facility census was 58.</p> <p>1. Review of the facility's Medication Administration policy, undated, showed:</p> <ul style="list-style-type: none"> <li>-Medication will be administered by persons licensed or permitted by this state to prepare, administer and document the administration of medications;</li> <li>-Medications will be administered in accordance with the orders, including any required time frame;</li> <li>-Residents may self-administer their own medications only if the attending practitioner, in conjunction with the Interdisciplinary Care Planning team, has determined that they have the decision-making capacity to do so safely.</li> </ul> <p>Review of <a href="https://www.ncbi.nlm.nih.gov/book">https://www.ncbi.nlm.nih.gov/book</a>, Nursing Skills, Chapter 15: Oral Medication Administration, undated, showed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) should remain with the patient until all medication has been swallowed before documenting to verify the medication has been administered.</p> <p>2. Review of Resident #7's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/25/24, showed staff assessed the resident as cognitively intact.</p> <p>Observation on 10/16/24 at 7:58 A.M., showed the resident at the dining room table with a plastic medication cup in front of him/her with medication inside. The RN D walked away, passed medication to other residents and passed food trays. The RN did not remain with the resident whiled the resident took the medication.</p> <p>Observation on 10/17/24 at 8:18 A.M., showed the resident at the dining room table with a plastic medication cup in front of him/her with medication inside. The RN D walked away, passed other residents medication and food trays. The RN did not remain with the resident whiled the resident took the medication.</p> <p>Observation on 10/17/24 at 8:38 A.M., the resident poured the medication onto the table and took them one by one.</p> <p>Observation on 10/18/24 at 8:16 A.M., showed the resident at the dining room table with two other residents. Observation showed a plastic cup contained medication next to his/her breakfast. RN D sat in the dining room with his/her back to the resident whiel he/she assisted another resident.</p> <p>3. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/16/24 at 7:58 A.M., showed the resident at the dining room table with a plastic medication cup in front of him/her with medication inside. The RN D walked away, passed medications to other residents and passed food trays. The RN did not remain with the resident while the resident took the medication.</p> <p>4. Review of Resident #26's Annual MDS, dated [DATE], showed staff assessed the resident as cognitively impaired.</p> <p>Observation on 10/16/24 at 7:58 A.M., showed the resident in the dining with a plastic medication cup of medication in front of him/her and a brown container with eye drops inside. He/She sat at a table with three other residents while RN D passed medication to other residents, passed breakfast trays and assisted other residents. The RN did not remain with the resident while the resident took the medication.</p> <p>Observation on 10/16/24 at 8:41 A.M., showed the resident took the medication but did not administer the eye drops.</p> <p>Observation on 10/16/24 at 8:51 A.M., showed RN D took the resident to the medication cart and administered the eye drops to the resident.</p> <p>Observation on 10/17/24 at 8:17 A.M., showed the resident in the dining room with a plastic medication container with medication in front of him/her at the table and a eye drops. The resident sat with another resident and a visitor. RN D did not monitor the administration of the medication before leaving the resident.</p> <p>Observation on 10/18/24 at 8:16 A.M., showed the resident at the dining room table with a cup of medication on his/her breakfast tray and eye drops. The RN did not remain with the resident while the resident took the medication.</p> <p>5. During an interview on 10/18/24 at 8:27 A.M., RN D said staff should not put medication in front of residents then walk away or someone else could take them. He/She said it is the person administering medication responsibility to ensure the resident takes the medication as ordered. He/She said he/she only puts the medications in front of the residents he/she feels will take them on their own.</p> <p>During an interview on 10/18/24 at 9:18 A.M., the Director of Nursing (DON) said staff should make sure the resident takes his/her medications before walking away from them to ensure the resident gets their medication, keep another resident from getting and taking it and/or monitor for any adverse effects of the administration and medication.</p> <p>During an interview on 10/18/24 at 09:41 A.M., the administrator said he/she expects the staff to remain with the resident during administration of medication to ensure the resident takes the medication and keep someone else from taking it.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43327</p> <p>Based on observations, interviews, and record review, the facility staff failed to properly secure potentially hazardous chemicals and objects in three facility rooms on 100 hall and properly secure the medicine cart on 300 hall, in a manner to prevent accidents. Facility staff failed to transfer one resident (Resident #17) of three sampled residents safely in the mechanical lift. The facility census was 58.</p> <p>1. Review of the facility's policies showed staff did not provide a storage of hazardous items policy.</p> <p>2. Observation on 10/15/24 1:47 P.M. showed the 100 hall spa door open and unsecured and unattended. The spa contained a wound cleanser, adhesive remover and one tube of zinc oxide maximum strength cream.</p> <p>Observation on 10/15/24 at 2:03 P.M., showed the 100 hall laundry door open and unsecured and unattended. The laundry room contained one container of premoistened wipes with an ethyl alcohol-based cleaning formula.</p> <p>Observation on 10/16/24 8:58 P.M. showed the 100 hall supply room door unsecured and unattended. The supply room counter and unlocked cabinet contained:</p> <ul style="list-style-type: none"> <li>-Odor eliminator bottle,</li> <li>-Eight bottles of perineal cleanser;</li> <li>-25 finger nail clippers;</li> <li>-70 disposable razors;</li> </ul> <p>During an interview on 10/18/24 9:08 A.M., Certified Medication Technician (CMT) E said all potentially hazardous chemicals should be locked up and out of reach of the residents. He/She said a confused resident could ingest them which may cause sickness or worse. He/she said sharp objects could cut someone. He/she said chemicals, razors, and nail clippers could be dangerous in the wrong hands. He/she said it was the responsibility of all staff to make sure potential hazardous chemicals and objects were properly secured.</p> <p>During an interview on 10/18/24 8:56 A.M., Registered Nurse (RN) K said all potentially hazardous chemicals should be locked up and out of reach of the residents. He/she said that a confused resident could get chemicals in their eyes and/or ingest the chemicals, causing sickness or poisoning. He/she said sharp objects could injury a resident or employee. He/she said that any one could properly secure the hazardous objects from the residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/18/24 9:19 A.M., the Director of Nursing (DON) said hazardous chemicals and sharp objects should be locked up and out of the reach of residents. He/she said that the residents could injure or poison themselves. He/she said chemicals, objects such as razors and nail clippers could be dangerous in the wrong hands.</p> <p>During an interview on 10/18/24 9:45 A.M., the administrator said hazardous chemicals and objects should be locked in a room or secured inside the room. He/she said the this is to prevent harm to the residents or staff. He/she said all staff had the responsibility to make sure hazards were properly secured and ultimately is the responsibility of nursing and the administrator.</p> <p>3. Review of the facility's Medication Storage policy, undated, showed:</p> <ul style="list-style-type: none"> <li>-The facility shall store all drugs and biologicals in a safe, secure, and orderly manner;</li> <li>-The nursing staff shall be responsible for maintaining medication storage in a safe manner;</li> <li>-Compartments, including but not limited to carts, containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</li> </ul> <p>Review of the Medication Administration policy, undated, showed during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide, clearly visible to the nurse administering medications, and all outward sides must be inaccessible to residents and others passing by.</p> <p>4. Observation on 10/17/24 at 8:46 A.M., showed RN D step away from the 300-hall medication cart and passed through a door that lead down the stairs. He/She did not lock the cart or keep the cart in visible view. Observation showed multiple resident and staff walked past the medication cart.</p> <p>Observation on 10/18/24 at 8:17 A.M., showed RN D step away from the 300-hall medication cart by the dining room and did not lock the cart or keep the cart in visible view. Observation showed multiple resident and staff walked past the medication cart.</p> <p>During an interview on 10/18/24 at 8:22 A.M., RN D said the medication cart should be locked or someone could get into it and take something. He/She said typically he/she locks the cart, but was in a hurry and got busy. He/She said it is his/her responsibility to ensure the cart is kept locked since he/she is responsible for the medications.</p> <p>During an interview on 10/18/24 at 9:18 A.M., the DON said staff responsible for medication administration are expected to keep the medication cart locked when he/she steps away from it to keep the contents safe and residents or others free from getting into the cart.</p> <p>During an interview on 10/18/24 at 9:41 A.M., the administrator said he/she would expect nursing to keep the medication cart locked when out of sight or when stepping away from it to keep unauthorized individuals from accessing it for safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Review of the facility's Safe Lifting of Residents policy, undated, showed floor-based lifts require a minimum of two person assist. The policy did not contain direction on how to complete a transfer with the lift.</p> <p>6. Review of Resident #17's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/08/23, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively impaired;</li> <li>-Dependent on staff for all transfers.</li> </ul> <p>Observation on 10/16/24 at 10:43 A.M., showed CNA F and CNA G provided transfer assistance to the resident using a mechanical lift from the bed to a reclining wheelchair. CNA G lifted the resident from the bed and left the resident suspended in the air without hands on the resident while CNA F positioned the reclining wheelchair.</p> <p>During an interview on 10/16/24 at 11:03 A.M., CNA G said two staff should perform mechanical lift transfers. One staff member to operate the lift and the second staff member to guide the resident. He/She said its not safe to leave the resident suspended without someone holding onto them while they are in the air and it could scare the resident. The CNA said that there isn't much room in the resident's room to position the chair and work the lift around so staff does the best they can.</p> <p>During an interview on 10/16/24 at 11:13 A.M., CNA F said he/she knew it was not ok to leave the resident suspended but needed to get the wheelchair in place. If you leave a resident suspended, they might fall and get hurt.</p> <p>During an interview on 10/18/24 at 8:27 A.M., RN D said staff should never leave a resident suspended in the mechanical lift without a staff member holding them for safety. The resident could slip out of the sling or the lift could tip over. He/She said that staff should be trained prior to using the lift.</p> <p>During an interview on 10/18/24 at 9:18 A.M., the DON said two staff should use the hoyer to ensure the resident remains safe. One staff is to guide the lift and the other staff is to keep hold of the resident to keep the resident from getting hurt. He/She said there are routine trainings regarding lift safety and would expect staff to follow the training.</p> <p>During an interview on 10/18/24 at 9:41 A.M., the Administrator said the nursing department is responsible to ensure resident lifts are done correctly and would expect staff to hold onto a resident while suspended in the air during a mechanical lift transfer for safety.</p> <p>50753</p>		