STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265843	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio, Appleton City, MO 64724

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interviews and record review, the facility failed to ensure all residents were treated with dignity and respect when staff yelled and cursed in the presence of residents. A sample of seven residents was reviewed in a facility with a census of 37. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included Alzheimer's disease (confusion or cognitive impairment), dementia with other behavioral disturbances (confusion or cognitive impairment with behaviors); and major depressive disorder (feeling low or sad persistently). Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 02/21/24, showed the following: -Severally impaired cognition; -Disorganized thinking present. Review of the resident's care plan, revised on 02/16/24, showed the following: -Resident is dependent upon staff for getting emotional, intellectual, physical, social needs related to cognitive decline. Staff will converse with the resident while providing care and introduce the resident to residents with similar background and interests; -Resident has communication problem related to hearing deficit. Resident has bilateral hearing aide, but he/she no longer uses them. Review of the Nurse Aide (NA) B's written statement showed the following: -Date of the incident 04/09/24; -Time of the incident 9:50 P.M.; (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/09/24, at 9:50 P.M., CNA A went and put a gait belt on the resident in the break room and made the resident stand up; -NA B told CNA A to be careful as the resident has been having to use a wheelchair and CNA A yelled and said I've been doing this for 13 fucking years don't tell me how to do my job. During an interview on 04/12/24, at 12:10 P.M., NA B said the following: -On 04/09/24, CNA A came in around 9:30 P.M.; -The resident was in the break room; -CNA A clocked in and CNA A seemed irritated; -NA B let CNA A know the resident was there and he/she was about to go do rounds; -CNA A put the gait belt around the resident. NA B was out by the nurses' desk; -CNA A walked out of the break room after NA B; -CNA A was trying to rush the resident and the resident was waving his/her hands and said whoa; -After NA B told CNA A about him/her using the wheelchair , CNA A said he/she has been doing this 13 fucking years. Review of NA D's written statement dated 04/10/24, at 1:40 P.M., showed the following: -Date of the incident 04/09/2024; -Time of the incident 9:50 P.M.; -At/around 9:50 P.M., on 04/09/24, CNA A went to put on a gate belt on the resident; -As they were walking away, another employee told CNA A to be careful because the resident hasn't had steady feet; -CNA A said to NA B that he/she knows what he/she is doing as he/she has been doing it for [AGE] years; -As CNA A was back talking. Review of Licensed Practical Nurse (LPN) C's written statement, dated 04/10/24, showed the following: -On 04/09/24, at 9:45 P.M., the nurses were behind the desk; -LPN C overheard NA B telling CNA A that the resident had been leaning over and stumbling frequently tonight and may need a wheelchair; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A replied by yelling he/she had been doing this for [AGE] years, don't tell me how to do my job. -The resident walked past the nurses' station with CNA A wearing a gait belt securely; During an interview on 04/12/24, at 3:10 P.M., LPN C said he/she was told about CNA A and he/she thought CNA A just had an attitude. Review CNA A's written statement, undated, showed the following: -On 04/09/24, CNA A came to work and found the resident in the employee break room; -CNA A put on a gait belt and behind the resident and directed the resident to his/her room; -No problem getting there nice and slow because that's the way the resident walks; -There was an aide that yelled at me, telling me to be careful that the resident might fall; -CNA A had total control of the resident there was no cussing or jerking the resident; -CNA A took the resident to his/her room and put him/her to bed. During an interview on 04/12/24, at 12:20 P.M., CNA A said the following: -He/she came to work on 04/09/24 around 9:45 P.M.: -He/she was in the employee break room to clock in, when he/she saw the resident sitting in a chair bent over; -He/she was upset to see the resident in the break room by him/herself; -CNA A talked to the resident and directed the resident to his/her room; -NA B yelled at him/her to use the wheelchair. During an interview on 04/12/24, at 1:30 P.M., LPN E said the following: -On 04/09/24, around 9:40 P.M., he/she noticed the resident sitting in the employee break room; -The resident was asleep and it looked like the resident had been moving furniture in the break room; -CNA A said let me see if I can get the resident to his/her room; -CNA A brought the resident out of the break room and NA B came from around the corner and said to be careful with the resident and don't drop him/her; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A turned around and looked at NA B and said I've been a CNA for [AGE] years and have a gait belt on the resident and he/she is secured. During an interview on 04/12/24, at 4:27 P.M., the Director of Nursing (DON) and Administrator said it is not appropriate for staff to act in an undignified manner around residents. MO00234468

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interviews and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the State Survey Agency (Department of Health and Senior Services - DHSS) when allegations were reported that one staff (Certified Nurse Aid (CNA A))cursed at two residents (Resident #1 and Resident # 2). The facility census was 45. Review of the facility's policy titled, Abuse, Prohibition, Prevention, Investigation, and Response, undated, showed the following: -It is the policy of the facility to take all reasonable and responsible measures to prevent the occurrence of abuse-including mental abuse-neglect, injuries of unknown sources, and misappropriation of resident property to ensure that all alleged, reported and suspected violations of Federal or State laws which involve mistreatment, abuse, neglect, avoidable accidents, incidents, injuries of unknown origin and misappropriation of resident property are reported to the state agencies within two hours after receiving said report. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance (confusion or cognitive impairment with behaviors); insomnia (sleep disorder); pain; blindness, one eye; and atherosclerosis of aorta (buildup of plaque in the largest artery in of the body). Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/31/24, showed the following: -Memory problem for both long and short-term; -Last four to six days resident has displayed physical behaviors and verbal behaviors and last one to three days rejection of cares; -Total dependency on staff for eating, toileting hygiene, dressing, personal hygiene, and bathing. Review of the resident's care plan, revised on 02/16/24, showed the following: -Resident has impaired cognition and impaired though processes related to dementia; -Resident has communication problem related to hearing loss; -Resident has an ADLs (activities of daily living - dressing, grooming, bathing, eating, and toileting) self-care performance deficit related to dementia. Resident is dependent upon staff for all daily living activities; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident has a behavior problem. Resident has had few episodes of agitated behavior related to dementia; -Resident has potential to be physically aggressive and resistive to cares; -Resident has potential to be verbally abusive to staff; -Resident has risk for pain; -Resident has bowel and bladder incontinence related to dementia. Review of the facility's investigation, dated 02/08/24, showed the following: -On 02/08/24, the Director of Nursing (DON) received a text from Nurse Aide (NA) G stating NA G needed to speak to the DON; -DON called NA G and NA G reported that CNA A had cursed Resident #1 and Resident #2; -It was reported the incident occurred on 02/02/24 (six days prior). Record review of the DHSS records showed the facility did not self-report the allegation of abuse. 2. Review of Resident #2's face sheet showed the following: -Current admitted [DATE]; -Diagnoses included metabolic encephalopathy (problem in the brain), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance , and anxiety, pneumonia (cough that produces thick yellowish spit), acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissue of your body), major depressive disorder (persistent low or depressed mood and loss of interest), seizures (uncontrolled electrical activity between the brain cells), hallucinations (false perceptions of objects), contracture (permanent tightening of the muscles) and unspecified psychosis not due to a substance or known physiological condition (mental state characterized by loss of touch with reality). Review of the resident's significant change MDS, dated [DATE], showed the following: -Severally impaired; -Psychosis with hallucinations and delusions; -Last four to six days resident has displayed verbal behaviors; -Total dependency on staff for eating, toileting hygiene, dressing, personal hygiene, and bathing. Review of the resident's care plan, revised on 02/06/24, showed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident has impaired cognitive function/dementia or impaired thought processes related to unspecified psychosis; -Resident has a communication problem related to cognitive deficits; -Resident is dependent upon staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, disease process, immobility, physical limitations and hospice status; -Resident is dependent upon staff for all ADLs; -Resident has behavior problems, yelling related to unspecified psychosis; -Resident has potential to be verbally aggressive exhibited by yelling out curse words related to unspecified psychosis. Review of the facility's investigation, dated 02/08/24, showed the following: -On 02/08/24, the Director of Nursing (DON) received a text from Nurse Aide (NA) G stating NA G needed to speak to the DON; -DON called NA G and NA G reported that CNA A had cursed Resident #1 and Resident #2; -It was reported the incident occurred on 02/02/24. Record review of the DHSS records showed the facility did not self-report the allegation of abuse. Review of the complaints turned into the state agency did not show a complaint had been filed by the facility for the allegation of abuse. 3. During an interview on 02/28/24, at 11:45 A.M., CNA A said the following: -It would not be appropriate to use profanity around or towards residents; -He/she said there have been times when he/she has cursed in the presence of Resident # 1 and Resident #2; -He/she doesn't remember exactly what profanity he/she used around the residents, or when he/she used the profanity; -If he/she witnessed staff using profanity towards or around a resident he/she would report to the charge nurse; -He/she doesn't know if cursing at a resident is supposed to be reported to the state. 4. During an interview on 02/24/24, at 10:55 A.M., CNA B said the following: -It would not be appropriate to curse at a resident or use profanity around a resident; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cursing at a resident would be abuse and around a resident would be disrespectful; -If he/she witnessed cursing at or around a resident he/she would tell the charge nurse. 5. During an interview on 02/24/24, at 11:00 A.M., CNA C said the following: -It would not be appropriate to use profanity towards a resident or around a resident. This would be disrespectful and could be abuse; -If he/she witnessed cursing at a resident he/she would intervene and report to the nurse. 6. During an interview on 02/28/24, at 12:17 P.M., CNA H said the following: -Using profanity around or cursing at a resident would be considered abuse and a dignity issues; -He/she would tell the charge nurse if he/she heard another staff cursing at or around a resident; -He/she said an allegation of abuse should be reported to the state within two hours. 7. During an interview on 02/28/24, at 12:24 P.M., Certified Medication Tech (CMT) I said the following: -Would not be appropriate to curse at or around a resident. It would definitely be a dignity issue and possibly abuse; -He/she would report any suspected abuse to the charge nurse and talk to the DON; -He/she thinks suspected abuse should be reported to the state within 24 hours. 8. During an interview on 02/24/24, at 11:05 A.M., CMT D said the following: -It is not appropriate to use profanity at or around a resident, this would be disrespectful and probably abuse too; -If he/she witnessed staff using profanity, he/she would report to the charge nurse, if nothing done, he/she would go to the DON and Administrator. 9. During an interview on 02/24/24, at 11:27 A.M., Licensed Practical Nurse (LPN) E said the following: -It is not appropriate to use profanity around a resident or talk to a resident using profanity, this would be unprofessional and disrespectful; -He/she would report anything inappropriate or abusive to his/her supervisor. 10. During an interview on 02/24/24, at 12:25 P.M., LPN J said the following: -He/she knows to report abuse to the state within two hours; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is not okay to cuss at resident or around residents. 11. During an interview on 02/24/24, at 11:05 A.M., Registered Nurse (RN) F said the following: -It would not be appropriate to use profanity around or towards a resident; -If he/she witnessed profanity being used at or around a resident he/she would intervene and report to his/her supervisor. 12. During an interview on 02/28/24, at 12:28 P.M., Social Service Designee (SSD) said the following: -It was not appropriate to curse at or around a resident. That would be abuse and dignity and respect issues; -He/she would report any suspected abuse to the DON and Administrator; -The facility is required to complete an investigation and report to the state within two hours. X. During interviews on 02/24/24, at 11:59 A.M., and on 02/28/24, at 1:12 P.M., the DON and Administrator said the following: -On 2/08/24, the DON was told by NA G that CNA A cursed at Resident #1 and Resident #2; -NA G told the Administrator that CNA A had been abusive/mean, but wouldn't write down details of what he/she meant by those accusations; -NA G would not write out a statement of the alleged incident; -DON suspended CNA A and began the investigation; -He/she did not report the allegation of abuse to the state; -It would not be appropriate to use profanity around or towards residents; -If staff curses at a resident it could be considered abuse; -He/she would expect staff to report abuse to their supervisor and the facility completes and investigation and notifies the state within 2 hours. MO00232266

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility failed to ensure all residents' drug regimes were free from unnecessary drugs when staff failed to adequately monitor blood pressure as ordered for one resident (Resident #2), who received medications to help control blood pressure. A sample of four residents were reviewed, with a facility census of 37. Review showed the facility did not have a a policy regarding following physician's orders and monitoring with administration of medications. 1. Review of Resident #2's face sheet (admission data) showed the following: -admitted [DATE]; -No diagnosis listed. Review of the resident's care plan, dated 01/19/24, showed staff did not care plan regarding the resident's blood pressure medications. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/25/24, showed the following: -Memory problems; -Moderately impaired decision making; -Diagnoses included atrial fibrillation (irregular and often rapid heart rhythm, heart failure (heart muscle can't pump enough blood to meet the body's needs), and high blood pressure. Review of the resident's January 2024 Physician's Order Sheet (POS) showed the following: -An order, dated 01/19/24, to administer metoprolol (medication used to treat high blood pressure) 50 milligrams (mg) daily; -An order, dated 01/19/24, to administer amoldipine (medication used to treat high blood pressure) 2.5 mg two times per day; -An order, dated 01/19/24, to record blood pressure each shift. Review of the resident's January 2024 Medication Administration Record (MAR) showed the following: -Staff did not document monitoring the resident's blood pressure on the second shift (2:00 P.M. to 10:00 .M.) on eight dates (01/20/24, 01/21/24, 01/22/24, 01/25/24, 01/26/24, 01/29/24, 01/30/24, and 01/31/24); (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff did not document monitoring the resident's blood pressure on the third shift (10:00 P.M. to 6:00 P.M.) in January 2024. During an interview on 04/12/24, at 1:10 P.M., Licensed Nurse Practitioner (LPN) H said the following: -Normally vitals are done monthly, sometimes depending on a resident's medications they might be done more often; -If the facility has an order to complete blood pressure each shift, staff should check the resident's blood pressure each shift; -There are assigned sheets to document the blood pressure readings and nurses chart in the nurses' notes as well; -He/she didn't remember if the resident had an order to check his blood pressure each shift; -If there was an order they were being done as far as he/she knew; -There are parameters listed on the MARs of when to hold a medication. During an interview on 04/12/24, at 1:30 P.M., LPN E said the following: -Vitals are done on residents depending upon their acuity such as if on oxygen or breathing treatments their done each shift; -If residents are on blood pressure medications we have parameters that tell staff when the mediations should be held; -If blood pressure readings are ordered each shift, he/she would expect staff to be taking them each shift and this is to be documented on the vitals sheets; -There is a spot on the MAR to document the blood pressure; -Orders should be followed as given from the nurse practitioner. During an interview on 04/12/24, at 3:10 P.M., LPN C said the following: -Staff know what medications and treatments to provide to resident by looking on the POS; -If the POS says the resident's blood pressure is to be checked every shift, staff should be checking it each shift; -The blood pressure is documented on the MAR in the resident's medical chart; -He/she remembers taking the residents blood pressure during his/her shift, and the first week or two it was daily and then it was changed to each shift; (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the blood pressure is under a certain level, there are given parameters and the medication may not be administered; -He/she doesn't know if anyone is reviewing the MARS and TARS to see if medications and orders are being done as prescribed. During an interview on 04/16/24, at 4:27 P.M., Family Nurse Practitioner (FNP) J said the following: -The resident had an order for two blood pressure medications; -There were orders for staff to complete blood pressure checks each shift. During an interview on 04/12/24, at 4:27 P.M., the Director of Nursing (DON) and Administrator said the following: -Staff know what treatments and medications are ordered by looking at the POS and the MARS. Nurses have MARs and CMTS have MARS; -If blood pressure is ordered each shift, he/she would expect it to be taken each shift; -He/she does not have staff that review the MARs and TARS to see if everything has been done correctly once completed; -When reviewing the resident's medical records it appears there was some shifts that missed doing the blood pressure. MO00233237

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45176 Based on interview and record review, the facility failed to ensure all residents' drug regimes were free from unnecessary drugs when staff failed to specify a diagnosis for use of a psychotropic medication for one resident (Resident #1). A sample of four residents was reviewed in a facility with a census of 37. Review showed the facility did not provide a policy regarding psychotropic medications. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included Alzheimer's disease (confusion or cognitive impairment), unspecified dementia with the other behavioral disturbances (confusion or cognitive impairment with behaviors). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 02/21/24, showed the following: -Severally impaired cognition; -Disorganized thinking is present; -Diagnosis include dementia and depression; -The resident was taking antianxiety medications. Review of the resident's care plan, revised on 03/18/24, showed the following: -Resident has impaired cognition or impaired thought processes related to Alzheimers. Administer medications as ordered and monitor/document for side effects and effectiveness. -Resident is resistive to care related to dementia. Allow the resident time to make decisions about treatment regime to provide a sense of control; -Resident has impaired cognitive dementia or impaired thought process related to Alzheimers. Staff to administer medications as prescribed. Staff to ask yes/no questions to determine resident's needs; -Resident has a mood problem related to depression and agitation related to Alzheimers. Staff to administer medication as ordered and monitor/document for side effects and effectiveness. -Monitor/record/report to physician as needed about acute episode feelings, sadness, or diminished ability to concentrate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265843	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio, Appleton City, MO 64724

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the the resident's February 2024, March 2024, and April 2024 Physicians' Order Sheet (POS) showed the following: -An order, dated 01/29/24, to administer Ativan (an antianxiety (psychotropic) medication) 0.5 mg every four hours as needed for agitation. Staff may administer IM (intramuscular) if resident refuses to take a pill. The order did not indicate a diagnosis for administration of Ativan, only the resident's symptom of agitation. Review of the resident's progress and nurses' notes showed staff did not document a diagnosis for the administration of Ativan. During an interview on 04/12/24, at 1:30 P.M., Licensed Practical Nurse (LPN) E said the resident has an order for as needed Ativan that staff administer about twice a day or sometimes three times per day. During an interview on 04/16/24, at 4:27 P.M., Family Nurse Practitioner (FNP) J said the following: -He/she reinstated the Ativan as needed for the resident' -The resident gets confused and wanders into other residents' rooms. During an interview on 04/12/24, at 4:27 P.M., the Director of Nursing (DON) and Administrator said the following: -The family nurse practitioner reviews the resident's medications and has made changes; -On 04/10/24, the DON sent out a note to staff asking when they are administering the as needed Ativan to document what interventions were tried previously; -They have been monitoring behaviors and completing medication changes. MO00233237