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	04/12/2024

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 1. Please refer to event ID NJ1P12. 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; (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	-Time of the incident 9:50 P.M.; -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; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN C overheard NA B telling CNA A that the resident had been leaning over and stumbling frequently tonight and may need a wheelchair; -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; (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 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; -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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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 1. Please refer to event ID NJ1P12. 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 1. Please refer to event ID NJ1P12. 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. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor/record/report to physician as needed about acute episode feelings, sadness, or diminished ability to concentrate. 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