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	02/27/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care that reflected the resident's wishes as expressed by the resident's advance directives (written instruction, such as a living will or durable power of attorney, relating to the provision of health care when the individual is incapacitated) when the facility failed to ensure one resident's (Resident #1) CPR order (CPR - a medical intervention used to restore circulatory and/or respiratory function) was clearly and consistently documented in the resident's chart resulting in staff failing to provide CPR when the resident was found unresponsive. The facility census was 35.The Administrator was notified on [DATE], at 5:10 P.M., of the Immediate Jeopardy (IJ) which occurred on [DATE]. The IJ was removed [DATE] as confirmed by surveyor on-site verification. Review of the facility's policy titled Advance Directives, revised [DATE], showed the following:-Advance directives will be respected in accordance with state law and facility policy;-Prior to or upon admission of a resident to the facility, the Social Services Director (SSD) or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives;-Prior to or upon admission of a resident, the SSD will inquire of the resident, and/or his/her family members, about the existence of any written advance directives;-The facility has defined advanced directives as preferences regarding treatment options and include but are not limited to Do Not Resuscitate (DNR - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to used.) 1. Review of Resident #1's face sheet (a document that gives a residents' information at a quick glance) showed the following:-admission date of [DATE];-Page one of the resident's face sheet showed code status DNR;-Page two of the resident's face sheet showed advance directive field with code status of CPR;-Diagnoses included schizophrenia (a chronic, severe brain disorder characterized by a disconnection from reality through hallucinations, delusions, and disorganized thinking), bipolar disorder (a chronic mental illness characterized by extreme mood swings, ranging from high-energy mania/hypomania to deep depression), hypertension (high blood pressure), and type two diabetes (a chronic condition causing high blood sugar). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated [DATE], showed the resident had moderate cognitive impairment. Review of the resident's care plan, dated [DATE], showed the resident had a guardian for all decision making. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility document titled Advance Directive Acknowledgement, dated [DATE], showed the following:-The resident's guardian did not select an option;-The guardian wrote and initialed, none at this time (indicating no advance directives at this time). Review of the facility document titled Health Care Directive, dated [DATE], showed the following:-Possible health care directive options included withholding CPR, surgery, artificially supplied nutrition, antibiotic, chemotherapy, radiation and all other life prolonging medical or surgical procedures; --The resident's guardian initialed the selection indicating he/she did not wish to make a health care directive at this time;-The document was signed by the resident's guardian. Review of the resident's current Physician's Order Sheet (POS) showed an order, dated [DATE], for CPR. Review of the resident's nursing progress note dated [DATE], at 8:53 A.M., showed Registered Nurse (RN) E documented the following:-Resident was found unresponsive at 7:50 A.M.;-Resident was found lying across the bed, face ashen (pale gray color), and lips purple with no respirations noted;-At 7:55 A.M., the resident was pronounced deceased with a second RN;-Placed call to Family Nurse Practitioner (FNP) and reported findings;-Staff notified guardian. During an interview on [DATE], at 2:30 P.M., certified nurse aide (CNA) F said the following:-He/she went and checked on the resident around 6:00 A.M., and the resident was sleeping;-He/she returned around 7:45 A.M., to start helping the resident's roommate when he/she noticed the resident was now laying across the bed;-He/she thought it looked like the resident was attempting to sit up and then slumped over;-He/she checked on the resident and he/she did not respond;-He/she yelled for the nurse and RN E responded to the room;-He/she left the room to check the emergency book and saw it indicated DNR. During interviews on [DATE], at 1:52 P.M. and 3:40 P.M., RN E said the following:-Yesterday morning ([DATE]) a CNA came and got him/her from the dining room to check on the resident;-The resident was laying across the bed and had no heartbeat or breath sounds;-The resident lips where blue and he/she had a gray appearance;-He/she went and notified the Administrator, and they returned to the room and pronounced the resident dead at 7:55 A.M.;-He/she and the Administrator did not start CPR;-The resident was listed as a DNR in the emergency book; -He/she would have started CPR if the resident was a full code;-If a resident was found unresponsive, staff were to call for help and check the code status;-Code statuses were kept in the emergency book and the computer;-If a resident was CPR, staff get the crash cart (a cart with emergency medical equipment) and begin CPR;-If there is no signed DNR staff should start CPR. During an interview on [DATE], at 2:27 P.M., CNA A said the following:-Staff should find the resident's code status on the resident's name tag on the door. A red sticker means DNR;-Facility staff should get the nurse if staff find a resident unresponsive;-The nurse checks the resident's code status. During an interview on [DATE], at 3:17 P.M., CNA B said the following:-Facility staff should find the code status in the binder located at the nurses' desk;-Facility staff should yell for help if they find a resident unresponsive;-Staff should initiate CPR if a resident code status is full code. During an interview on [DATE], at 3:50 P.M., Licensed Practical Nurse (LPN) C said the following:-Facility staff should stay with a resident if they are found unresponsive, call for help, and check (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for vital signs;-Facility staff should find the code status in the computer or the emergency binder which has the code status on the face sheet;-If a resident or representative did not sign a health care directive, it defaulted to full code status;-The resident's code status on the computer showed the profile section as a DNR code status. The physician orders showed CPR code status. The resident's health care directive was initialed to not make a directive which means full code status. During an interview on [DATE], at 3:49 P.M., LPN G said the following:-Resident code status was kept in the emergency book at the nurses' station;-If a resident was found unresponsive staff check pulse and breathing and start CPR if resident is a full code;-Once staff start CPR staff continue until emergency medical services arrive;-If staff are not sure of code status, the resident is a full code;-If there is conflicting information in the chart, the resident is a full code and staff should start CPR. During an interview on [DATE], at 3:54 P.M., the MDS Coordinator said the following:-He/she worked the floor sometimes and provided RN coverage for the facility;-If a resident was found unresponsive staff are to check pulse and breathing and start CPR if the resident is a full code;-Code status was kept in the emergency book. Also, there will be a red dot outside the door indicating DNR;-If code status does not match, staff should start CPR and continue until emergency medical services arrive;-Social Services was responsible for updating a resident's code status. During an interview on [DATE], at 2:40 P.M., the SSD said the following:-The resident's code status paperwork was completed upon admission with the responsible party and/or resident and explains the difference of code status;- The resident or representative signs the DNR form and she places it in the physician's box to sign;-The nursing staff give her the signed DNR form, she copies it onto purple paper, uploads it into the electronic medical record, and places it in the emergency book located at the nurses' station;-Nurses enter the orders into the computer;-She enters information on the face sheet and on the profile, section including emergency contacts and physicians, and she can enter the code status in the electronic medical record;-She informs the nurses of a resident's code status of a new admission, and the code status also populates on the computer;-She did not enter the resident's code status. The former SSD reviewed the resident's code status;-The resident's record showed the resident's code status as CPR and the physician's orders, dated [DATE], showed CPR;-The resident's profile page showed DNR. She did not see a signed DNR uploaded in the resident's electronic medical record;-The resident's health care directive showed the resident's representative initialed did not wish to make a health care directive dated [DATE], which means a full code status;-She was responsible for updating residents' code status if changes. During interviews on [DATE], at 1:39 P.M. and [DATE], at 1:04 P.M., the Director of Nursing (DON) said the following: -Resident DNR or CPR status is uploaded in the charts in the electronic chart;-Staff also have a red emergency binder at the nurses' station with all residents' code statuses;-The SSD reviews code status upon admission with residents and/or representative;-The resident/representative signs a DNR form which staff give to the physician to sign; -The SSD scans the signed DNR document into the miscellaneous tab in the computer. She or the MDS Coordinator can enter a resident's code status in the computer;- She is not sure what happened with the resident's code status when staff entered it on admission. The resident's profile page on the computer showed a DNR code status and the banner showed a full code status for the resident;-The resident's health care directive signed by his/her guardian indicated he/she was a full code (CPR to be started if found unresponsive);-She expected staff to perform CPR on the resident; -Staff must have removed the resident's face sheet after he/she passed away, as it is not in the binder at this time. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 4:10 P.M., the Nurse Practitioner (NP) said the following:-He/she expected all staff to follow advance care directives;-If code status is CPR, staff start chest compressions and call 911;-He/she finds code statuses in electronic medical record and staff also use a colored dot system;-He/she received a call from the Administrator stating the resident was blue from the head up and had no pulse;-Social services updates code statues;-If a resident or representative did not complete a health care directive, it would default to a full code status;-He/she did not ask if staff started CPR or instruct them to start CPR as staff reported the resident was already gone. During an interview on [DATE], at 12:52 P.M., the Medical Director said the following:-If a resident was found unresponsive staff on duty should report to the DON, Administrator, and NP, and call 911;-He expected staff to check a resident's code status to determine whether to perform CPR or if they had a DNR code status;-He expected a resident's code status to match throughout the medical record;-Facility staff should initiate CPR if a resident is a full code status immediately due to time matters;-If the resident was a full code status, staff should have initiated CPR. During an interview on [DATE], at 4:30 P.M., the Administrator said the following:-Staff were to check resident code status using the emergency binder and the nurses' station;-Social services updates code status on admission and any licensed staff can update or make changes after that;-The resident had DNR listed on the front page of his/her face sheet and the second page indicated CPR;-The resident's physician orders showed the resident was CPR;-Staff did not start CPR on the resident;-She and RN E did not perform CPR because the resident's face sheet showed a DNR code status and did not question it;-She did not find a signed uploaded DNR for the resident in the electronic medical record;-The resident's representative initialed a health care directive form stating did not wish to make one at this time which defaults to a full code status;-He/she called the NP who was on their way to the facility when this happened;-He/she did not question the code statuses on the face sheet;-He/she expected all code statues on face sheets to match the resident's actual code status;-She expected a resident's code status to match throughout the medical record;-The resident was a full code when he/she passed away;-Staff were to start CPR when a resident was a full code and found unresponsive. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. Complaint #2788657