

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>41787</p> <p>Based on interview and record review, the facility failed to develop and implement abuse policies that established steps to prevent abuse, including proper screening of staff upon hire, when the facility failed to follow-up on requested Criminal Background Checks (CBC) for four staff (Nurse Aide (NA) D, Restorative Aide (RA) G, NA I, and Certified Medication Technician (CMT) F) out of ten sampled staff. The facility had a census of 38.</p> <p>Review of the facility's policy Policy and Procedures for New Hires, dated 09/09/13, showed the following:</p> <ul style="list-style-type: none"> <li>-All potential new hires have a background check initiated prior to beginning employment;</li> <li>-No new employee will be allowed to have direct contact with a resident until this steps has been completed.</li> </ul> <p>1. Review of NA D's personnel record showed the following information:</p> <ul style="list-style-type: none"> <li>-Hire date of 05/09/22;</li> <li>-Staff requested a criminal background check on 05/09/22;</li> <li>-The facility did not document the completion/findings of the NA's criminal background check.</li> </ul> <p>2. Review of RA G's personnel record showed the following information:</p> <ul style="list-style-type: none"> <li>-Hire date of 08/15/23;</li> <li>-Staff requested a criminal background check on 08/11/23;</li> <li>-The facility did not document the completion/findings of the RA's criminal background check.</li> </ul> <p>3 .Review of NA I's personnel record showed the following information:</p> <ul style="list-style-type: none"> <li>-Hire date of 09/06/23;</li> <li>-Staff requested a criminal background check on 08/22/23;</li> </ul> <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The facility did not document the completion/findings of the NA's criminal background check.</p> <p>4. Review of CMT F's personnel record showed the following information:</p> <p>-Hire date of 10/26/23;</p> <p>-Staff requested a criminal background check on 10/19/23</p> <p>-The facility did not document the completion/findings of the CMT's criminal background check.</p> <p>5. During an interview on 09/05/24, at 11:15 A.M., the Business Office Manager said that he/she started the current position in August 2024. He/she had made a checklist of things that needed to be completed for newly hired staff since starting the position. The Business Office Manager reviewed the four personnel records and found no criminal background checks completed. He/she said that all of the required checks should be completed before an employee works with residents.</p> <p>6. During an interview on 09/06/24, at 1:30 P.M., the Administrator said that she expected staff to complete all required documentation and criminal background checks before a new employee worked with the residents. He/she was not aware that the checks had not been completed for the listed staff.</p> <p>MO00238445</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49585</p> <p>Based on interview and record review, the facility failed to provide a bed hold policy for one resident (Resident #36) who transferred/discharged to the hospital on two separate occasions. The facility census was 38.</p> <p>Review showed the facility did not provide a policy regarding bed holds.</p> <p>1. Review of the Resident #36's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Resident had a responsible party;</li> <li>-Diagnoses included Alzheimer's disease and vascular dementia (disease affecting blood vessels in the brain causing changes to memory, thinking, and behavior).</li> </ul> <p>Review of the resident after visit summary from the hospital, dated 08/09/24, showed the resident was seen in the emergency roiaognom on [DATE] and discharged back to the facility on [DATE].</p> <p>Review of the resident's medical record showed staff did not document providing written bed hold information to the resident, or responsible party, and did not have a copy bed hold provided to the resident, or responsible party, for the discharge/transfer on 08/09/24.</p> <p>Review of the resident's discharge Minimum Data Sheet (MDS - a federally mandated assessment completed by facility staff), dated 08/13/24, showed the resident discharged with return anticipated.</p> <p>Review of the resident's after visit summary from the hospital, dated 08/28/24, showed the resident admitted on [DATE] and discharged back to the facility on [DATE].</p> <p>Review of the resident's medical record showed staff did not document providing written bed hold information to the resident, or responsible party, and did not have a copy bed hold provided to the resident, or responsible party, for the discharge/transfer on 08/13/24.</p> <p>During an interview on 09/09/24, at 12:30 P.M., the Licensed Practical Nurse (LPN) C said the following:</p> <ul style="list-style-type: none"> <li>-Social services is responsible for bed holds;</li> <li>-The admission packet contains information about bed holds;</li> <li>-He/she is unsure if a resident needs a copy when discharged /transferred from the facility.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/09/24, at 12:30 P.M., the Assistant Director of Nursing (ADON) said staff should have bed holds signed and a copy made for all transfers.</p> <p>During an interview on 09/06/24, at 9:00 A.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-Nurses should complete and send bed holds with residents when they are transferred;</li> <li>-The social worker should follow up on bed holds;</li> <li>-The social worker should maintain a log with bed holds, but it has not been done;</li> <li>-He/she did not have any recent bed holds for resident.</li> </ul>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41787</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan for all residents when staff failed to complete a baseline care plan with 48 hours of admission one resident (Resident #39). The facility census was 38.</p> <p>Review of the facility's Resident Assessment Policy, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-It is the policy of the facility to conduct and document comprehensive assessments on all residents admitted to the facility;</li> <li>-Comprehensive assessments describe the resident's capability to perform daily life functions and significant impairment in functional capacity;</li> <li>-Comprehensive assessments will commence upon admission or readmission of a resident and be completed no later than 14 days after admission or readmission.</li> </ul> <p>1. Review of Resident #39's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted on [DATE];</li> <li>-Diagnoses included congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic kidney disease stage 4 (CKD - kidneys are damaged and can't filter blood the way they should), chronic respiratory failure (condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), lymphedema (localized swelling of a body part), atrial fibrillation (an irregular and often very rapid heart rate that can lead to blood clots in the heart), and chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe).</li> </ul> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/09/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Resident dependent on staff for toileting hygiene, bathing, dressing, personal hygiene, and transferring.</li> </ul> <p>Review of the resident's electronic medical record showed on 06/03/24, at 5:30 P.M., nursing staff documented the resident arrived from the hospital via wheelchair with oxygen cannisters.</p> <p>Review of the resident's medical record showed staff did not document completion of a baseline or comprehensive care plan located in the resident's record.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/06/24, at 9:15 A.M., Licensed Practical Nurse (LPN) C said that baseline care plans should be done in the first 24 hours after resident admission. Staff can find the care plan in the resident's chart and it should be used to assist with resident care needs.</p> <p>During an interview on 09/06/24, at 11:50 A.M., LPN B said that care plans should be in the residents' charts and accessible for nursing staff after a resident is admitted to the facility.</p> <p>During an interview on 09/06/24, at 1:30 P.M., the Administrator said that baseline care plans should be done within 24 hours of admission and then the comprehensive care plan completed very shortly afterwards.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585</b></p> <p>Based on observation, interview, and record review, the facility failed to have a process in place to ensure the timely and accurate identification of code status (whether a resident wished to receive cardiopulmonary resuscitation (CPR - an emergency treatment that's done when someone's breathing or heartbeat has stopped)) for all residents when staff failed to have physician orders related to code status for three residents (Resident #36, #30, and #3) and when the medical records of two residents (Resident #11 and #26) had conflicting code status information. A sample of 15 residents was selected for review out of a facility census of 38.</p> <p>Review showed the facility did not provide a policy regarding advance directives or code status processes.</p> <p>1. Review of Resident #36's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included Alzheimer's disease and vascular dementia (disease affecting blood vessels in the brain causing changes to memory, thinking, and behavior).</li> <li>-Resident had a code status of do not resuscitate (DNR - the resident did not wish to received CPR if his/her heart stopped or he/she stopped breathing).</li> </ul> <p>Review of the resident's DNR form, dated [DATE], showed the form signed and dated by physician and resident's representative.</p> <p>Review of the resident's care plan, revised on [DATE], showed staff did not care plan related to the resident's choice of code status.</p> <p>Review of resident's [DATE], [DATE], and [DATE], Physician Order Sheet showed no physician order related to the resident's choice of code status.</p> <p>2. Review of Resident #30's face showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Had a responsible party;</li> <li>-Diagnoses included dilated cardiomyopathy (condition where the heart muscle becomes weakened and enlarged), depression, and anxiety disorder;</li> <li>-The resident had a code status of full code (wished to received CPR if his/her heard stopped or he/she stopped breathing).</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Outside Hospital Do Not Resuscitate Order (OHDNR), dated [DATE], showed the form signed and dated by the physician and the resident's representative.</p> <p>Review of the resident's care plan, revised on [DATE], showed staff care planned the resident a DNR code status.</p> <p>Review of resident's [DATE], [DATE], and [DATE], Physician Order Sheet showed no physician order related to the resident's choice of code status.</p> <p>3. Review of Resident #3's face sheet, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included Multiple Sclerosis (MS - central nervous system autoimmune condition), heart disease, and history of stroke.</li> <li>-Code status of DNR.</li> </ul> <p>Review of the resident's care plan, last reviewed [DATE], showed the resident's code status as DNR.</p> <p>Observation of the outside of the resident's paper chart showed an orange sicker of DNR.'</p> <p>Review of the resident's [DATE] physician order sheet (POS) showed the sheet was blank under Code Status with no physician order related to the resident's choice of code status.</p> <p>4. Review of Resident #11's face sheet, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included heart disease, heart failure, type 2 diabetes (when the body has difficulty maintaining the level of sugar in the body), and dementia (a brain disease that causes a range of conditions that cause a loss of mental functioning that affects daily life);</li> <li>-Code status of Full Code - See Advanced Directives.</li> </ul> <p>Review of the resident's OHDNR showed it was signed by the resident's family on [DATE] and signed by the facility physician on [DATE].</p> <p>Review of the resident's care plan, last reviewed [DATE], showed the resident changed his/her mind to be full code in [DATE].</p> <p>Observation of the outside of the resident's paper chart showed a sicker with 'Full Code.'</p> <p>Review of the resident's [DATE] POS showed a current order for DNR.</p> <p>5. Review of Resident #26's face sheet, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses included history of stroke and depression;</p> <p>-Code status of DNR.</p> <p>Review of the resident's OHDNR showed it was signed by the resident on [DATE] and signed by the facility physician on [DATE]. Staff noted at the bottom of the form, on [DATE], said reviewed DNR and remained the same.</p> <p>Review of the resident's care plan, last reviewed [DATE], showed the resident's code status as DNR.</p> <p>Observation of the outside of the resident's paper chart showed an orange sicker with 'DNR.'</p> <p>Review of the resident's [DATE] POS showed a current order of full code.</p> <p>6. During an interview on [DATE], at 12:30 P.M., Nursing Aide (NA) E said the following:</p> <p>-A resident's code status is in the chart;</p> <p>-A sticker on the chart indicated code status;</p> <p>-Charts may have a colored sheet inside that indicated code status.</p> <p>7. During an interview on [DATE], at 12:30 P.M., Licensed Practical Nurse (LPN) C said the following:</p> <p>-Social Services reviewed code status with residents upon admission to facility;</p> <p>-Code status should be included under the advance directive tab in the chart;</p> <p>-A sticker should be placed on front of the chart indicating code status;</p> <p>-Social services would address any changes in code status with resident.</p> <p>8. During an interview on [DATE], at 1:33 P.M., the Director of Nursing (DON) said code status should be in the chart under the advance directive tab. He/she is unsure if it was documented anywhere else.</p> <p>9. During an interview on [DATE], at 2:35 P.M., the Administrator said the following:</p> <p>-The Social Worker is responsible for admission paperwork which included code status;</p> <p>-The social worker and medical records staff worked together to ensure the code status was in the right location;</p> <p>-Code status was reviewed in care plan meetings;</p> <p>-A green or purple sheet located in the front of the chart should indicate code status;</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Code status should be included on the physicians' orders;</p> <p>-A resident's face sheet and physician order should have matching code status.</p> <p>36974</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49585</p> <p>Based on interview and record review, the facility failed to provide care per standards of practice for all residents when staff failed to administer medications as ordered, failed to monitor the resident as ordered, and failed to notify and follow-up with the physician as ordered and in a timely manner for one resident (Resident #23) with edema (fluid retention) resulting in increased edema, weight gain, and an inability of the resident to wear his/her shoes. The facility census was 38.</p> <p>Review showed the facility did not provide a policy related to monitoring of changes in condition.</p> <p>Review of the facility policy, Medication Administration Policy and Procedure, undated, showed the following:</p> <p>-Medications are administered to residents in a safe, efficient, timely manner in accordance with accepted standards of practice and resident's usual preferred routine;</p> <p>-Medications are administered in accordance with the written orders of the attending physician/nurse practitioner.</p> <p>1. Review of Resident #23's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included intracerebral hemorrhage (bleeding into the brain tissue), hemiplegia (paralysis) of left side, seizures, and muscle weakness.</p> <p>Review of the resident's care plan, revised on 06/13/24, showed staff to monitor for and document any edema and notify physician.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) dated [DATE], showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Resident not taking a diuretic (medication to reduce fluid buildup in the body).</p> <p>Review of resident's July 2024 Physician Order Sheet (POS) showed the following:</p> <p>-An order, dated 07/15/24, to check blood pressure daily for one week;</p> <p>-An order, dated 07/15/24, to decrease amlodipine (medication to reduce blood pressure) to 5 milligrams (mg) due to edema.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurse practitioner progress note, dated 07/17/24, showed the resident had +2 pitting edema (swelling that occurs due to excessive fluid buildup and when pressure is applied an indentation, referred to as pitting, remains) to feet bilaterally. New orders to decrease amlodipine to 5 mg daily, monitor and log blood pressure daily, and present to the clinic. Staff to monitor lower extremity edema.</p> <p>Review of the resident's nursing progress note, dated 07/17/24, showed the nurse practitioner did rounds in facility. The resident had been having a lot of fluid on his/her body. Received new order to decrease the blood pressure medication due to it causing of edema and to check blood pressure daily for one week, then report.</p> <p>Review of resident's July 2024 Medication Administration Report (MAR) showed the following:</p> <p>-An order, dated 07/17/24, for amlodipine 5 mg once daily. Staff documented administering the medication as ordered.</p> <p>-An order, dated 07/17/24, for staff to take blood pressure daily for one week then report. Staff documented checking the resident's blood pressure on 07/18/24, 07/19/24, and 07/25/24.</p> <p>Review of resident's July 2024 weight showed a weight of 253.2 pounds.</p> <p>Review of the resident's July 2024 nursing progress notes showed staff made no further entries related to the resident's edema, monitoring of the resident's blood pressure, or notification to the clinic.</p> <p>Review of resident's August 2024 POS showed an order, dated 07/15/24, for amlodipine 5 mg once daily.</p> <p>Review of resident's August 2024 MAR showed the following:</p> <p>-An order, dated 02/09/22, for amlodipine 10 mg once daily. Staff documented administered daily as ordered except on 08/26/24 (twice the ordered amount).</p> <p>Review of resident's August 2024 weight showed a weight of 262.6 pounds (a gain of nine pounds).</p> <p>Review of the resident's physician progress note, dated 08/01/24, showed the resident had +2 pitting edema to feet bilaterally.</p> <p>Review of the resident's nursing progress note, dated 08/18/24, showed the resident was unable to wear shoes. Both lower extremities +4 edema, cool to touch, and unable to feel pedal pulses. Staff faxed information to clinic for further assessment or treatment.</p> <p>Review of the resident's nutrition evaluation, dated 08/23/24, showed the resident had +4 edema.</p> <p>Review of the resident's medical record, dated 08/18/24 to 08/28/24, showed staff did not document contact received from clinic or further monitoring edema.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nursing progress note, dated 08/29/24, showed the nurse practitioner in facility for rounds and resident had a new order for diuretic due to feet and ankles swelling so much.</p> <p>Review of resident's August 2024 POS showed an order, dated 08/29/24, for Lasix (mediation to reduce fluid buildup in the body) 20 mg once daily for a diagnosis of pedal edema.</p> <p>Review of the resident's nursing progress note, dated 08/30/24, showed the resident had order for a diuretic for edema to bilateral lower extremities.</p> <p>Review of resident's September 2024 POS showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 07/15/24, for amlodipine 5 mg once daily;</li> <li>-An order, dated 08/29/24, for Lasix 20 mg once daily for a diagnosis of pedal (foot) edema.</li> </ul> <p>Review of resident's September 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 07/17/24, for amlodipine 5 mg once daily;</li> <li>-An order, dated 08/22/24, for Lasix 20 mg once daily;</li> <li>-Staff documented both as administered daily.</li> </ul> <p>Review of resident's September 2024 weight showed a weight of 267.4 pound (a gain of 5.2 pounds since last weight and a total weight gain of 14.2 pounds).</p> <p>During an interview on 09/06/24, at 10:10 A.M., Nurse Aide (NA) E said the resident's legs have increased swelling. He/she would report that to the nurse, but had not told the nurse yet.</p> <p>During an interview on 09/06/24, at 10:20 A.M., NA D said the resident's legs had been swollen for a couple of months.</p> <p>During an interview on 09/09/24, at 1:00 P.M., Licensed Practical Nurse (LPN) C said if a resident had increased edema, he/she would call the physician, review medications, evaluate feet, obtain a physician order, and monitor intake and output. He/she would expect a response to a fax regarding a resident by the end of the day or he/she would contact physician by telephone.</p> <p>During an interview on 09/09/24, at 1:00 P.M., the Assistant Director of Nursing (ADON) said edema should be included on the care plan. If a resident had +4 pitting edema, he/she would notify the physician, obtain vital signs, and complete an assessment. He/she would call the physician, but if a fax was sent, he/she would expect a response that day or would follow-up with a call.</p> <p>During an interview on 09/09/24, at 1:33 P.M., the Director of Nursing (DON) said the physician should be notified for increased edema. Staff should follow physician orders.</p> <p>MO00238710</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0684	41787
Level of Harm - Actual harm	36974
Residents Affected - Few	50185

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585</b></p> <p>Based on observations, interview, and record review, the facility failed to provide care per standards of practice when the staff failed to document full regular full assessments wounds, failed to update care plans of wounds, failed to notify the physician in a timely manner of new or changing wounds, and failed to ensure physician's orders were followed for all wounds for two residents (Resident #30 and #36). The facility census was 38.</p> <p>Review of the facility policy titled Treatment/Services to Prevent/Heal Pressure Ulcers, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility will ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing;</li> <li>-Pressure sores will be evaluated weekly, and the nurse will document the size, location, odor (if any), drainage (if any), and current treatment order;</li> <li>-Nurse will notify physician anytime the pressure sore is showing signs of nonhealing or infection and request treatment order changes.</li> </ul> <p>Review of the facility policy titled Wound Management, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The admitting nurse will complete an initial wound exam for each wound identified;</li> <li>-The unit manager or supervisor will document wounds on appropriate tracking log;</li> <li>-Unit manager or supervisor will update the log and every Thursday and turn the completed tracking logs to the Director of Nursing, Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument) Department, and dietary department;</li> <li>-Facility provides an outside wound care specialist who visits residents with wounds weekly;</li> <li>-Unit manager or designee will be responsible for completing the wound exam observation form.</li> </ul> <p>1. Review of the Resident #30's face showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included dilated cardiomyopathy (condition where the heart muscle becomes weakened and enlarged), depression, and anxiety disorder.</li> </ul> <p>Review of the resident's care plan, revised on 05/30/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident at risk for skin breakdown;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitor and treat pressure ulcer on coccyx (a small triangular bone at the base of the spinal column) per physician orders;</p> <p>-Monitor and document location, size, and treatment of skin injury;</p> <p>-Report abnormalities, failure to heal, infection, and maceration (softening and breaking down of the skin due to prolonged exposure to moisture) to physician;</p> <p>-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, exudate (drainage), and any other notable changes.</p> <p>Review of the resident's nursing progress note dated 07/02/24, at 12:00 A.M., showed wounds on coccyx and buttocks were raw. Staff applied dressing. (Staff did not document a full assessment of the wound.)</p> <p>Review of the resident's nursing progress note dated 07/02/24, at 8:45 A.M., showed the following:</p> <p>-To the right of coccyx, excoriated (abrasion) area of 7 centimeters (cm) by 3.5 cm by 0.1 cm;</p> <p>-New order received to cleanse open area with saline wound wash, pat dry, apply collagen (medication to promote wound healing) to wound bed and cover with hydro cellular foam dressing.</p> <p>-Change dressing every Tuesday, Thursday and as needed.</p> <p>Review of the resident's July 2024 Physician Order Sheet (POS) showed the following:</p> <p>-An order, dated 07/02/24, to cleanse open area to coccyx with saline wound wash, pat dry, apply collagen to open areas, cover with hydro cellular foam dressing, and change Tuesday, Thursday and as needed.</p> <p>Review of the resident's July 2024 Weekly Skin Integrity Report showed on 07/03/24 staff documented resident had a skin tear to a toe and an open area to the coccyx. Staff noted coccyx excoriated and treatment done. (Staff did not document a full assessment of the wounds.)</p> <p>Review of the resident's July 2024 POS showed an order, dated 07/03/24, to apply triple antibiotic ointment and cover with nonadherent dressing daily for skin tear to right great toe until healed.</p> <p>Review of the resident's nursing progress note dated 07/06/24, at 9:00 A.M., showed resident noted to have necrotic (dead tissue) area on left outer ankle approximately 1 cm by 0.5 cm round, raised nodule like lesion, firm and painful to touch. The resident grimaced and stated it hurt when touched. (Staff did not document physician notification of the new area on the resident's ankle.)</p> <p>Review of resident's July 2024 Weekly Skin Integrity Report showed on 07/10/24 staff documented the resident had skin redness, coccyx had an open area with treatment in place, and a skin tear to the toe. (Staff did not document related to the area on the resident's ankle or a full assessment of each wound area.)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's July 2024 Physician Order Sheet (POS) showed an order, dated 07/11/24, for skin prep to left ankle wound twice daily for seven days and reevaluate for unstageable pressure ulcer (not stageable due to coverage of wound bed by slough (dead tissue usually yellow or cream in color) or eschar (non-viable tissue due to reduced blood supply)). (Order received five days after staff first documented regarding the ankle wound.)</p> <p>Review of the resident's nursing progress note dated 07/16/24, at 2:20 A.M., showed heel protectors in place and treatment to right heel as ordered. (The resident's record did not identify a wound or treatment to the resident's right heel.)</p> <p>Review of resident's July 2024 Weekly Skin Integrity Report showed on 07/17/24 staff documented skin intact. Staff noted resident had rough skin to coccyx and an unstageable pressure ulcer to the left ankle. (Staff did not document a full assessment of the resident's wounds. Staff did not address the area on the resident's right great toe.)</p> <p>Review of resident's July 2024 Treatment Administration Record (TAR) showed the following:</p> <ul style="list-style-type: none"> <li>-Order for skin prep to left lateral ankle shown as completed twice daily 07/11/24 to 07/31/24. (Order's end date was 07/18/24.);</li> <li>-Treatment to right great toe documented as completed as ordered;</li> <li>-Treatment to coccyx documented as completed as ordered.</li> </ul> <p>Review of the resident's nursing progress note dated 07/20/24, at 9:45 A.M., showed treatment to left ankle and coccyx completed. Staff noted no open area, but skin was dark and fragile. (Staff did not document a full assessment of all areas and did not document regarding the resident's right great toe.)</p> <p>Review of the resident's nursing progress note dated 07/21/24, at 1:45 P.M., showed the resident had an open area on the scrotum approximately 2 to 3 cm in size and calmoseptine applied. Staff noted message left for hospice of area and need of treatment order.</p> <p>Review of resident's July Weekly Skin Integrity Report showed on 07/24/24 staff documented redness to buttock and new area to scrotum. (Staff did not document a full assessment of each area and did not address the areas on the resident's toe or ankle.)</p> <p>Review of the resident's medical record showed and facility record's showed the staff did not document of complete wound assessment for the month of July 2024.</p> <p>Review of the resident's July 2024 POS showed staff did not note an order for treatment to new area on the resident's scrotum.</p> <p>Review of the resident's care plan showed staff did not care plan the new skin areas identified in July 2024.</p> <p>Review of the resident's August 2024 POS showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 07/02/24, to cleanse open area to coccyx with saline wound wash, pat dry, apply collagen to open areas, cover with hydro cellular foam dressing and change Tuesday, Thursday and as needed.</p> <p>Review of the resident's nursing progress note dated 08/02/24, at 1:30 P.M., showed the following:</p> <p>-A reddened lesion on right side of the penis with small, raised area;</p> <p>-Left outer ankle red with necrotic areas on top of wound;</p> <p>-Red pressure area on left outer foot;</p> <p>-Heel protectors in place.</p> <p>(Staff did not document a full assessment of each area. Staff did not document physician notification of the new area on the penis. Staff did not address the identified area on the scrotum or great toe.)</p> <p>Review of the resident's nursing progress note dated 08/04/24, at 2:00 P.M., showed staff noted blisters on the resident's right leg from pressure of catheter pressed on leg and penis had blisters on foreskin and redness under foreskin. (Staff did not document a full assessment of each area. Staff did not document physician notification of the identified areas.)</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) dated 08/05/24, showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Has a Foley catheter (a device that drains urine from the bladder into a collection bag) and is incontinent of bowel;</p> <p>-Dependent for transfers and mobility;</p> <p>-Resident had two Stage 2 pressure ulcers (shallow open ulcer with red or pink wound bed);</p> <p>-Resident had one unstageable ulcer;</p> <p>-Had a pressure reducing device to bed.</p> <p>Review of the resident's nursing progress note dated 08/15/24, at 10:45 A.M., showed the following:</p> <p>-Coccyx wound closed. Staff to discontinue order for coccyx treatment and start calmoseptine (moisture barrier for skin) to coccyx twice daily and as needed;</p> <p>-New open area to right buttock 2.0 cm by 0.8 cm by 0.1 cm. Staff to cleanse with saline wound wash and cover with hydro cellular foam dressing every three days and as needed.</p> <p>Review of the resident's August 2024 POS showed the following orders:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 08/15/24, to discontinue previous treatment order to coccyx;</p> <p>-An order, dated 08/15/24, to apply calmoseptine to coccyx twice daily and as needed;</p> <p>-An order, dated 08/15/24, to cleanse wound to right buttocks with wound cleanser of choice, cover with hydrocolloidal dressing every three days and as needed for seven days, then reevaluate;</p> <p>-An order, dated 08/15/24, for skin prep to left ankle wound twice daily and as needed.</p> <p>Review of resident's August 2024 Weekly Skin Integrity Report showed on 08/19/24 resident had an open area to right buttock. (Staff did not document a full assessment of the resident's areas and did not address the ankle wound.)</p> <p>Review of the resident's August 2024 TAR showed the following:</p> <p>-Staff completed the wound to treatment to the right buttock open area on 08/15/24 to 08/16/24, 08/18/24 to 08/25/24, 08/27/24 to 08/30/24. (The original order ended on 08/22/24.);</p> <p>-Staff completed the wound treatment to the coccyx on 08/15/24 to 08/16/24, 08/18/24 to 08/19/24, 08/21/24 to 08/25/24, and 08/28/23 to 08/30/24.</p> <p>-Staff completed skin prep to left lateral ankle twice daily. (The initial order was for 07/11/24 through 07/18/24. The new order began 0815/24.)</p> <p>Review of the resident's medical record and facility records showed the facility did not have documentation of completed wound assessment for the month of August 2024.</p> <p>Review of the resident's care plan showed staff did not care plan the new skin areas identified in August 2024.</p> <p>Review of the resident's September 2024 POS showed the following orders:</p> <p>-An order, dated 07/02/24, to cleanse open area to coccyx with saline wound wash, pat dry, apply collagen to open areas, cover with hydro cellular foam dressing, and change Tuesday, Thursday and as needed.</p> <p>(The POS did not have orders listed for the treatment to right buttocks, calmoseptine to coccyx, or left ankle treatment.)</p> <p>Review of the resident's nursing progress note dated 09/03/24, at 1:24 P.M., showed the resident had stage two pressure ulcer to right buttock measuring 4.3 cm by 3.0 cm x 0.1 cm. Staff completed treatment done that morning and noted slight foul smell and minimal drainage. (Staff did not document notification of the physician of the increased size and foul odor.)</p> <p>Review of the resident's medical record and facility records showed the facility did not have documentation of completed wound assessment for the month of September 2024.</p> <p>Observation on 09/05/24, at 2:15 P.M., showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Licensed Practical Nurse (LPN) B and Registered Nurse (RN) T (hospice) entered the resident's room to provide wound care. The resident rested in bed. The wound on right buttocks noted to be circular in shape with black tissue surrounding the wound bed the upper portion of the wound. The wound bed appeared to be pinkish red in color with a whitish colored covering. RN T reported wound measurements to be 4 cm by 5.5 cm by 1 cm. (an increase in size).</p> <p>During an interview on 09/05/24, at 2:30 P.M., Licensed Practical Nurse (LPN) B said he/she had never provided wound care for resident. He/she would describe the wound as having a white center with black, red, and pink around wound bed. He/she would say that the wound on the right buttocks is stage 1 (non-blanchable redness of the skin) or unstageable, but LPNs are not allowed to stage wounds. Nurses should do skin assessments once per week. The Director of Nursing (DON) is responsible for wound assessments. He/she does not know anything about wound assessments.</p> <p>During an interview at 09/05/24, at 2:45 P.M., RN T said wound on right buttock noted one to two weeks ago and was unstageable. The facility was responsible for resident wound care and he/she monitored wounds.</p> <p>2. Review of Resident #36's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included Alzheimer's disease and vascular dementia (disease affecting blood vessels in the brain causing changes to memory, thinking, and behavior).</p> <p>Review of the resident's care plan, revised on 06/19/24, showed the following:</p> <p>-Resident had potential for pressure ulcer;</p> <p>-Monitor, document, and report any changes in skin status;</p> <p>-Required moderate to maximum staff assistance with bed mobility and transfers;</p> <p>-Require maximum staff assistance with hygiene, toileting, and showers.</p> <p>Review of the resident's July 2024 POS showed an order, dated 05/23/24, for skin assessment, check and record weekly on Thursday.</p> <p>Review of the resident's July 2024 Skin Assessments showed on 07/07/24 staff noted skin intact with redness noted to buttocks. (Staff did not document a full assessment of the areas.)</p> <p>Review of the resident's nursing progress note, dated 07/09/24, showed the resident returned from hospital and had new order for heel.</p> <p>Review of the resident's July 2024 Skin Assessments showed on 07/10/24 staff noted redness to buttocks and heels. (Staff did not document a full assessment of the areas.)</p> <p>Review of the resident's July 2024 POS showed an order, dated 07/11/24, for skin prep to blister on right heel twice daily for seven days, then reevaluate.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's July 2024 Skin Assessments showed on 07/17/24 staff noted blister noted to right heel. (Staff did not document a full assessment of the area.)</p> <p>Review of the resident's nursing progress note, dated 07/18/24, showed right heel dry and measuring 4 cm by 2 cm and new order to continue skin prep to heel until healed.</p> <p>Review of the resident's July 2024 POS showed an order, dated 07/18/24, for skin prep to right heel twice daily until healed.</p> <p>Review of the resident's July 2024 Skin Assessments showed on 07/25/24 staff noted blister on right heel and old open area to right buttocks measuring 0.5 cm by 0.5 cm.</p> <p>Review of resident's wound assessment, dated 07/29/24, showed an unstageable pressure wound to right heel measuring 2 cm by 2.4 cm x 0.1 cm with eschar/slough. (Staff did not document regarding the area on the resident's buttocks.)</p> <p>Review of the resident's nursing progress note, dated 07/29/24, showed resident has an unstageable pressure ulcer to right heel. Skin prep and foam dressing to cover. Wound measured 2 cm by 2.4 cm by 0.1. (Staff did not document regarding the area on the resident's buttocks.)</p> <p>Review of the resident's July 2024 TAR showed the following:</p> <ul style="list-style-type: none"> <li>-Staff documented skin assessments completed weekly;</li> <li>-Staff documented prep to blister on right heel completed twice daily;</li> <li>-Staff documented application of calmoseptine to right buttock three times daily. (The resident's POS did not contain an order for application of calmoseptine.)</li> </ul> <p>Review of the resident's August 2024 POS showed an order, dated 05/23/34, for staff to complete skin assessment, check and record weekly on Thursday.</p> <p>Review of the resident's August 2024 Skin Assessments showed the following:</p> <ul style="list-style-type: none"> <li>-On 08/01/24, staff noted resident skin intact with right heel healed blister with ongoing treatment;</li> <li>-On unknown date, resident had a wound to right heel measuring 7 cm x 2.4 cm with a treatment of skin prep. No further information listed. (Staff did not document a full wound assessment of the wound.)</li> </ul> <p>Review of the resident's medical record showed the resident was out of the facility in the hospital from 08/13/24 to 08/28/24.</p> <p>Review of the resident's nursing progress note, dated 08/28/24, showed resident moaned and grimaced when nurse touched right foot. Necrotic area on right heel with purulent (containing pus) drainage. Nurse changed dressing. (Staff did not document physician notification of pain to right foot, purulent (drainage containing pus) drainage, or necrotic area to heel.)</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician order sheet, dated August 2024, showed an order, dated 08/29/24, for skin prep to right heel twice daily for until healed.</p> <p>Review of resident's August TAR showed the following:</p> <ul style="list-style-type: none"> <li>-Weekly skin assessments not documented for the month;</li> <li>-Skin prep to right heel documented as completed as ordered.</li> </ul> <p>Review of the resident's undated skin assessment for September 2024 showed a right heel wound measuring 1.1 cm by 1.9 cm by 0.1 with treatment applied.</p> <p>Review of the resident's nursing progress note, dated 09/03/24, showed resident treatment completed. Wound measured 1.1 cm by 1.9 cm by 0.1 cm with a foul odor. Staff notified hospice nurse.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment.</li> <li>-Resident is at risk for pressure ulcers;</li> <li>-Resident had no pressure ulcers.</li> </ul> <p>Review of the resident's September 2024 POS showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 05/23/24, for staff to complete skin assessment, check and record weekly on Thursday;</li> <li>-An order, dated 08/29/24, for skin prep to right heel twice daily for until healed;</li> <li>-An order, dated 09/04/24, to discontinue skin prep to right heel;</li> <li>-An order, dated 09/04/24, to cleanse open area on right heel with saline wound wash, pat dry and cover with hydrocellular foam dressing every three days and as needed.</li> </ul> <p>Review of the resident's care plan showed staff did update the care plan with the heel wound.</p> <p>Observation on 09/06/24, at 10:30 A.M., showed resident sat in wheelchair with heel protectors in place. LPN B removed heel protector and sock to show wound to right heel. No bandage was in place and no apparent drainage or odor noted. Wound on right heel was circular in shape with a pink wound bed.</p> <p>3. During an interview on 09/09/24, at 1:00 P.M., Licensed Practical Nurse (LPN) C said the care plan should include any wounds a resident has and be updated with new wounds. The Director of Nursing (DON) is responsible for updating care plans. The nurse aides notify nurses of any skin changes. There is a book at the nurse station that includes weekly wound monitoring. The day shift nurse would do wound assessment and notify the DON for changes. Wound assessments in the wound book are the only assessments done, but nurses may document in progress notes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on 09/09/24, at 1:00 P.M., the Assistant Director of Nursing (ADON) said pressure ulcers should be included on the care plan. The care plan should be updated for a change in status. Nurses should conduct weekly skin assessments. Wound assessment should include description of wound and measurement. Wounds should be assessed weekly. Nurses should notify the physician of wounds.</p> <p>5. During an interview on 09/09/24, at 1:33 P.M., the DON said he/she was responsible for care plans, but had recently started and is still learning about them. Pressure ulcers should be included and updated in the care plan. Nurses should conduct weekly wound and skin assessments. Nurses should notify the physician immediately for wounds that are getting worse. If a wound is not improving in one or two weeks, the nurse should notify physician. Physician orders should be followed.</p> <p>6. During an interview on 9/09/24, at 2:35 P.M., the Administrator said an initial skin assessment should be done upon admission and weekly skin assessments after that. He/she was unsure if skin assessments were completed for all residents. The DON or ADON should make sure weekly skin assessments were completed. If a resident had a wound, staff should document, measure, and describe the wound.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49585</p> <p>Based on interview, observation, and record review, the facility failed to ensure all residents received care to help maintain or improve range of motion (ROM - full movement potential of a joint) when staff failed to ensure an ordered hand split was used to consistently, was monitored, and was care planned for one resident (Resident #23). The facility census was 38.</p> <p>Review showed the facility did not provide a policy related to restorative care or assistive devices.</p> <p>1. Review of Resident #23's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included intracerebral hemorrhage (bleeding into the brain tissue), hemiplegia of left side, seizures, and muscle weakness.</p> <p>Review of the resident's restorative notes and assessments, dated 11/26/22, showed the resident admitted to facility with no contracture and did not use a positioning or support device.</p> <p>Review of the resident's care plan, revised on 06/13/24, showed the following:</p> <p>-Resident had impaired function and required staff assistance with self-care and mobility;</p> <p>-Dependent on two staff with transfer, mobility, dressing, and hygiene.</p> <p>Review of the resident's progress note, dated 07/17/17, showed the Nurse Practitioner (NP) noted the resident was seen for a routine visit. The resident noted to have left hand contracture with tenderness, but no swelling. NP recommended left hand splint for contracture and discomfort.</p> <p>Review of the resident's nursing progress note, dated 07/17/24, showed the Nurse Practitioner ordered a left-hand brace by restorative for a diagnosis of left-hand contracture.</p> <p>Review of the resident's July 2024 Physician Order Sheet (POS) showed an order, dated 07/17/24, for a left-hand brace by restorative for a diagnosis of left-hand contracture.</p> <p>Review of the resident's care plan showed staff did not care plan new order for the use of the left hand brace.</p> <p>Review of the resident's July 2024 Medication Administrator Record (MAR) and Treatment Administration Record (TAR) showed no document order for application or monitoring of a left-hand brace.</p> <p>Review of the resident's restorative notes and assessments showed staff did not document any further progress notes or updates since 11/26/22.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 08/15/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Dependent on staff for transfers, mobility, dressing, and showering;</li> <li>-Resident was not receiving restorative services;</li> <li>-Resident did not use splint or a brace.</li> </ul> <p>Review of the resident's August 2024 POS showed staff did not not an order for the use of a left-hand brace.</p> <p>Review of resident's August 2024 MAR and TAR showed staff did not an order for application or monitoring of left-hand brace.</p> <p>Review of the resident's September 2024 POS showed staff did not document an no order for a left-hand brace.</p> <p>Review of facility's restorative care binder showed staff did not document regarding the resident requiring a brace to the left hand.</p> <p>Observation on 09/04/24, at 1:56 P.M., showed the resident did not have a brace on his/her left hand.</p> <p>Observation on 09/04/24, at 3:50 P.M., showed the resident sat at the nurses' station with a brace sitting on the television stand in resident room.</p> <p>Observation on 09/05/24, at 12:30 P.M., showed the resident wore a brace on his/her left hand.</p> <p>Observation on 09/06/24, at 8:00 A.M., showed the resident rested in bed and a brace located on side table in room.</p> <p>Observation at 09/09/24, at 12:45 P.M., showed the resident sat in a wheelchair at the nurses' station with a brace in place to left hand.</p> <p>During an interview on 09/06/24, at 10:00 A.M., Nurse Aide (NA) E said the restorative aide applies hand braces unless he/she was not there. He/she just followed what was done before when applying braces.</p> <p>During an interview on 09/09/24, at 12:50 P.M., Restorative Aide (RA) G said the resident had an order for a grip splint. Nurses are responsible for assistive device orders. The physician ordered the resident's splint during a visit. There was a restorative book at the nurses' station with any resident changes or splints. He/she placed a paper in-service in the book to instruct aides on what to do for residents. He/she updated the restorative book for new admits or changes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/09/24, at 1:00 P.M., Licensed Practical Nurse (LPN) C said if a resident used a hand brace it should be included on the communication sheet in the restorative book. The brace should be included in the orders and on the TAR. The RA and nurse aides apply braces, but it should be monitored by a nurse.</p> <p>During an interview on 09/09/24, at 12:30 P.M., the Assistant Director of Nursing (ADON) said any restorative needs should be included in the care plan. Any assistive device should have an order and be on the treatment administration record. Nurses should be responsible for checking on the brace and assessing circulation during the day.</p> <p>During an interview on 09/09/24, at 1:33 P.M., the Director of Nursing (DON) said staff should follow physician orders. An order for a brace should be included on the care plan.</p> <p>During an interview on 09/09/24, at 2:35 P.M., the Administrator said the RA would monitor braces and place the information in the communication log. There should be a sign in the report book notifying staff of a device. A device should have an order and be included on the TAR for nurses to monitor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50185</p> <p>Based on observation, interview, and record review, the facility failed to provide incontinence care per nursing standards and in a manner to help prevent possible infection when staff failed to provide complete peri-care and failed to perform proper hand hygiene while providing peri-care for two residents (Resident #12 and #6). The facility census was 38.</p> <p>Review of the manual titled Nurse Assistant in Long Term Care Facility, 2001 Revision Edition, showed staff, when providing incontinent care, should wash the resident from front to back to prevent from spreading fecal matter from the anal area to the urethra (opening to bladder).</p> <p>Review of the facility's policy titled Incontinence Care, undated, showed the following procedure:</p> <ul style="list-style-type: none"> <li>-Wash all soiled skin areas and dry very well, especially between skin folds;</li> <li>-Change linen and apply linen with no wrinkles.</li> </ul> <p>1. Review of Resident #12's face sheet (brief look at resident information) showed the following information:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue) , unspecified mental disorder, functional quadriplegia (is the lack of ability to use one's limbs or to ambulate due to extreme debility or frailty caused by another medical condition), and muscle spasm.</li> </ul> <p>Review of the resident's care plan, last revised on 04/09/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-Assistance from two staff required for toileting;</li> <li>-Observe for incontinent episodes every two hours and provide incontinence care as needed.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 06/05/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Dependent on staff assistance for toileting, personal hygiene, and mobility;</li> <li>-Incontinent of bowel and bladder.</li> </ul> <p>Observation on 09/04/24, at 2:11 P.M., showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Nursing Aide (NA) H and NA D entered the resident's room and donned gloves without performing hand hygiene;</p> <p>-Resident lay in bed, uncovered from the abdomen down;</p> <p>-The resident rolled toward NA D, and NA H cleaned the residents gluteal (buttocks) area with one wipe and several swipes. NA H discarded the wipe.</p> <p>-Without changing gloves or performing hand hygiene NA H placed a new bed pad underneath the resident.</p> <p>-The resident rolled toward NA H and NA D obtained a wipe and cleansed the resident's gluteal area again. Bowel could be seen on the wipe. NA D did several swipes with one wipe, folding the wipe in between swipes;</p> <p>-NA D removed soiled bed pad and adjusted the clean pad without changing his/her gloves or performing hand hygiene;</p> <p>-Neither aide cleansed the resident's genitalia area;</p> <p>-Both aides then grabbed each side of the bed pad and adjusted the resident higher up in bed;</p> <p>-Both aides took off their gloves and covered the resident with his/her blanket;</p> <p>-Both aides exited the room, NA H with the trash. The aides did not perform hand hygiene. No hand hygiene.</p> <p>2. Review of Resident #6's face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included heart failure, vitamin deficiency, hyperlipemia (a condition in which there are high levels of fat particles (lipids) in the blood), and severe protein calorie malnutrition.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following information:</p> <p>-Severe cognitive impairment;</p> <p>-Dependent on staff for toileting, dressing, personal hygiene, and mobility;</p> <p>-Frequently incontinent of bowel and bladder.</p> <p>Review of the resident's care plan, last revised on 07/24/24, showed the following information:</p> <p>-Dependent on staff for toileting;</p> <p>-Staff to check resident every two hours for episodes of incontinence;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff to wash, rinse, and dry perineum (bottom region of the pelvic cavity) and change clothing as needed after incontinence episodes.</p> <p>Observation on 09/04/24, at 2:14 P.M., showed the following:</p> <p>-Certified Nursing Assistant (CNA) I, Nursing Assistant (NA) H, and NA D entered the resident's room;</p> <p>-NA H washed his/her hands in the resident's bathroom, NA H and CNA I did not. CNA I and NA D donned gloves.</p> <p>-The resident laid in bed, while CNA I raised the bed to an appropriate working height;</p> <p>-NA H was ungloved and gathered incontinence care supplies and handed NA D several wipes. NA D cleaned the resident's genital area, down the left side first and then down the middle with one wipe he/she had folded. Staff did not clean the urethral meatus (where urine leave the body);</p> <p>-The resident rolled toward CNA I and NA D obtained the soiled brief from under the resident. Without changing gloves or performing hand hygiene NA D proceeded to cleanse the residents gluteal (buttocks) area. He/she used one wipe with bowel seen on the wipe. NA D folded the wipe and cleansed the resident again. NA D threw the first wipe away and obtained a second wipe, He/she cleansed and folded the second wipe three times with bowel noted each time, before obtaining a third wipe. NA D disposed of the second wipe and obtained the third wipe and cleansed the resident, folded the wipe, and cleansed the resident a final time;</p> <p>-Without performing hand hygiene or changing gloves NA D adjusted the residents bed pad. The resident then rolled toward NA D and CNA I adjusted the resident's bed pad on his/her side. Resident laid back onto his/her back, and was covered with previous linen.</p> <p>3. During an interview on 09/05/24, at 1:27 P.M., Nursing Assistant (NA) E said the following:</p> <p>-Incontinent care should be performed every two hours and as needed;</p> <p>-Proper incontinence care should be done with one wipe per swipe;</p> <p>-Staff should cleanse the area front to back.</p> <p>4. During an interview on 09/06/24, at 12:10 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-Staff should knock on the resident's door, enter the room, and explain the care prior to performing;</p> <p>-Staff should wash their hands, and gather their supplies for the care, such as wipes, linens, and a brief;</p> <p>-Staff should cleanse the residents going front to back;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff should cleanse with one wipe per swipe. He/she would not recommend folding the wipe;</p> <p>-Incontinent care should be performed every two hours and as needed;</p> <p>-Staff should practice appropriate hand hygiene and glove changes during the care.</p> <p>5. During an interview on 09/09/24, at 10:27 A.M., the Director of Nursing (DON) said the following:</p> <p>-She is not sure what the incontinence care procedure is at the facility;</p> <p>-Staff should cleanse the residents going front to back;</p> <p>-It is acceptable to fold the wipes in between swipes, if the wipe is a big enough. If the wipes are small, she recommends one wipe per swipe;</p> <p>-Staff is expected to be toileting and or performing incontinence care every two hours and as needed;</p> <p>-Staff should practice appropriate hand hygiene and glove changes during care.</p> <p>6. During an interview on 09/09/24, at 2:20 P.M., the Administrator said the following:</p> <p>-Staff were expected to perform incontinence care every two hours and as needed;</p> <p>-Staff should cleanse residents going front to back;</p> <p>-Staff should practice appropriate hand hygiene and glove changes during the care.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185</b></p> <p>Based on observation, interview, and record review, the facility to ensure all residents received recommended interventions to help maintain acceptable parameters of nutritional status when staff failed to care plan, notify the physician of, and implement the Registered Dietitian (RD's) recommendations for a dietary supplement for one resident (Resident #33) who had been identified as experiencing some weight loss. The facility census was 38.</p> <p>Review of the facility's policy, titled Dietary Services, undated, showed the following information:</p> <ul style="list-style-type: none"> <li>-Dietary services meet the individual nutritional needs of each resident;</li> <li>-The dietician develops therapeutic diets to meet the specialized need of each resident;</li> <li>-All therapeutic diets are prescribed by the resident's physician and/or his/her designee.</li> </ul> <p>Review showed the facility did not provide a policy regarding documenting, obtaining, and implementing physician orders.</p> <p>1. Review of Resident #33's face sheet (brief look at resident information) showed the following information:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included coronary artery disease (a narrowing or blockage in the coronary arteries, which supply oxygen-rich blood to the heart) , dementia, high blood pressure, and heart disease.</li> </ul> <p>Review of the resident's care plan, last revised on 01/04/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Monitor, document, and report any signs and symptoms of dysphagia (difficulty swallowing);</li> <li>-Monitor, document, and report to the physician any signs and symptoms of malnutrition;</li> <li>-Provide and serve diet as ordered;</li> <li>-RD to evaluate and make diet change recommendations.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 05/08/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Independent with eating and mobility;</li> <li>-No swallowing disorder;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No weight loss or gain of more than five percent in the last six months.</p> <p>Review of the resident's dietary note by the RD, dated 07/17/24, showed the following:</p> <p>-Weight as of July was 187.2 pounds;</p> <p>-Weight loss of 3.4 pounds in 30 days;</p> <p>-Weight loss of 7.2 pounds in 180 days;</p> <p>-The resident remains on hospice services, is a regular diet, attends meals, and has adequate intake. No new orders for labs.</p> <p>-Recommendations include larger servings at meals, encourage intake, and Carnation Instant Breakfast (CIB) daily for weight maintenance.</p> <p>Review of the resident's current care plan showed staff did not care plan the RD's recommendations, including the CIB.</p> <p>Review of the resident's September Physician Order Sheet (POS) showed a current order for a regular diet. The POS did not include an order for the RD's recommended CIB.</p> <p>Observation on 09/04/24, at 12:20 P.M., of the CIB list that the dietary staff had in the kitchen showed the resident was not listed as receiving CIB.</p> <p>Review of the resident's record showed staff did not document follow-up regarding the RD's recommendations, including the CIB.</p> <p>During an interview on 09/05/24, at 1:27 P.M., Nursing Assistant (NA) E said the following:</p> <p>-It is the dietary department's responsibility to know what residents get supplements, such as CIB;</p> <p>-It is the dietary department's responsibility to ensure the residents get dietary supplements;</p> <p>-The dietician is who decides if a resident should be on a dietary supplement;</p> <p>-He/she does not believe that the resident is one who received supplements.</p> <p>During an interview on 09/06/24, at 12:10 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <p>-The dietician comes to the facility on ce a month;</p> <p>-The dietician makes recommendations for the residents and relays that information to the nursing staff;</p> <p>-After the recommendations are relayed, it is the nursing department's responsibility to notify the physician, and document the order into the POS;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she does not believe the resident is one who receives CIB;</p> <p>-The LPN looked at the resident's chart and said he/she saw the recommendation and was not sure why new orders weren't documented;</p> <p>-All staff does chart filing, so the recommendations may have just been overlooked;</p> <p>-Dietary supplements are something that should also be found in the care plan.</p> <p>During an interview on 09/09/24, at 12:23 P.M., the RD said the following:</p> <p>-She comes to the facility on ce a month. At that time the nursing department gives her a list of residents to see;</p> <p>-Her recommendations and dietary progress notes are found in the chart;</p> <p>-She also verbally tells the dietary staff and sends the recommendations to the staff in administration, such as the Administrator and the DON;</p> <p>-She is not sure whose responsibility it was to implement the recommendations;</p> <p>-If it is a recommendation such as a medication, it would be the nursing staff's responsibility to obtain an order from the physician.</p> <p>During an interview on 09/04/24, at 12:20 P.M., and on 09/06/24, at 9:58 A.M., the Dietary Manager said the following:</p> <p>-The CIB list is for dietary staff's use and is found in the kitchen;</p> <p>-Only residents who receive CIB are on the list;</p> <p>-It is the dietary staff's responsibility to ensure the residents who are ordered CIB get it served to them;</p> <p>-There are no other resident's that she is aware of that should be receiving CIB, only the residents on the list;</p> <p>-The RD comes to the facility on ce a month;</p> <p>-When the RD is at the facility, she makes recommendations for dietary supplements. The RD tells the recommendation directly to the dietary staff and the dietary staff begin implementing the supplement;</p> <p>-It is the nursing department's responsibility to notify the physician and get an order.</p> <p>During an interview on 09/09/24, at 10:27 A.M., the Director of Nursing (DON) said the following:</p> <p>-She is not sure when the RD comes or makes new recommendations;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-She is not sure whose responsibility it is to document the recommendations or orders;</p> <p>-She is not aware of any new orders for the resident;</p> <p>-If a new recommendation is given to the nursing staff, she expects them to obtain and order and document it in the POS;</p> <p>-Care plans should include dietary supplements;</p> <p>-It is her responsibility to update the care plans. She would prefer that each department took care of their own part on the care plan.</p> <p>During an interview on 09/09/24, at 2:20 P.M., the Administrator said the following:</p> <p>-Staff are expected to document and implement all new orders in a timely manner;</p> <p>-The care plan should be updated with any new orders in a timely manner.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185</b></p> <p>Based on observation, interview, and record review, the facility failed to provide respiratory care per standards of practice for all residents when staff failed to obtain physician orders for use and care of a Continuous Positive Airway Pressure (CPAP- is a machine that uses mild air pressure to keep breathing airways open while asleep) machine and failed to care plane the use of the CPAP machine for one resident (Resident #15). The facility census was 38.</p> <p>Review of the facility's policy, titled Oxygen Administration, undated, showed staff to check physician's order for liter flow and method of administration.</p> <p>Review of the facility's policy, titled Admission Orders, undated, showed the following information:</p> <ul style="list-style-type: none"> <li>-The facility will have physician orders for the resident's immediate care at the time of a resident's admission;</li> <li>-The admitting nurse will call the attending physician and clarify all orders on admission;</li> <li>-The admitting orders will be transcribed to the admission Physician Order Sheets (POS) once the orders are clarified or entered into the facility electronic medical record;</li> <li>-The POS's will be faxed or transmitted electronically to the pharmacy in a timely manner to ensure receipt of the resident's medications on the next pharmacy delivery.</li> </ul> <p>Review showed the facility did not provide a policy related to CPAP use and procedures.</p> <p>1. Review of the Resident #15 's face sheet (brief first look at resident information) showed the following information:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses include diabetes, high blood pressure, atrial fibrillation (a-fib - irregular heart beat), obesity, and chronic kidney disease.</li> </ul> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 07/28/24, showed the following information:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Substantial to maximum assistance from staff for mobility;</li> <li>-Shortness of breath with exertion;</li> <li>-Non-invasive mechanical ventilator, such as a CPAP.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 09/03/24, at 9:35 A.M., showed the resident had a CPAP machine sitting on his/her bedside table. The resident said he/she used the CPAP machine every night for his/her sleep apnea. The nursing assistants were aware and helped him/her with the set up. He/she wasn't sure of what setting was supposed to be used, or when the staff were put water in the humidifier.</p> <p>Review of the resident's care plan, last revised on 08/09/24, showed staff did not care plan related to CPAP use.</p> <p>Review of the resident's September 2024 Physician's Order Sheet (POS) showed staff did not document an order for the resident use a CPAP or what settings should be used.</p> <p>Review of the resident's September 2024 Medical Administration Record (MAR) and Treatment Administration Record (TAR) showed did not document an order CPAP use or the settings to use.</p> <p>During an interview on 09/05/24, at 1:27 P.M., Nursing Assistant (NA) E said the following:</p> <ul style="list-style-type: none"> <li>-The resident does have a CPAP machine;</li> <li>-He/she was unsure if that required a physician order or should be on the care plan;</li> <li>-The only thing he/she did with the machine, was turn it off in the morning;</li> <li>-He/she didn't know anything about the machine, other than it goes in the resident's nose. He/she had not received any education or direction on the machine.</li> </ul> <p>During an interview on 09/06/24, at 12:10 P.M., Licensed Practical Nurse (LPN) B said the following:</p> <ul style="list-style-type: none"> <li>-The resident does have and use a CPAP machine;</li> <li>-The resident does not have a physician's order for the CPAP machine, but he/she should;</li> <li>-The physician's order should include the diagnosis and what settings the resident required;</li> <li>-There should also be an additional physician's order with directions of when and how to clean the machine, and when and how to fill the humidifier with water;</li> <li>-He/she was not aware of who was currently providing this care for the resident, but all staff should be aware of the CPAP use, as the resident admitted to the facility with it.</li> </ul> <p>During an interview on 09/09/24, at 10:27 A.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-The resident did have and use a CPAP machine;</li> <li>-There should be physician orders for CPAP use and care;</li> <li>-CPAP use and care should be in the care plan;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff wouldn't be aware of how to care for a resident with a CPAP or for the CPAP itself, without a physician's order.</p> <p>During an interview on 09/09/24, at 2:20 P.M., the Administrator said the following:</p> <p>-There should be physician orders for CPAP use and care;</p> <p>-CPAP use and care should be in the care plan.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>41787</p> <p>Based on interview and record review, the facility failed to provide the services of a registered nurse (RN) for at least eight consecutive hours per day seven days per week. The facility census was 37.</p> <p>Review of the facility's policy Nursing Services, undated, showed the following:</p> <p>-It is the policy of the facility to assure that there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being;</p> <p>-Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week;</p> <p>-The Director of Nursing (DON) may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>1. Review of the Monthly Work Schedule, dated July 2024, showed no RN scheduled on 07/07/24, 07/13/24, or 07/27/24.</p> <p>Review of the Monthly Work Schedule, dated August 2024, showed no RN scheduled on 08/04/24, 08/10/24, 08/11/24, 08/17/24, 08/24/24, and 08/25/24.</p> <p>Review of the Monthly Work Schedule, dated September 2024, showed no RN scheduled on 09/06/24 and 09/07/24.</p> <p>During an interview on 09/05/24, at 2:50 P.M., Licensed Practical Nurse (LPN) B said that he/she worked as as needed floor nurse and was IV (intravenous medications) certified. He/she did not know if there was an RN in the facility every day.</p> <p>During an interview on 09/05/24, at 3:00 P.M., Certified Medication Tech (CMT) F said there was always a nurse working, but unsure if there was always a RN available eight hours per day.</p> <p>During an interview on 09/06/24, at 1:30 P.M., the Administrator said that the previous DON did not clock in or out as he/she was salaried. Currently there were two RNs employed by the facility, one was employed to work every other weekend part-time basis.</p> <p>MO00240217</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>41787</p> <p>Based on observation, interview, and record review, the facility failed to ensure eight nurse aides (NA) (NA D, NA E, NA H, NA I, NA K, NA L, NA M, and NA N) of eight sampled NAs completed a certified nurse aide (CNA) training program within four months of employment at the facility as a nurse aide. The facility census was 38.</p> <p>Review of the facility policy, titled CNA Certification Policy, dated 8/22/22, showed the following:</p> <ul style="list-style-type: none"> <li>-This policy was made to ensure the residents' health and safety and to meet the residents' needs;</li> <li>-All nursing assistants shall successfully complete the entire basic course (including passing the final examination) of the nursing assistant training program and be certified within four months of employment;</li> <li>-Nursing assistants who have not successfully completed the nursing assistant training program prior to employment may begin duties as a nursing assistant and may provide direct resident care only if under the direct supervision of a licensed nurse prior to the completion of the seventy-five classroom hours of the training program;</li> <li>-Direct supervision means close contact, where the licensed nurse can respond quickly to the needs of the resident;</li> <li>-The nursing assistant shall not perform any care or services for which he/she has not been trained nor found proficient by a licensed nurse;</li> <li>-Prior to any direct resident contact, all staff will be enrolled in the nursing assistant training program's basic course completing at least sixteen of the required seventy-five hours of instruction training in communication and interpersonal skills; infection control; safety/emergency procedure; promoting residents' independence; and respecting resident rights;</li> <li>-We will conduct an annual in-service/educational meeting for nursing personnel including training in restorative nursing;</li> <li>-A registered nurse or qualified therapist will teach;</li> <li>-The training will include: turning and position for bedridden resident, range of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder retraining and self-care activities of daily living;</li> <li>-A registered nurse shall be responsible for the planning and then assuring the implementation of the in-service education program for nursing personnel.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Review of the facility provided list of NAs and hire dates showed NA N's date of hire was 04/18/19.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA N was certified as a CNA (five years and four months and 21 days from the date of hire).</p> <p>2. Review of the facility provided list of NAs and hire dates showed NA H's date of hire was 05/02/19.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA H was certified as a CNA (five years and four months and 7 days from the date of hire).</p> <p>Observations on 09/04/24, at 3:30 P.M., showed NA H working, providing direct care to residents in the facility.</p> <p>3. Review of the facility provided list of NAs and hire dates showed NA E's date of hire was 10/08/20.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA E was certified as a CNA (three years and eleven months and 1 day from the date of hire).</p> <p>Observations on 09/04/24, at 9:30 A.M., showed NA E working, providing direct care to residents in the facility.</p> <p>Observations on 09/06/24, at 9:30 A.M., showed NA E working, providing direct care to residents in the facility.</p> <p>During an interview on 09/06/24, at 10:20 A.M., NA E said he/she had been employed as a nurse aide for four years at the facility. In that time, he/she had been in the CNA class several times. There was never a date set up to complete the certification class due to various reasons from the facility staff. He/she said that he/she attended all of the classes.</p> <p>4. Review of the facility provided list of NAs and hire dates showed NA K's date of hire was 12/04/20.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA K was certified as a CNA (three years and nine months and 5 days from the date of hire).</p> <p>5. Review of the facility provided list of NAs and hire dates showed NA D's date of hire was 05/09/22.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA D was certified as a CNA (two years and four months from the date of hire).</p> <p>Observations on 09/04/24, at 9:30 A.M., showed NA D working, providing direct care to residents in the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observations on 09/06/24, at 9:30 A.M., showed NA D working, providing direct care to residents in the facility.</p> <p>During an interview on 09/06/24, at 10:40 A.M., NA D said that he/she had been working at the facility as a nurse aide for three years. He/she said that the CNA classes had been restarted about four or five time for various reasons. The last instructor became ill before the he/she could be scheduled for certification testing. He/she said each time he/she had been almost to the point of testing and something occurred. He/she was ready to complete the course and receive the title of CNA.</p> <p>6. Review of the facility provided list of NAs and hire dates showed NA L's date of hire was 07/28/22.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA L was certified as a CNA (two years and one month and 12 days from the date of hire).</p> <p>Observations on 09/04/24, at 3:30 P.M., showed NA L working, providing direct care to residents in the facility.</p> <p>7. Review of the facility provided list of NAs and hire dates showed NA I's date of hire was 08/23/23.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed the NA I had an inactive CNA certificate as of 02/25/22 (one year and 20 days from the date of hire).</p> <p>8. Review of the facility provided list of NAs and hire dates showed NA M's date of hire was 09/21/23.</p> <p>Review of the state agency CNA registry website, on 09/09/24, showed no documentation that NA M was certified as a CNA (eleven months and 17 days from the date of hire).</p> <p>9. During an interview on 09/06/24, at 1:30 P.M., the Administrator said nurse aides should be certified in a timely manner once hired by the facility. The facility had hired an instructor that would begin classes sometime after 09/10/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>41787</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review, the facility failed to post the required daily nurse staffing information that included the name of the facility and the total and actual number of hours worked for each category of licensed and unlicensed staff directly responsible for resident care per shift in a prominent place readily accessible to residents and visitors. The facility census was 38.</p> <p>Review showed the facility did not provide a policy related to posted staffing hours.</p> <p>1. Observation on 09/04/24, at 10:30 A.M., of a posting titled Staff Posting (Staff Scheduled), on a bulletin board at the nurses' station, showed the following:</p> <ul style="list-style-type: none"> <li>-Date 09/04/24;</li> <li>-Census: 37;</li> <li>-Three shifts, 6-2, 2-10, 10-6, with first names of staff working in each position;</li> <li>-Blank line for registered nurse (RN) name, Director of Nursing (DON) name, and Assistant Director of Nursing (ADON) name;</li> <li>-Line for medical records filled in with a staff first name;</li> <li>-The posting was not easily accessible to residents;</li> <li>-The posting did not show the name of the facility and did not show the total or actual number of hours worked.</li> </ul> <p>Observation on 09/05/24, at 2:17 P.M., of a posting titled Staff Posting (Staff Scheduled), on a bulletin board at the nurses' station, showed the following:</p> <ul style="list-style-type: none"> <li>-Date 09/04/24;</li> <li>-Census: 37;</li> <li>-Three shifts, 6-2, 2-10, 10-6, with first names of staff working in each position;</li> <li>-Blank line for RN name, DON name, and ADON name;</li> <li>-Line for medical records filled in with a staff first name;</li> <li>-The posting was not easily accessible to residents;</li> <li>-The posting did not show the name of the facility and did not show the total or actual number of hours worked.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observation on 09/06/24, at 9:00 A.M., of a posting titled Staff Posting (Staff Scheduled), on a bulletin board at the nurses' station, showed the following:</p> <ul style="list-style-type: none"> <li>-Date 09/06/24;</li> <li>-Census: 36;</li> <li>-Three shifts, 6-2, 2-10, 10-6, with first names of staff working in each position;</li> <li>-Blank line for RN name, DON name, ADON name;</li> <li>-Line for medical records filled in with a staff first name;</li> <li>-The posting was not easily accessible to residents;</li> <li>-The posting did not show the name of the facility and did not show the total or actual number of hours worked.</li> </ul> <p>During an interview on 09/06/24, at 9:15 A.M., Licensed Practical Nurse (LPN) B said he/she did not know who was responsible for posting the daily schedule and did not know what information was required on the posting.</p> <p>During an interview on 09/06/24, at 9:21 A.M., the Administrator said that the facility should have a posting that included the total hours worked available for residents and visitors to view.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787</b></p> <p>Based on observation, record review, and interview the facility failed to provide pharmaceutical services to meet the needs of each resident when staff failed to obtain and administer medications as ordered after admission for one resident (Resident #4). The facility also failed to implement an effective system of destroying medications that could not be returned to the pharmacy a timely manner for sixteen residents (Resident #191, #11, #8, #19, #37, #18, #7, #22, #4, #15, #36, #190, #32, #29, #139, and #39) The facility census was 38.</p> <p>1. Review of an facility policy, Medication Administration Policy and Procedure, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-Medications are administered to residents in a safe, efficient, timely manner in accordance with accepted standards of practice and resident's usual preferred routine;</li> <li>-Medications are administered in accordance with the written orders of the attending physician/nurse practitioner;</li> <li>-If a dose of medication is withheld or refused, the dose will be circled on the front of the medication administration record and the explanation will be documented on the back of that record.</li> </ul> <p>Review of Resident #4 face sheet (brief information sheet about the resident) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included paroxysmal atrial fibrillation (fast and irregular heartbeat that last for a short time), hypokalemia (lower than normal potassium in the blood stream) and hypertension (high blood pressure).</li> </ul> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument, completed by facility staff), dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Taking an antiplatelet (medications that prevent platelets from sticking together and forming blood clots).</li> </ul> <p>Review of the resident's care plan, last updated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had impaired cognitive function;</li> <li>-Staff should administer mediations as ordered;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had altered cardiovascular status related to hypertension, severe aortic stenosis (narrowing of the valve in the large blood vessel branching off the heart), atrial fibrillation (an irregular heartbeat), coronary artery disease (damage or disease in the heart's major blood vessels), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs);</p> <p>-Staff should administer cardiac medications per physician orders.</p> <p>Review of the resident's [DATE] Medication Administration Record (MAR) showed the following:</p> <p>-An order for amlodipine (medication used to lower blood pressure) 2.5 milligram (mg) daily. From [DATE] to [DATE], staff initialed and circled each dose indicating it was not administered;</p> <p>-An order for magnesium oxide (medication used to help treat migraine and constipation, reduce blood pressure, improve blood sugar management, or decrease levels of stress and anxiety) 250 mg daily. From [DATE] through [DATE], staff initialed and circled each dose indicating it was not administered;</p> <p>-An order for potassium chloride (medication used to treat or prevent low amounts of potassium in the blood) 10 milliequivalent (meq) daily. From [DATE] through [DATE], staff initialed and circled each dose indicating it was not administered;</p> <p>-On [DATE] through [DATE], staff documented all circled meds not available.</p> <p>Review of the resident's nursing notes showed staff did not document information related to not receiving medications in [DATE] and did not document any notification to the physician regarding medications not available.</p> <p>During an interview on [DATE], at 3:00 P.M., Certified Medication Tech (CMT) F said medications should be administered according to the physicians' orders. If a medication was not available the staff should notify the nurse and sometimes the pharmacy. The resident's medications were not available in [DATE]. He/she notified the nurse. The CMT did not know if the nurse notified the pharmacy or physician</p> <p>During an interview on [DATE], at 12:30 P.M., Licensed Practical Nurse (LPN) B said he/she remembered that the resident's medication was not available in [DATE]. He/she did not know if the doctor was notified and did not remember why the medications were not available. The staff should check the emergency kit (e-kit) if a medication was not available and contact the pharmacy. If the medication would not be available at all, the staff should contact the physician. The resident should not miss nine days of medications without the physician being notified. Staff should have documented a progress note that the physician was aware.</p> <p>During an interview on [DATE], at 1:30 P.M., the Administrator said that residents should be provided medications per the physician orders, including newly admitted residents. If a medication was not available the staff should contact the physician for alternative orders and contact the pharmacy for urgent delivery. A resident should not have to wait nine days for medications.</p> <p>49585</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review showed the facility did not provide a policy regarding the disposal or destruction of medications.</p> <p>3. Observation on [DATE], at 2:00 P.M., of the 100-hall medication room showed a locked cabinet with three baskets inside that included at least 63 medication cards.</p> <p>4. Review of the facility's medication destruction log showed Resident #191's medications waiting to be destroyed for an undocumented reason included the following:</p> <ul style="list-style-type: none"> <li>-Ten tablets of atorvastatin (medication used to lower cholesterol) 20 milligrams (mg);</li> <li>-Ten tablets of bupropion (an antidepressant medication) 300 mg;</li> <li>-Three tablets of folic acid (a vitamin supplement) 1 mg;</li> <li>-Six tablets of olanzapine (used to treat bipolar disorder (a disease that causes episodes of depression, episodes of mania, and other abnormal moods)) 10 mg;</li> <li>-Four tablets of gabapentin (an anticonvulsant (used to treat seizures and nerve pain)) 300 mg;</li> <li>-Three tablets of levothyroxine (a thyroid hormone) 150 mg;</li> <li>-Three tablets of prednisone (a steroid medication (used to decrease inflammation in body)) 10 mg;</li> <li>-Three tablets of Spironolactone (a potassium-sparing diuretic used to treat fluid retention caused by various conditions, including heart, liver, or kidney disease) 25 mg;</li> <li>-A Trelegy inhaler (inhaled steroid (an anti-inflammatory medication)).</li> </ul> <p>5. Review of the facility's medication destruction log showed Resident #11's medications waiting to be destroyed included the following:</p> <ul style="list-style-type: none"> <li>-One expired tablet of fluticasone (a steroid used to decrease inflammation) 50 microgram (mcg);</li> <li>-One discontinued tablet of Januvia (medication to treat diabetes).</li> </ul> <p>6. Review of the facility's medication destruction log showed Resident #8's medications waiting to be destroyed included the following:</p> <ul style="list-style-type: none"> <li>-Sixteen tablets of fluoxetine (an antidepressant) 20 mg.</li> </ul> <p>7. Review of the facility's medication destruction log showed Resident #19's medications waiting to be destroyed due to discontinuation of medication by the physician included the following:</p> <ul style="list-style-type: none"> <li>-Five tablets of oxycodone (an opioid pain medication) 5 mg;</li> <li>-Two tablets of sodium chloride 1 gram (g);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Nineteen tablets of Pravastatin (medication used to lower cholesterol) 20 mg. ,</p> <p>8. Review of the facility's medication destruction log showed Resident #37's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <p>-Five tablets of Lorazepam (an antianxiety medication) 0.5 mg;</p> <p>-Five tablets of Gabapentin 400 mg;</p> <p>-Five tablets of Gabapentin 100 mg;</p> <p>-Nineteen tablets of Folic acid 1 mg;</p> <p>-Two tablets of Lisinopril (blood pressure medication) 20 mg;</p> <p>-Two tablets of Diltiazem (blood pressure medication) 300 mg;</p> <p>-One tablet of escitalopram (an antidepressant) 5 mg;</p> <p>-Eight tablets of olanzapine (an antipsychotic) 5 mg.</p> <p>9. Review of the facility's medication destruction log showed Resident #18's medications waiting to be destroyed included the following:</p> <p>-Fifteen expired tablets of guaifenesin (cough medication) 200 mg.</p> <p>10. Review of the facility's medication destruction log showed Resident #7's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <p>-Twenty-two tablets of Promethazine (an antihistamine) 25 mg.</p> <p>11. Review of the facility's medication destruction log showed Resident #22's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <p>-Twelve tablets of Macrobid (an antibiotic) 100 mg.</p> <p>12. Review of the facility's medication destruction log showed Resident #4's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <p>-Thirty tablets of Trazodone (an antidepressant) 25 mg.</p> <p>13. Review of the facility's medication destruction log showed Resident #15's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <p>-Thirteen tablets of Niacinamide (a vitamin supplement) 500 mg;</p> <p>-Amoxicillin/Clavulanic Acid (an antibiotic) 875 mg - 125 mg.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>14. Review of the facility's medication destruction log showed Resident #36's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <ul style="list-style-type: none"> <li>-Thirty-three tables of Quetiapine (an antipsychotic medication) 25 mg;</li> <li>-Fourteen tablets of Metoprolol (a medication used to lower blood pressure) 25 mg;</li> <li>-Three tablets of Trazodone 50 mg;</li> <li>-Thirty-two tablets of Memantine (medication used to treat Alzheimer's Disease) 10 mg;</li> <li>-Seven tablets of Donepezil (medication used to treat Alzheimer's Disease) 10 mg;</li> <li>-Nine tablets of escitalopram (an antidepressant medication) 20 mg;</li> <li>-Fifty-five tablets of Gabapentin 100 mg;</li> <li>-Thirty-six tablets of hydrocodone-acetaminophen (an opioid pain medication) ,d+[DATE] mg;</li> <li>-Fifty-nine tablets of Clonazepam (a benzodiazepine (medication that produces sedation)) 0.5 mg.</li> </ul> <p>15. Review of the facility's medication destruction log showed Resident #190's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <ul style="list-style-type: none"> <li>-Eighty-three tablets of Fenofibrate (medication used to lower cholesterol) 145 mg;</li> <li>-Thirty-eight tablets of Potassium (a supplement) 10 milliequivalent ((NAME));</li> <li>-Eighty-three tablets of Atorvastatin 10 mg;</li> <li>-Thirty-five tablets of Alprazolam (an antianxiety medication) 0.5 mg;</li> <li>-Fifteen tablets of hydrocodone-acetaminophen ,d+[DATE] mg.</li> </ul> <p>16. Review of the facility's medication destruction log showed Resident #32's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <ul style="list-style-type: none"> <li>-Ninety tablets of Hydralazine (medication to treat high blood pressure) 25 mg;</li> <li>-Four tablets of Amoxicillin (an antibiotic) 875 mg;</li> <li>-Four tablets of Doxycycline (an antibiotic) 100 mg.</li> </ul> <p>17. Review of the facility's medication destruction log showed Resident #29's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <ul style="list-style-type: none"> <li>-Twenty-eight tablets of Amlodipine (medication to treat high blood pressure) 5 mg;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Eight tablets of escitalopram 10 mg;</p> <p>-Five tablets of Amoxicillin/Clavulanic Acid 875 mg - 125 mg;</p> <p>-Atropine (an anticholinergic (used to reduce saliva and treat low heart rate)) 1% eye drops.</p> <p>18. Review of the facility's medication destruction log showed Resident #139's medications waiting to be destroyed due to discontinuation of medication by physician included the following:</p> <p>-Seven tablets of olanzapine 5 mg;</p> <p>-Twenty-five tablets of Magnesium Oxide (mineral supplement) 500 mg;</p> <p>-Fourteen tablets of citalopram (an antidepressant) 20 mg;</p> <p>-Thirty-two tablets of Levothyroxine 88 mcg;</p> <p>-Thirteen tablets of Torsemide (a diuretic (medication to reduce fluid in the body)) 10 mg;</p> <p>-Fifty-five tablets of losartan (mediation to treat high blood pressure) 50 mg;</p> <p>-Sixteen tablets of olanzapine 2.5 mg;</p> <p>-Six tablets of Trazadone 100 mg;</p> <p>-Seventy tablets of Lorazepam 0.5 mg;</p> <p>-Forty tablets of Tramadol (pain medication) 50 mg.</p> <p>19. Review of the facility's medication destruction log showed Resident #39's medications waiting to be destroyed included the following:</p> <p>-118 milliliters of Max Tussin (a cough medication) 200 mg/10 milliliters that expired on [DATE].</p> <p>20. During interviews on [DATE], at 2:00 P.M. and 3:00 P.M., Certified Medication Technician (CMT) F said the following:</p> <p>-Discontinued medications, including narcotics, are placed in a locked cupboard in the medication room;</p> <p>-The CMT completed the mediation destruction record and placed the medication and narcotic sheet in the cupboard;</p> <p>-Nurses date and complete the information on the medication destruction log when medications are destroyed;</p> <p>-He/she does not know schedule, but it has been a month or more since the medications have been destroyed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>21. During an interview on [DATE], at 1:00 P.M., Licensed Practical Nurse (LPN) C said medication should be destroyed within thirty days. Two nurses destroy medications and then sign medication destruction sheet.</p> <p>22. During an interview on [DATE], at 12:00 P.M., the Administrator said two nurses should log number and type of medications destroyed on the medication destruction log. This should be done once a week or monthly. The previous Assistant Director of Nursing and Director of Nursing should have completed this before leaving the facility.</p> <p>.</p> <p>MO00238710</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49585</p> <p>Based on interview and record review, the facility failed to ensure pharmacy consultant recommendations were acted upon for gradual dose reductions (GDR - a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) in an effort to reduce or discontinue psychoactive medications for one resident (Resident #1). The facility also failed to complete monthly drug regimen reviews for three residents (Resident #17, #11, and #26). The facility census was 38.</p> <p>Review of the undated facility policy titled Pharmacy Services - Drug regimen free From Unnecessary Drugs, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The intent of the policy was to ensure each resident's entire medication regimen was managed and monitored to promote or maintain the resident's highest practicable wellbeing;</li> <li>-The facility implements GDRs and non-pharmacological interventions prior to initiating or instead of continuing psychotropic medications;</li> <li>-Residents who use psychotropic drugs receive gradual dose reductions in an effort to discontinue these drugs.</li> </ul> <p>Review of the facility policy titled Pharmacy Services - Drug regimen Review, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The drug regimen of each resident will be reviewed at least monthly by a pharmacist and the pharmacist will report any irregularities to the attending physician, medical director, and the Director of Nursing (DON) and these reports will be acted upon;</li> <li>-Any irregularities noted by the pharmacist will be documented on a separate, written report that is sent to the attending physician, medical director, and DON;</li> <li>-Attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it.</li> </ul> <p>1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included anxiety disorder, depression, schizoaffective disorder (mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms (mood swings ranging from depressive lows to manic highs)), and Alzheimer's disease.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/03/24 showed the following:</p> <ul style="list-style-type: none"> <li>-Resident had moderate cognitive impairment;</li> <li>-No behavior or mood symptoms;</li> <li>-Resident had taken antipsychotic, antianxiety, and antidepressant medications;</li> <li>-No GDR had been attempted;</li> <li>-GDR had not been documented by a physician as being clinically contraindicated.</li> </ul> <p>Review of the resident's August 2024 Physician Order Sheet (POS) showed an order, dated 03/20/24, for risperidone (an antipsychotic medication) 2 milligram (mg) at bedtime.</p> <p>Review of the resident's pharmacy consultation, dated 07/01/24 through 07/18/24, showed pharmacy recommendation for a GDR to decrease risperidone from 2 mg to 1 mg nightly. The physician did not note a response or sign the pharmacy recommendation sheet.</p> <p>Review of the resident's pharmacy consultation, dated 08/01/24 through 08/27/24, showed pharmacy recommendation for a GDR to risperidone. The physician did not note a response or sign the pharmacy recommendation sheet.</p> <p>2. Review of Resident #17's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included unspecified dementia (a brain disease that causes a range of conditions that cause a loss of mental functioning that affects daily life) with behaviors, insomnia, and dizziness.</li> </ul> <p>Review of the resident's Care Plan, last reviewed 02/16/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Agitated behavior related to dementia. Staff to administer medications as ordered;</li> <li>-Potential to be physically aggressive and resistive to cares. Staff to administer medications as ordered;</li> <li>-Potential to be verbally abusive to staff. Staff to administer medications as ordered;</li> <li>-Impaired cognitive function/dementia. Staff to administer medications as ordered;</li> <li>-Use of psychotropic medications. Staff to consult with the pharmacy, physician to consider dosage reduction when clinically appropriate, at least quarterly.</li> </ul> <p>Review of the resident's August 2024 and September 2024 POS showed the following orders:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order, dated 07/01/23, for quetiapine (an antipsychotic medication) 25 mg every morning for agitation;</p> <p>-An order, dated 01/14/24, for quetiapine 50 mg every afternoon for agitation;</p> <p>-An order, dated 05/31/24, for lorazepam intensol (an anti-anxiety medication) 0.25 milliliters (mL) (equal to 0.5 mg) by</p> <p>-An order, dated 07/19/24, for aripiprazole (an antipsychotic medication) 5 mg every morning for behaviors; mouth every hour as needed (no diagnosis given);</p> <p>-The physician failed to sign the POS for August 2024 and September 2024.</p> <p>Review of the resident's August 2024 Medication Administration Record (MAR) show staff administered the following medication:</p> <p>-Aripiprazole 5 mg once a day, every morning, except 08/02/24 and 08/22/24;</p> <p>-Quetiapine 50 mg every afternoon for the entire month;</p> <p>-Quetiapine 25 mg every morning for the entire month;</p> <p>-Lorazepam intensol 0.25 mL (equal to 0.5 mg) was not listed on the resident's MAR for August 2024.</p> <p>Review of the resident's MAR for September 2024 show staff administered the following medication:</p> <p>-Aripiprazole 5 mg once a day, every morning through the review date (09/06/2024);</p> <p>-Quetiapine 25 mg every morning through the review date;</p> <p>-Quetiapine 50 mg every afternoon through the review date;</p> <p>-Lorazepam intensol 0.25 mL (equal to 0.5 mg) was not listed on the resident's MAR for September 2024.</p> <p>Review of the resident medical record showed no documentation of a monthly medication review (MMR) completed by a pharmacist.</p> <p>During an interview on 09/09/24, at 12:50 P.M., the administrator said the facility was unable to find any MMRs for the resident.</p> <p>3. Review of Resident #11's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included heart disease, heart failure, insomnia, unspecified dementia, and anxiety.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's medical records showed no record of MMRs completed by a pharmacist.</p> <p>During an interview on 09/09/24, at 12:50 P.M., the administrator said the facility was unable to find any MMRs for the resident.</p> <p>4. Review of Resident #26's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included arthritis, history of depression, and history of seizures.</p> <p>Review of the resident's medical record showed no record of an MMR completed by a pharmacist for the month of August, 2024.</p> <p>During an interview on 09/09/24, at 12:50 P.M., the administrator said the facility was unable to find a MMRs for the month of August for the resident.</p> <p>5. During an interview on 09/09/24, at 12:30 PM, the Assistant Director of Nursing (ADON) said he/she does not know who is responsible for MMRs or GDRs.</p> <p>6. During an interview on 09/09/24, at 1:00 PM, Licensed Practical Nurse (LPN) C said the Director of Nursing (DON) was responsible for MMRs and physician notification for any GDRs received from pharmacy.</p> <p>7. During an interview on 09/09/24, at 1:33 P.M., the DON said he/she was unsure who is responsible for MMRs and GDRs. He/she could be responsible for this or possibly it is a ADON or medical records responsibility.</p> <p>8. During an interview on 09/09/24, at 2:35 P.M., the Administrator said medications should be reviewed by the pharmacist and physician monthly.</p> <p>36974</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49585</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident #36) was free from unnecessary psychotropic as needed (PRN) medications (medication affecting mind, emotions, and behavior) limited to fourteen days unless evaluated by the physician. The facility also failed to attempt a gradual dose reduction (GDR) for psychotropic medications for one resident (Resident #17). The facility census was 38.</p> <p>1. Review of an undated facility policy Pharmacy Services - Drug Regimen Free From Unnecessary Drugs should the following:</p> <ul style="list-style-type: none"> <li>-PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited;</li> <li>-PRN orders for psychotropic drugs is limited to 14 days.</li> </ul> <p>Review of Resident #36's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included Alzheimer's disease and vascular dementia (disease affecting blood vessels in the brain causing changes to memory, thinking, and behavior).</li> </ul> <p>Review of the resident's significant change in status Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/05/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-No behavioral symptoms.</li> </ul> <p>Review of the resident's care plan, revised on 06/19/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident used psychotropic medications related to paranoia and dementia;</li> <li>-Resident had impaired cognitive function or thought processes;</li> <li>-Staff should monitor psychotropic medications for side effects and effectiveness every shift;</li> <li>-Consult with pharmacy and physician to consider dosage when clinically appropriate;</li> <li>-At risk for falls related to psychotropic drug use.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's July 2024 Physician's Orders Sheet (POS) showed an order, dated 07/09/24, for clonazepam (medication used to treat anxiety disorders) tablet 0.5 milligrams (mg), give one tablet by mouth three times daily as needed for anxiety/agitation. The order did not have an end date listed.</p> <p>Review of the resident's July 2024 Medication Administration Record (MAR) showed the resident received as needed clonazepam a total of 27 times during the month. Clonazepam was given one to three times on 07/10/24, 07/11/24, 07/12/24, 07/13/24, 07/14/24, 07/15/24, 07/16/24, 07/17/24, 07/18/24, 07/19/24, 07/21/24, 07/24/24, 07/25/24, 07/28/24, 07/29/24 and 07/31/24. (The 14th day after the PRN order was written was 07/23/24.)</p> <p>Review of the resident's August 2024 POS showed the following:</p> <ul style="list-style-type: none"> <li>-An order for clonazepam tablet 0.5 mg, give one tablet by mouth three times daily as needed for anxiety/agitation with a discontinue date of 08/07/24 (29 days after the original order was written).</li> <li>-An order, dated 08/28/24, for olanzapine (medication used to treat psychotic disorders) tablet 2.5 mg, one tablet by mouth every eight hours as needed. (The order did not contain a diagnosis or an end date.)</li> </ul> <p>Review of the resident's August 2024 MAR showed the following:</p> <ul style="list-style-type: none"> <li>-The As needed clonazepam was administered a total of seven times during the month on 08/01/24, 08/02/24, 08/04/24, 08/05/24, 08/06/24, and 08/07/24.</li> <li>-Staff did not administer the as needed olanzapine.</li> </ul> <p>2. Review of the facility policy, titled Pharmacy Services - Drug regimen free From Unnecessary Drugs, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The intent of the policy was to ensure each resident's entire medication regimen was managed and monitored to promote or maintain the resident's highest practicable wellbeing;</li> <li>-The facility implements gradual dose reductions (GDRs) and non-pharmacological interventions prior to initiating or instead of continuing psychotropic medications;</li> <li>-Each resident's drug regimen must be free of unnecessary drugs;</li> <li>-An unnecessary drug is any drug used for excessive duration, without adequate monitoring, and in an excessive dose;</li> <li>-Residents who use psychotropic drugs receive GDRs in an effort to discontinue these drugs.</li> </ul> <p>2. Review of Resident #17's face sheet (brief information sheet about the resident) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included unspecified dementia (a brain disease that causes a range of conditions that cause a loss of mental functioning that affects daily life) with behaviors, insomnia, dizziness, and giddiness.</p> <p>Review of the resident's Care Plan, last reviewed 02/16/2024, showed the following:</p> <p>-Resident has agitated behavior related to dementia. Staff to administer medications as ordered;</p> <p>-Resident has potential to be physically aggressive resistive to cares. Staff to administer medications as ordered;</p> <p>-Resident has potential to be verbally abusive to staff. Staff to administer medications as ordered;</p> <p>-Resident has impaired cognitive function/dementia. Staff to administer medications as ordered;</p> <p>-Resident uses psychotropic medications. Staff to consult with the pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly.</p> <p>Review of the resident's August 2024 and September 2024 POS showed the following orders:</p> <p>-An order, dated 07/01/23, for quetiapine (an antipsychotic medication) 25 mg every morning for agitation;</p> <p>-An order, dated 01/14/24, for quetiapine 50 mg every afternoon for agitation;</p> <p>-An order, dated 05/31/24, for lorazepam intensol (an antianxiety medication) 0.25 milliliters (mL) (equal to 0.5 mg) by</p> <p>-An order, dated 07/19/24, for aripiprazole (an antipsychotic medication) 5 mg every morning for behaviors; mouth every hour as needed (no diagnosis given);</p> <p>-The physician failed to sign the POS for August 2024 and September 2024.</p> <p>Review of the resident's August 2024 Medication Administration Record (MAR) show staff administered the following medication:</p> <p>-Aripiprazole 5 mg once a day, every morning, except 08/02/24 and 08/22/24;</p> <p>-Quetiapine 50 mg every afternoon for the entire month;</p> <p>-Quetiapine 25 mg every morning for the entire month;</p> <p>-Lorazepam intensol 0.25 mL (equal to 0.5 mg) was not listed on the resident's MAR for August 2024.</p> <p>Review of the resident's MAR for September 2024 show staff administered the following medication:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Aripiprazole 5 mg once a day, every morning through the review date (09/06/2024);</p> <p>-Quetiapine 25 mg every morning through the review date;</p> <p>-Quetiapine 50 mg every afternoon through the review date;</p> <p>-Lorazepam intensol 0.25 mL (equal to 0.5 mg) was not listed on the resident's MAR for September 2024.</p> <p>Review of the resident's medical record showed staff did not document attempts of a GDR for the quetiapine 25 mg (start date 07/01/23) or quetiapine 50 mg (start date 01/14/24).</p> <p>During an interview on 09/09/24, at 12:50 P.M., the Administrator said the facility was unable to find any GDRs for the resident's</p> <p>3. During an interview on 09/09/24, at 12:30 P.M., the Assistant Director of Nursing (ADON) said GDRs should be completed for psychotropic medications. He/she was unsure who was responsible for medication reviews and GDRs. As needed psychotropic medication orders should be renewed every sixty days or discontinued if not being used.</p> <p>4. During an interview on 09/09/24, at 1:00 P.M., Licensed Practical Nurse (LPN) C said psychotropic as needed medications should have an expiration date. He/she was unsure of the specific time limit they are allowed, but medications should be renewed every quarter.</p> <p>5. During an interview on 09/09/24, at 1:33 P.M., the Director of Nursing (DON) said he/she was unsure if as needed psychotropic medications needed an expiration date.</p> <p>6. During an interview on 09/09/24, at 2:35 P.M., the Administrator said as needed psychotropic medications should have an end date of fourteen days.</p> <p>36974</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>50185</p> <p>Based on interview and record review, the facility failed to employ sufficiently qualified staff when the Director of Food and Nutrition Services (Dietary Manager) did not have required certification and/or experience. The facility census was 38.</p> <p>Review of the facility's policy titled, Dietary Services, undated, showed the following information:</p> <ul style="list-style-type: none"> <li>-The Director of Food Services (Dietary Manager) is designated by the facility administrator as responsible for the total dietetic service. The Dietary Manager receives frequently scheduled consultations from the qualified Dietitian;</li> <li>-Sufficient and competent dietary staff are employed to carry out the functions of the dietary services.</li> </ul> <p>Review showed the facility did not provide a policy regarding what the required qualifications were for a Dietary Manager.</p> <p>1. Review of the facility's employee list showed the Dietary Manager was hired on 09/07/05.</p> <p>Review showed the facility did not provide documentation that the Dietary Manger met the minimum qualifications to serve in the Dietary Manger position.</p> <p>During an interview on 09/06/24, at 9:58 A.M., the Dietary Manager said the following:</p> <ul style="list-style-type: none"> <li>-She had been employed with the facility since 2005;</li> <li>-She was hired for the Dietary Manager position in May of 2024. Prior to that, she was the Activities Director and a nursing assistant;</li> <li>-She has not received any training or certification in food service management.</li> </ul> <p>During an interview on 09/09/24, at 2:20 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-She would expect the Dietary Manager to have some training;</li> <li>-She is aware that a lot of education is needed;</li> <li>-She is working on getting the Dietary Manager into some educational classes;</li> <li>-She has written down the dates and times of the classes offered and plans to get the Dietary Manager enrolled as soon as possible.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50185</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when the facility staff failed to keep food contact and non-food contact surfaces clean; when staff failed to ensure the refrigerators maintained proper temperatures for food storage; when staff failed to ensure stored food was properly stored/sealed; and when staff failed to ensure spoiled or contaminated foods were discarded. The facility census was 38.</p> <p>1. Review of the Food and Drug Administration (FDA) Food Code (2022 edition) showed nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>Review of the facility's policy, titled Dietary Services, undated, showed effective procedures were established for cleaning of all equipment and work areas.</p> <p>Review of the facility's policy, titled Infection Control- Food Services, undated, showed the facility was to store, prepare, distribute, and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of food borne illnesses in accordance with State and Federal regulations.</p> <p>Observations on [DATE], starting at 11:23 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The kitchen floor had debris present;</li> <li>-Stackable containers holding serving utensils showed a yellow greasy residue on the exterior, including handles;</li> <li>-A thick yellow greasy residue on the exterior of the stove and stove top;</li> <li>-Debris and soiled (previously used) cookware sat on top of the stove;</li> <li>-Steam table handles with yellow greasy residue;</li> <li>-Three compartment refrigerator handles were brownish tinged and slick textured to touch.</li> </ul> <p>During an interview on [DATE], at 9:58 A.M., the Dietary Manager (DM) said the following:</p> <ul style="list-style-type: none"> <li>-She has been doing the cleaning in the kitchen. All surfaces are wiped down and floors are mopped daily;</li> <li>-She does not have a cleaning list or assignment sheet.</li> </ul> <p>2. Review of the FDA Food Code (2022 edition) showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized. They may also be passed on by consumers or employees directly, or indirectly from used tableware or food containers.</p> <p>-Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contamination.</p> <p>Review of the facility's policy, titled Dietary Services, undated, showed the following information:</p> <p>-Food is prepared, distributed, and served to residents under sanitary conditions.</p> <p>-Effective procedures are established for cleaning of all equipment and work areas.</p> <p>Review of the facility's policy, titled Infection Control- Food Services, undated, showed the following information:</p> <p>-The facility is to store, prepare, distribute, and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of food borne illnesses in accordance with State and Federal regulations.</p> <p>Observations on [DATE], starting at 11:23 A.M., showed the following:</p> <p>-Debris on the food preparation tables;</p> <p>-A box fan, turned on, and with brown, fuzzy debris blowing toward food preparation tables;</p> <p>-Dietary Aide (DA) P bagged trash and took it outside. He/she came in and rolled out trash bags on top of food prep area, put the bag in a trash can, and then washed his/her hands. The food prep area was not immediately cleaned or sanitized by staff after staff.</p> <p>Observation on [DATE], at 11:16 A.M., during lunch serve-out, showed the following:</p> <p>-Flies landing on kitchen serving items and the steam table;</p> <p>-Doors to the dining room, hallways, dishwashing room, and the outside were open;</p> <p>-Resident preference and diet cards were placed on top of the steam table, above the food. Some had debris on them. Staff touched the diet cards and then put plates (touching the food contact area) on trays before serving to residents;</p> <p>-Cook Q opened debris covered stackable containers with gloved hand and obtained serving utensils and began serving.</p> <p>During an interview on [DATE], at 9:58 A.M., the DM said the following:</p> <p>-She has been doing the cleaning in the kitchen. All surfaces are wiped down and floors are mopped daily. She does not have a cleaning list or assignment sheet;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-She has had heard some concerns about flies in the dining room. Maintenance put up fly strips in kitchen, but none in dining. Kitchen staff will let maintenance know when the fly strip is full. She did not know of any other efforts in the facility to prevent flies.</p> <p>3. Review of the facility's policy, titled Dietary Services, undated, showed the following information:</p> <p>-Food is prepared, distributed, and served to residents under sanitary conditions;</p> <p>-Hot food is served above 140 degrees Fahrenheit (F) and cold food is served below 45 degrees F;</p> <p>-Refrigerator temperature is maintained at 45 degrees F or below.</p> <p>Review of the facility's policy, titled Infection Control- Food Services, undated, showed the following information:</p> <p>-The facility is to store, prepare, distribute, and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of food borne illnesses in accordance with State and Federal regulations;</p> <p>-Temperatures of refrigerators and freezers will be monitored daily and documented. Refrigerator temperatures should be less than 40 degrees F and freezers should be at 0 degrees Fahrenheit, or below;</p> <p>-Food are to be held at appropriate temperatures while being served. Monitoring of food temperatures using a food thermometer should be performed regularly.</p> <p>Observations on [DATE], starting at 11:23 A.M., of the refrigeration and freezer units showed:</p> <p>-A thermometer on the exterior of the three-door refrigerator showed 50 degrees F. The interior thermometer showed 48 degrees F;</p> <p>-Temperature log papers hung on the side of the refrigerators showed staff had not made any temperature entries.</p> <p>Observation on [DATE], during lunch preparation, showed the following:</p> <p>-DA P obtained packaged ham and oven roasted turkey breast from the three-door refrigerator to make sandwiches. The exterior thermometer of the refrigerator read 48 degrees F. The interior thermometer read 51 degrees F.</p> <p>-The refrigerator also contained mayonnaise, uncooked bacon in a wrapper, applesauce, raw eggs, sour cream, cottage cheese, raw lettuce, peppers, and apples;</p> <p>-Temperature checks showed the refrigeration temperature to be 51 degrees F close to the door, 48.5 degrees F in the middle of the refrigerator, and 46.9 degrees F close to where staff stored the ham and oven roasted turkey breast.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation and interview on [DATE], at 4:18 P.M., showed DA R obtained the temperature of the oven roasted turkey breast, ham (deli meat previously used to make sandwiches for residents), and mayonnaise from the three-door refrigerator. The ham was found to be at 41.7 degrees F, turkey at 45.8 degrees F, and mayonnaise at 43.1 degrees F.</p> <p>During an interview on [DATE], at 9:58 A.M., the DM said the following:</p> <ul style="list-style-type: none"> <li>-The three-compartment refrigerator was serviced yesterday, but it still did not maintain an appropriate temperature for cooling foods;</li> <li>-Staff should take the temperature of all food items before serving;</li> <li>-Staff should monitor and log refrigerator temperatures twice a day. Not all staff are recording and monitoring refrigerator temperatures as directed;</li> <li>-An appropriate range for cold storage should be below 40 degrees F, and above 32 degrees F. If any food is outside of those parameters, it should be discarded by kitchen staff;</li> <li>-Appropriate freezer temperature should be 32 degrees F and below.</li> </ul> <p>During an interview on [DATE], at 12:23 P.M., the Registered Dietician (RD) said the following:</p> <ul style="list-style-type: none"> <li>-She expected the temperature range for cold food storage to be between 32 degrees F and 40 degrees F;</li> <li>-If food items were not within the appropriate temperature range, she expected staff to discard those food items;</li> <li>-Staff should take temperatures of food prior to it being served.</li> </ul> <p>During an interview on [DATE], at 4:00 P.M., the Administrator said the following:</p> <ul style="list-style-type: none"> <li>-Foods in cold storage should have a temperature of 45 degrees F and lower;</li> <li>-If a food item is ever outside of the appropriate temperature range, the food should be discarded.</li> </ul> <p>4. Review of the FDA Food Code (2022 edition) showed products which are damaged, spoiled, or otherwise unfit for use may become mistaken for safe and wholesome products and/or cause contamination of other foods, equipment, utensils, linens, or single-service or single-use articles. To preclude this, separate and segregated areas must be designated for storing unsalable goods.</p> <p>Review of the facility's policy, titled Dietary Services, undated, showed food in unlabeled or damaged containers is not accepted or retained.</p> <p>Review of the facility's policy, titled Infection Control- Food Services, undated, showed foods should be properly labeled and expired foods should be discarded.</p> <p>Observations on [DATE], starting at 11:23 A.M., of the refrigeration and freezer units showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The three-door refrigerator contained a package of ham dated [DATE]; a cling-wrapped item that contained an item black and blue with fuzz; two cling-wrapped undated packages of American cheese; cling wrapped undated sliced onion; pork inside a container thawing above a carton of eggs; open, undated containers of yogurt, cottage cheese, and mayonnaise; precooked hamburgers on top level of fridge above fresh vegetables; a jar of cherries dated [DATE], and a bag of undated red-tinged lettuce and celery;</p> <p>-The chest freezer contained an approximately five pound roll of ground beef with cling wrap on one end. The ground beef roll appears to have been thawed and refrozen and was about half the size of other ten pound rolls sealed in original packaging.</p> <p>Observations on [DATE], starting at 11:23 A.M., in the dry goods pantry showed the following:</p> <p>-Serving scoop inside of bulk flour in a two gallon bucket;</p> <p>-Open box of cream of wheat 28 ounce, dated ,d+[DATE], and unsealed;</p> <p>-Open box of cultured dry buttermilk with no date and unsealed.</p> <p>During an interview on [DATE], at 9:58 A.M., the DM said the following:</p> <p>-Once staff has opened a food item, staff should seal and label it with date and time;</p> <p>-Prepared foods should only be kept for seven days and then discarded;</p> <p>-Leftover food (cooked, prepared) items should only be kept for three days and then discarded;</p> <p>-She sometimes lets freezer items half-ways thaw, to where she can cut off the amount that is needed, and then she will place the half not needed, back in the freezer.</p> <p>During an interview on [DATE], at 12:23 P.M., the RD said the all food should be sealed and labeled with a date and time.</p> <p>9. During an interview on [DATE], at 4:00 P.M., the Administrator said previously opened foods should be wrapped and sealed with an open date and time.</p> <p>36974</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787</b></p> <p>Based on interview and record review, the facility failed to maintain all residents' records in a manner that was complete and accurate when the facility failed to document related to changes in conditions for two residents (Resident #39 and #36) that resulted transfers to the hospital. The facility census was 38.</p> <p>Review of facility records showed the facility did not provide a policy related to accuracy of or documentation in resident records, including changes in condition.</p> <p>1. Review of Resident #39's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic kidney disease stage 4 (CKD - kidneys are damaged and can't filter blood the way they should), chronic respiratory failure (condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), lymphedema (localized swelling of a body part), atrial fibrillation (an irregular and often very rapid heart rate that can lead to blood clots in the heart), and chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/09/24, showed the following:</p> <p>-Cognitively intact;</p> <p>-Dependent on staff for toileting hygiene, bathing, dressing, personal hygiene, and transferring.</p> <p>Review of the resident's medication record showed the following:</p> <p>-No care plan located in the resident's record;</p> <p>-No nurses' progress notes related to being transferred to the emergency room ;</p> <p>-No nurses' progress notes related to returning from the emergency room ;</p> <p>-A social service, dated 06/25/24, showed the resident was taken to the emergency room as his/her labs were not good. emergency room staff called around 3:00 P.M. and asked facility to come pick up the resident from ER. The resident was being returned back to facility for compassionate care per his/her request and the Power of Attorney's (POA) request.</p> <p>49585</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #36's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included Alzheimer's disease and vascular dementia (disease affecting blood vessels in the brain causing changes to memory, thinking, and behavior).</li> </ul> <p>Review of the resident's care plan, revised on 06/19/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Required assistance of one staff for transfers, toileting, dressing, and hygiene;</li> <li>-Resident had potential for incontinence of urine;</li> <li>-Resident had impaired cognitive function or thought processes;</li> <li>-At risk for falls related to confusion, incontinence, and psychotropic drug use.</li> </ul> <p>Review of the resident's significant change in status MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-No behavioral symptoms;</li> <li>-No Impairment in range of motion to upper and lower extremities;</li> <li>-Partial to moderate assistance with bed mobility, walking, and transfers;</li> <li>-Uses wheelchair for mobility.</li> </ul> <p>Review of the resident's nursing progress note dated 08/13/24, at 11:25 A.M., showed staff documented resident observed in his/her room resting in bed. Resident combative while vital signs obtained. Resident very confused and hardly opening eyes, but was talking. Staff will continue to monitor.</p> <p>Review of the resident's hospital after visit summary dated 08/28/24, at 10:07 A.M., showed resident admitted on [DATE] to an inpatient psychiatric unit due to a major neurocognitive disorder. Resident discharged back to the skilled nursing facility on 08/28/24.</p> <p>Review of the resident's nursing progress note dated 8/28/24, at 1:30 P.M., showed staff noted resident returned to facility via transport from hospital at 12:10 P.M. Staff faxed physician order sheet to pharmacy and notified clinic notified of resident return and discharge paperwork via fax.</p> <p>Review of the resident's nursing progress notes, dated 08/13/24 to 08/28/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Staff made no further entries prior to admission to hospital;</li> <li>-Staff documented no assessment findings, indication for transfer to hospital, or notification to physician documented.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's August 2024 Physician Order Sheet showed staff did not note an order for transfer of resident to hospital on 08/13/24.</p> <p>3. During an interview on 09/06/24, at 12:30 P.M., Licensed Practical Nurse (LPN) B said that if a resident had a change in condition staff should contact the Director of Nursing (DON), Administrator, physician and family. Staff should follow the physicians' new orders if applicable, should send the resident out if needed. Staff should chart in the progress notes any time a resident is being transferred to the hospital and when returned to the facility including the change of condition or cause of transfer.</p> <p>4. During an interview on 09/09/24, at 1:00 P.M., LPN C said a nurse progress note should include vital signs, notification to family and physician, reason for transfer to hospital, order from physician, and steps taken prior to discharge.</p> <p>5. During an interview on 09/09/24, at 12:30 P.M., the Assistant Director of Nursing (ADON) said nurse documentation for transfer should include resident assessment, time, and type of transport for transfer, and notification to physician and family in nurse progress note.</p> <p>6. During an interview on 09/09/24, at 1:33 P.M., the Director of Nursing (DON) said nurses should document the residents change in condition, why resident is transferring out of the facility, how the resident was transported, and notification to the physician and family.</p> <p>7. During interviews on 09/06/24, at 1:30 P.M., and on 09/09/24, at 2:35 P.M., the Administrator said the charge nurse is responsible for completing transfer and discharge paperwork. The DON should review information to confirm nurses complete it. The nursing staff should document any change in condition and any transfer to and from the hospital in the progress notes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>41787</p> <p>Based on record review and interview, the facility failed to submit payroll based data to the Centers of Medicare and Medicaid Services (CMS) in a timely fashion as required. The facility census was 38.</p> <p>1. Review of the facility's Payroll Based Journal (PBJ) Staffing Data Report, for fiscal year quarter two of 2024 (04/01/24 to 06/30/24), showed the facility triggered for failing to submit data for the quarter.</p> <p>During an interview on 09/06/24, at 9:21 A.M., the Administrator said that she had just started the PBJ for July, August, September. She found it had not been done for a while. She took the administrator position in July. She had completed the report for July, but was unable to go back and enter data for the previous period. She did not know who had been responsible for entering the report.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>36974</p> <p>Based on interview and record review, the facility failed to implement and maintain an effective, comprehensive Quality Assurance and Performance Improvement (QAPI) plan that demonstrated identification, reporting, investigation, analysis, and prevention of adverse events, and documentation that demonstrated the development, implementation, and evaluation of corrective actions or performance improvement activities. The facility census was 38 at the time of survey.</p> <p>Review showed the facility did not provide a policy or procedure related to a comprehensive QAPI Plan.</p> <p>1. Review of facility records showed the following:</p> <ul style="list-style-type: none"> <li>-The facility did not have documentation of Performance-Improvement-Plans (PIP's) or evidence of good-faith attempts to correct identified deficient practices;</li> <li>-The facility did not have a current identified infection preventionist to participate.</li> <li>-The facility did not have documentation of medical director input as part of the QAPI process.</li> </ul> <p>During an interview on 09/09/24, at 12:51 P.M., the Administrator said she was unable to find any policy or procedure for QAPI. The facility was unable to find any documentation of PIPs for any items. For problems identified by QAPI, the facility should follow up with weekly reviews including documentation, measurements, etc. The administrator said she was unable to show weekly reviews had been completed for specific problems identified by QAPI.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>36974</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and interview, the facility failed to maintain documentation of maintaining a functioning Quality Assessment and Assurance (QAA) Committee that met at least quarterly with the required members. The facility census was 38.</p> <p>Review showed the facility did not provide a policy regarding a QAA Committee.</p> <p>1. Review of facility records showed the following:</p> <ul style="list-style-type: none"> <li>-Staff did not have documentation to show a QAA Committee met a minimum quarterly with the required members.</li> <li>-The facility did not currently have an Infection Preventionist to participate in a QAA Committee.</li> <li>-The medical director did not attempt QAA Committee meeting regularly.</li> </ul> <p>During an interview on 09/09/24, at 12:51 PM, the Administrator said they did not have an infection preventionist and she could not determine when the medical director met with the rest of staff, or how often he visited as part of the QAA Committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787</b></p> <p>Based on observation, record review and interview, the facility failed to implement a complete and effective infection control program when staff failed to have a process in place to monitor for Legionella (severe form of pneumonia); failed to cover clean laundry when returning to resident rooms; failed to wear a mask or cover mouth when coughing; failed to use appropriate infection control measures to prevent or reduce the risk of spreading bacteria or other infectious causing contaminants when staff failed to provide a clean barrier for supplies for two residents (Resident #30 and #1); and when the home failed to implement an enhanced barrier precaution (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities) policy. The facility census was 38.</p> <p>1. Review of the facility policy, titled Legionella Policy, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The key to preventing Legionaries' disease was to the reduce the risk of Legionella growth and spread. The facility will do this by maintaining building water systems and implementing controls for Legionella;</li> <li>-Building water systems and devices that might grow and spread Legionella include showerheads and sink faucets; cooling towers; whirlpool tubs; decorative fountains and water features; hot water tanks and heaters; and large complex plumbing systems;</li> <li>-The facility will establish discussion about water management program during Quality Assurance and Performance Improvement (QAPI) meetings quarterly;</li> <li>-Describe the building water systems using text and flow diagrams;</li> <li>-Identify areas where Legionella could grow and spread;</li> <li>-Decide where control measure should be applied and how to monitor them;</li> <li>-Establish ways to intervene when control limits are not met;</li> <li>-Evaluate the program to ensure it is running as designed and is effective;</li> <li>-Document and communicate all activities;</li> <li>-The principles of effect water management include maintaining water temperatures outside the ideal range for Legionella growth, check daily; preventing water stagnation by running water in unused areas every day; and maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella;</li> <li>-Documentation of water temps will occur daily, and the chlorine levels will be done weekly;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Once established, water management programs requires regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met.</p> <p>Review of facility records showed the facility did not provide documentation related to following the facilities Legionella program.</p> <p>During an interview on 09/06/24, at 11:42 A.M., the Maintenance Supervisor said that the previous Director of Nursing (DON) had been responsible for the Legionella program. He did not do any monitoring for Legionella. He did monitor water temperatures and chlorine levels. He had no tracking information related to the Legionella policy.</p> <p>During an interview on 09/06/24, at 1:30 P.M., the Administrator said that she had a call out to previous DON to see if they could find any information about Legionella monitoring. She expected staff to follow the Legionella policy.</p> <p>2. Review of the facility policy, Infection Control - Standard and Transmission-Based Precautions, undated, showed the following:</p> <p>-It was the policy of the facility to ensure that appropriate infection prevention and control measures were taken to prevent the spread of communicable disease and infections in accordance with State and Federal Regulations, and national guidelines;</p> <p>-Staff were to perform respiratory hygiene by coughing and sneezing into arm, sleeve, or tissue;</p> <p>-Hand hygiene was to be performed after discarding soiled tissue or after soiling hands;</p> <p>-Staff that are symptomatic of influenza-like illness were not to provide direct resident care for 7 days after symptom onset or until 24 hours after resolution of symptoms, whichever was longer</p> <p>Observation on 09/06/24, at 11:30 A.M., showed Restorative Aide (RA) G was coughing in hallway. The RA did not wear a mask and did not cover his/her mouth when coughing. The RA told the hospice RN at the nursing desk that he/she had pneumonia and was not contagious. The RA continued working with residents in the dining room without wearing a mask and without covering his/her mouth when coughing.</p> <p>During an interview on 09/06/24, at 1:30 P.M., the Administrator said if a staff member had a cough, she would expect that they cover their mouth when coughing and sanitize hands. Depending on the reason for the cough the staff should be wearing a face mask.</p> <p>3. Review of the facility policy, Infection Control - Linen Management, undated, showed the following:</p> <p>-It was the policy of the facility to ensure linens were handled in a way to prevent cross-contamination and the spread of infection in accordance with State and Federal Regulations, and national guidelines;</p> <p>-Clean linens were to be kept covered and protected from dust and other contaminants prior to use;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Clean linens were not to come in contact with staff clothing (example: carry linens away from the body);</p> <p>-Clean linens should not touch the floor when folded;</p> <p>-Clean and dirty linens areas should be separate and clearly designated;</p> <p>-Only clean linens were transported on clean carts and only dirty linens are transported in containers designated for dirty linens.</p> <p>During an observation and interview on 09/06/24, at 11:56 A.M., Housekeeper A was in the hall with a metal cart with clean resident clothing on hangers with no cover over the clothing. The housekeeper said that when returning clean laundry to resident rooms the cart was not covered. They do cover the dirty laundry when taking out of resident rooms and do cover the clean clothing protectors with a sheet when returning to the dining room. Otherwise, the clean clothing was not covered when leaving the laundry room.</p> <p>During an interview on 09/06/24, at 12:30 P.M., Licensed Practical Nurse (LPN) B said he/she had not seen clean clothing carts covered when returning items to resident rooms.</p> <p>During an interview on 09/06/24, at 1:30 P.M., the Administrator said that she expected staff to cover clean laundry when returning to resident rooms. The housekeeping staff just notified her that this was not the current process.</p> <p>49585</p> <p>4. Review of facility policy Infection Control - Clean Dressing Change, undated, showed the following:</p> <p>-It was the policy of the facility to ensure dressing changes were in accordance with state and federal regulations and national guidelines;</p> <p>-Staff should clean the bedside table with a germicidal cloth and establish a clean field;</p> <p>-Supplies should be set up on a barrier;</p> <p>-Hand hygiene should be performed after supplies are set up, after removing used dressing, after wound is cleansed, and when wound care is complete.</p> <p>5. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included paraplegia (paralysis in the lower half of the body, usually due to a spinal cord injury) and diabetes mellitus.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/03/24 showed the following:</p> <ul style="list-style-type: none"> <li>-Resident had moderate cognitive impairment;</li> <li>-Dependent on staff assistance with dressing, transfers, and bed mobility;</li> <li>-Had one stage two pressure ulcers (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. ).</li> </ul> <p>Review of the resident's August 2024 Physician Order Sheet (POS) showed an order, dated 03/20/23, to cleanse right buttock with wound cleanser and apply skin prep to peri wound (tissue surrounding wound), apply collagen powder (assists with wound healing) once daily, and cover with bordered gauze.</p> <p>Observation of wound care on 09/04/24, at 3:23 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-Licensed Practical Nurse (LPN) O obtained supplies from the treatment cart and entered the resident's room to provide wound care. Nurse Assistant (NA) L was present to assist with positioning resident during wound care.</li> <li>-LPN O placed the wound care supplies including wound cleanser bottle, bandage, medication, and gauze on resident's bedside table (possibly contaminating supplies or resident's table with infectious organisms).</li> </ul> <p>6. Review of Resident #30's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included dilated cardiomyopathy (condition where the heart muscle becomes weakened and enlarged), depression, and anxiety disorder.</li> </ul> <p>Review of the resident's care plan, revised on 05/30/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident at risk for skin breakdown and had a stage two pressure ulcer;</li> <li>-Has a Foley catheter (a device that drains urine from the bladder into a collection bag);</li> <li>-Resident at risk for signs of infection.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Resident has two Stage 2 pressure ulcers;</li> <li>-Resident had one unstageable ulcer (not stageable due to coverage of wound bed by slough (dead tissue usually yellow or cream in color) or eschar (non-viable tissue due to reduced blood supply)).</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's August 2024 POS showed an order, dated 08/15/24, to clean wound to right buttock with wound cleanser of choice, cover with hydrocolloidal dressing every three days and as needed for seven days then reevaluate.</p> <p>Observation on 09/05/24, at 2:15 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-LPN B obtained supplies from the treatment cart and entered the resident's room to provide wound care. Resident's hospice Registered Nurse (RN) T was present during wound care and assisted with positioning resident.</li> <li>-LPN B placed the wound care supplies including wound cleanser bottle, bandage, and gauze on resident's bedside table without a barrier (possibly contaminating supplies or resident's bed with infectious organisms).</li> </ul> <p>7. During an interview on 09/06/24, at 12:30 P.M., the Assistant Director of Nursing (ADON) said was not acceptable to place supplies on a resident's bed.</p> <p>8. During an interview on 09/09/24, at 2:19 P.M., the Administrator said wound care supplies should be placed on a barrier and not on resident beds.</p> <p>9. Review of the Centers for Disease Control's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 07/12/22, showed the following:</p> <ul style="list-style-type: none"> <li>-MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;</li> <li>-EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;</li> <li>-EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status or infection or colonization with an MDRO.</li> <li>-Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care.</li> </ul> <p>10. Review showed the home did not provide a facility policy related to EBP.</p> <p>11. Review of Resident #1's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included paraplegia and diabetes mellitus.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE] showed resident had one stage two pressure ulcer.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's August 2024 POS showed an order, dated 03/20/24, to cleanse right buttock with wound cleanser and apply skin prep to peri wound, apply collagen powder once daily, and cover with bordered gauze.</p> <p>Observation of wound care on 09/04/24, at 3:23 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-LPN O obtained supplies from the treatment cart and entered the resident's room to provide wound care. NA L was present to assist with positioning resident during wound care. LPN O did not sanitize or wash hands and placed gloves on, but did not don a gown. NA L did not don a gown, but did have gloves on. LPN O provided wound care.</li> </ul> <p>12. Review of the resident #30's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included dilated cardiomyopathy, depression, and anxiety disorder.</li> </ul> <p>Review of the resident's care plan, revised on 05/30/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Resident had a stage two pressure ulcer (shallow open ulcer with red or pink wound bed);</li> <li>-Had a Foley catheter;</li> <li>-Resident is at risk for signs of infection;</li> <li>-EBP are in place due to chronic wound and Foley catheter.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Resident has two Stage 2 pressure ulcers;</li> <li>-Resident has one unstageable ulcer.</li> </ul> <p>Review of the resident's August 2024 POS showed an order, dated 08/15/23, to clean wound to right buttock with wound cleanser of choice and cover with hydrocolloidal dressing every three days and as needed for seven days then reevaluate.</p> <p>Observation on 09/05/24, at 2:15 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-LPN B obtained supplies from the treatment cart and entered the resident's room to provide wound care. RN T was present during wound care and assisted with positioning resident, he/she did not don a gown, but placed gloves on. LPN B washed his/her hands and placed gloves on, but did not don a gown. LPN B provided wound care to resident.</li> </ul> <p>Observation on 09/05/24 at 2:15 P.M., showed staff had not placed signage to indicate the resident was was on EBP. There was no PPE cart near the room.</p> <p>13. During an interview on 09/06/24 10:10 A.M., Nurse Aide (NA) E said the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-EBP would include use of barrier creams and turning residents;</p> <p>-He/she would wear gloves if caring for a resident with a Foley catheter or wound, but unsure of any other PPE.</p> <p>14. During an interview on 09/06/24, at 10:20 A.M., NA D said the following:</p> <p>-EBP would include washing hands and changing gloves;</p> <p>-He/she would wear gloves and sometimes a gown if a resident had a wound.</p> <p>15. During an interview on 09/09/24, at 1:55 P.M., CNA S said the following:</p> <p>-EBP are precautions used for infection control;</p> <p>-Residents with catheters, certain infections, and wounds require extra precautions;</p> <p>-EBP requires staff to wear gloves, facial coverings, eye goggles, and to place trash in proper cans.</p> <p>16. During an interview on 09/06/24, at 1:00 P.M., LPN C said EBP are creams that prevent redness due to moisture.</p> <p>17. During an interview on 09/06/24, at 12:30 P.M., the ADON said staff should follow EBP when providing wound care;</p> <p>18. During an interview on 09/09/24, at 1:33 P.M., the DON said EBP are protective creams.</p> <p>19. During an interview on 09/09/24, at 2:19 P.M., the Administrator said the following:</p> <p>-Staff should be following EBP;</p> <p>-Staff probably do not know what EBP are.</p> <p>50185</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787</b></p> <p>Based on interview and record review, the facility failed to implement an effective and complete antibiotic stewardship program when staff failed to track residents on antibiotics for various infections in the facility by not completing a current and ongoing antibiotic log of residents with active infections and failed to care plan antibiotic usage for two residents (Resident #30 and #15). The facility census was 38.</p> <p>Review of the facility's policy, Infection Control - Antibiotic Stewardship, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-It is the policy of the facility to support the judicious use of antibiotics in accordance with State and Federal Regulations, and national guidelines;</li> <li>-The facility will establish protocols for antibiotic prescribing in accordance with national guidelines and treatment protocols;</li> <li>-The facility will establish algorithms for appropriate diagnostic testing (example: obtaining cultures) for specific infections;</li> <li>-The facility will summarize antibiotic use on a quarterly basis and use the data to evaluate adherence to antibiotic prescribing protocols and appropriate diagnostic testing protocols;</li> <li>-The facility will provide an antibiogram annually to medical staff to support prescribing practices;</li> <li>-Prescribers are to document, dose, duration, and indication for all antibiotic prescriptions.</li> </ul> <p>1. Review of the facility provided 3-ring binder that was labeled Infection Control showed the following:</p> <ul style="list-style-type: none"> <li>-One paper titled Antibiotic List, dated July 2024, with ten resident names listed with antibiotic name, directions, why taking, and start and stop dates;</li> <li>-One paper titled Infection Control Log, dated August 2024, with six resident names listed with onset of infection, infection diagnosis, antibiotic name, and date resolved;</li> <li>-Staff did not have other information in the binder. The binder did not include other months or tracking in the binder.</li> </ul> <p>During an interview on 09/06/24, at 8:41 A.M., the Administrator said he/she was used to seeing full tracking with colored maps and details of infections and wounds. This information was not located in the binder.</p> <p>2. Review of Resident #30's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-admitted [DATE];</p> <p>-Diagnoses included intraspinal abscess and granuloma (infection in the spine) and osteomyelitis (infection of the bone).</p> <p>Review of the resident's care plan, revised on 05/30/24, showed resident at risk for infection. Staff did not care plan related to antibiotic therapy.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed facility staff), dated 08/05/24, showed the following:</p> <p>-Severe cognitive impairment;</p> <p>-Resident was on an antibiotic.</p> <p>Review of the resident's September 2024 Physician Order Sheet (POS) showed an order, dated 07/15/25, for doxycycline hyclate (an antibiotic medication) 100 milligrams (mg), take one capsule by mouth twice daily continuously for a diagnosis of intraspinal abscess and granuloma.</p> <p>Review of the facility's Infection Control Log, dated August 2024, showed staff did not have the resident on the list.</p> <p>Review of the facility's Infection List, dated July 2024, showed staff did not have the resident on the list.</p> <p>During an interview on 09/06/24, at 9:20 A.M. the Registered Nurse (RN) T (hospice) said the resident was on antibiotics for spinal abscess and osteomyelitis. The resident was taken off the antibiotic at one time, but placed back on it due to an increase in abscesses. The physician ordered the antibiotic for prophylactic (to prevent infection) indications.</p> <p>3. Review of Resident #15's face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included orthopedic aftercare following surgical amputation, diabetes, osteomyelitis (infection of the bone) of the ankle and foot, and chronic kidney disease.</p> <p>Review of the resident's admission MDS, dated [DATE], showed the following information:</p> <p>-Cognitively intact;</p> <p>-Major orthopedic surgery;</p> <p>-Receives surgical wound care;</p> <p>-Not on antibiotic therapy;</p> <p>-No intravenous (IV- existing, taking place, or administered into a vein) site.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the resident's care plan, last revised on 08/09/24, showed pain related to osteomyelitis and amputation of both big toes. (Staff did not care plan related to antibiotic therapy.)</p> <p>Review of the resident's September 2023 Physician Order Sheet (POS) showed the following :</p> <ul style="list-style-type: none"> <li>-An active order for Cefepime (a cephalosporin antibiotic used in the treatment of infections caused by susceptible bacteria) 2 grams (gm) via IV every 24 hours;</li> <li>-An active order for ciprofloxacin (a fluoroquinolones group antibiotic that treats bacterial infections) 500 milligrams (mg) by mouth two times a day;</li> <li>-An active order for daptomycin (a cyclin lipopeptide antibiotic derived from the organism streptomyces roseosporus, which treats bacterial infections caused by gram-positive bacteria) 800 mg via IV every 24 hours;</li> <li>-Flush IV port with 10 milliliters (ml) of normal saline before and after infusing antibiotics, two times a day;</li> </ul> <p>Review of the resident's September 2024 Medication Administration Record (MAR) showed the resident received all three antibiotics at the appropriate times for 09/01/24 to 09/05/24.</p> <p>During an interview on 09/03/24, at 2:32 P.M., the resident said he/she is currently and had been on antibiotic therapy for a foot infection.</p> <p>4. During an interview on 09/04/24, at 3:35 P.M., Licensed Practical Nurse (LPN) C said that he/she had not taken the infection preventionist course and was not tracking antibiotic stewardship. The previous Director of Nursing was in charge of the antibiotic stewardship program and when the previous DON left, LPN B had started the process before working only as needed shifts. LPN C said he/she did not know of any staff nurse working on antibiotic stewardship or infection prevention.</p> <p>5. During interviews on 09/06/24, at 12:10 P.M. and 12:30 P.M., LPN B said the following:</p> <ul style="list-style-type: none"> <li>-He/she was not in charge of antibiotic stewardship and did not know which staff was responsible;</li> <li>-If a resident was on antibiotics, they should be on the tracking/monitoring list;</li> <li>-He/she used to be responsible for the antibiotic stewardship program, until July 2024 when his/her role changed;</li> <li>-After a resident finishes the antibiotic course, the nurses will document a 72-hour post monitoring in the nurses notes;</li> <li>-Antibiotic use should be found in the care plan as well.</li> </ul> <p>6. During an interview on 09/06/24, at 10:27 A.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-She was not aware the antibiotic tracking wasn't being completed;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-She was not sure if the tracking sheet was the same thing as the antibiotic stewardship program. She is not responsible for it, the new Assistant Director of Nursing will be;</p> <p>-Antibiotic use should be found in the care plan as well.</p> <p>7. During interviews on 09/04/24, at 11:30 A.M., on 09/06/24, at 1:30 P.M., and on 09/09/23. at 2:20 P.M., the Administrator said the following:</p> <p>-She did not know which staff was responsible antibiotic stewardship at the time;</p> <p>-The nursing staff should be monitoring and tracking antibiotics, infections, and wounds;</p> <p>-She had taken the infection preventionist course but had not taken the test;</p> <p>-If a resident was on antibiotics, she expected it to be monitored, tracked, and documented on;</p> <p>-Antibiotic use should be found in the care plan as well.</p> <p>49585</p> <p>50185</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265843	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Appleton City Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>41787</p> <p>Based on record review and interview, the facility failed to have a designated certified staff person as the infection preventionist (IP) who was responsible for the facility's infection prevention and control program (ICPC). The facility census was 38.</p> <p>Review showed the facility did not provide a policy related to the infection preventionist position.</p> <p>1. During an interview on 09/04/24, at 11:30 A.M., the Administrator said she was unsure who was monitoring infections. She had taken the infection preventionist course, but had not taken the test. She thought possibly Licensed Practical Nurse (LPN) C was monitoring infections.</p> <p>During an interview on 09/04/24, at 3:35 P.M., LPN C said that he/she did not have infection preventionist certification and was not tracking infections. He/she said that the previous Director of Nursing (DON) and the previous Assistant Director of Nursing (ADON) had been monitoring the process. He/she did not know of any staff nurse in charge of infection prevention.</p> <p>During an interview on 09/06/24, at 11:50 A.M., LPN B said that he/she did not have an infection preventionist certificate and was not monitoring any infection program.</p> <p>During an interview on 09/06/24, at 1:30 P.M., the Administrator said that there should be a staff member responsible for monitoring and tracking antibiotics, infections, and wounds.</p>