STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265853	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joplin Gardens	2810 South Jackson Avenue Joplin, MO 64804

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - mandated federal assessment completed by facility staff) assessment was accurate and complete for one resident (Resident #24) of 22 residents whose MDS were reviewed. Review of the Resident Assessment Instrument manual, version 1.19.1, dated October 2023, showed the following: -The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status; -In addition, an accurate assessment required collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, and/or other legally authorized representative, or significant other as appropriate or acceptable. 1. Review of Resident #24's Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), showed the following: -admitted [DATE]; -Diagnoses included heart failure, kidney disease, and a stroke. Review of the resident's quarterly MDS, located in the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 05/21/24, showed staff did not assess the resident in the following care areas: -Section C: Cognitive Patterns; -Section D: Mood; -Section E: Behaviors. During an interview on 08/22/24, at 10:36 A.M., the Social Services Director (SSD) said he/she was responsible for coding Sections C, D, and E on the MDS assessments. The SSD said she was unsure why those areas were no coded and thought maybe he/she had been out that week. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/24, at 10:26 A.M., the MDS Coordinator (MDSC) said he/she did not know why he/she did not code the missing sections. He/she did sign off on the assessment as complete.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to provide care per standards of practice when staff failed to document and follow physician's orders related to blood sugar tests for one of one resident (Resident #23) reviewed for insulin use out of a total sample of 22. 1. Review of Resident #23's Face Sheet,' located in the 'Face Sheet tab of the EMR, showed the following: -admitted [DATE]; -Diagnoses included diabetes and bilateral (both sides) shoulder fractures. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), located in the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 07/11/24, showed the following: -Cognitively intact for daily decision-making' -Administered insulin on six out seven days during the observation period. Review of the resident's Physician Orders, located under the Orders tab of the EMR, showed an order for the resident's blood sugar level to be checked before meals. Review of the resident's nursing Progress Notes, dated 08/01/24 at 12:46 P.M., and located in the 'Progress Notes tab of the EMR, showed the following: -Licensed Practical Nurse (LPN) #2 documented blood sugar at approximately 12:40 P.M. read 468 milligrams/deciliter (mg/dL). Nurse retook blood sugar on opposite hand with a reading 449 mg/dL. -LPN contacted the physician and received orders to administer 7 units of insulin and recheck blood sugar level in three three hours at 4:00 P.M. Staff to call if the resident's blood glucose level measured over 300 mg/dL. Review of the resident's Progress Notes and Orders tab of the EMR showed no documentation LPN #2 obtained the resident's blood sugar level at 4:00 PM. There was no documentation that the physician was notified of any results. There was no documentation the resident received any insulin. There was no documentation LPN #2 communicated with other nursing staff responsible for the resident's care. Review of the resident's nursing Progress Notes, located in the Progress Notes tab of the EMR and dated 08/01/24 at 10:19 PM, showed LPN #4 documented recheck resident blood sugar this time measured 371 mg/dL. The LPN notified the physician and received orders to administer 4 units of Humalog (short-acting insulin) per resident sliding scale. The nurse administered insulin. The LPN did not document why the resident's blood sugar was checked at this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24, at 9:32 A.M., the resident said his/her sugars have been over 200 mg/dL since he/she has been at the facility. There was one time it was over 400 mg/dL. During an interview on 08/23/24, at 8:13 A.M., LPN #8 said there was no documention of the resident's blood sugaring being obtained on 08/01/23, at 4:00 P.M. The LPN said if it was not documented, then the blood sugar was not done as ordered. During an interview on 08/23/24, at 9:38 A.M., LPN #2 said at 4:17 P.M., the resident's blood sugar level was 330 mg/dL and he/she notified the physician. The physician gave an order to administer five units of insulin plus the resident's sliding scale insulin to equal eight units of insulin. He/she was supposed to recheck the resident's blood sugar in one hour and call the physician if it was over 300. Dinner had been served late, so she gave the resident the insulin at 5:30 P.M. He/she should have documented the physician order, but forgot to. He/she remembered at 8:30 P.M., called LPN #4, and told him/her to get the blood sugar and call the physician if it was over 300. LPN #2 said he/she failed to document the blood sugar and write a nursing Progress Note regarding the phone call with the physician and write the order. During an interview on 08/23/24, at 12:25 P.M., the Director of Nursing (DON) said physician orders, blood sugar checks, and communication between staff in regard to the resident's blood sugar levels should have been documented in the EMR as an order, a progress note written, and it should be reported to the next nurse at shift change.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on record review and interview, the facility failed to ensure an environment as free of hazards of possible when staff failed to transfer one resident (Resident #38), of 22 sample residents, with two staff members as care planned when using the mechanical lift (Hoyer Lift). 1. Review of Resident #38's Face Sheet, located in the electronic medical record (EMR) under the Resident tab, showed the following: -admitted [DATE]; -Diagnoses included of type II diabetes mellitus with diabetic neuropathy (causes weakness, numbness and pain, usually in the hands and feet), cerebral infarction (stroke), and acquired absence of left leg below the knee (BKA). Review of the resident's comprehensive care plan, initiated 07/14/21, located under the RAI tab in the EMR, showed an identified problem as required assistance of 2+ people for mobility and transfers/Hoyer lift to wheelchair and toilet. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), with an assessment reference date (ARD) of 04/04/24, showed the resident was cognitively intact. Review of the Incident Report provided by the Administrator showed the following: -On 08/09/24, at 12:52 A.M., called to resident room by Certified Nurse Aide (CNA). The resident's right great toenail was bleeding and slightly pulled back from nail bed. The CNA reported it happened during transfer via Hoyer lift. It was hit and then started bleeding. -Resident is diabetic and will need close monitoring for the wound. Area cleaned with pure and clean, wrapped with gauze, and taped. New order placed. Wound nurse will assess and adjust treatment as necessary. Resident denied pain. Review of the resident's Progress Notes, located in the EMR under the Resident tab, showed the following: -On 08/09/24, 12:52 A.M., called to resident room by CNA. The resident's right great toenail bleeding and slightly pulled back from nailbed. CNA reported it happened during transfer via Hoyer lift. It was hit and then started bleeding. The resident is diabetic and will need close monitoring for the wound. Staff cleaned the area with pure and clean, wrapped with gauze, and taped. New order placed. Wound will nurse assess and adjust treatment, as necessary. Resident denied pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/09/24, 10:40 A.M., nurse notified that resident toenail had been bumped and was bleeding. Upon assessment the bottom of the toenail has a small open area between toenail and cuticle, the toenail is intact at this time. No sign/symptom of infection noted. Orders placed. Staff will monitor daily and discontinue when healed. -On 08/11/24, at 9:24 P.M., reassessed resident's great toe for signs and symptoms of infection. No signs noted with no increased warmth, no redness, and no pain noted. Resident requested prophylactic antibiotic due to previous difficulties with wounds to his left foot and is requested an urgent podiatry appointment; -On 08/10/24, at 9:21 P.M., recorded as late entry on 08/11/24, at 9:24 P.M., resident requested that this nurse look under bandage to right great toe while administering bedtime insulin. When removing bandage, noted toenail to be disconnected from nail bed except small amount of tissue in inner aspect of nail bed. No new bleeding, no signs/symptoms of infection noted, and no redness or pain noted. Staff reapplied bandage. -On 08/12/24, 5:50 P.M., Nurse Practitioner (NP) rounded on resident and gave new orders for Keflex (antibiotic) 500 mg (milligrams) PO (by mouth) BID (twice a day) for five days for pulled away toenail. Staff entered orders entered in the electronic medical record. Staff updated resident on treatment plan during rounds. During an interview on 08/20/24, at 4:15 P.M., the resident said CNA #2 bumped his/her foot into the wall and he/she is now losing the nail. The CNA had the resident on the crane (mechanical lift) by him/herself. During an interview on 08/22/24, at 4:20 A.M., CNA 5 said there are five mechanical lifts on the resident's. The CNAs we always help each other with the lifts. If the float CNA isn't available, the nurse will help. Staff safely transfer the resident with only one person. During an interview with CNA #2, on 08/23/24 at 8:48 A.M., the CNA confirmed that he/she was the CNA transferring the resident with the Hoyer lift at the time of the incident. The resident hit his/her toe on the doorframe. The CNA #2 declined to respond when asked if he/she was transferred the resident by him/herself, or if a Hoyer lift required two staff members to use. During an interview on 08/23/24, at 8:58 A.M., the Director of Nurses (DON) said the Hoyer lift has to be two people. CNA #2 did not have another staff with him/her during the transfer. The DON confirmed there was no identification of a second staff person noted on the incident report, nor was there an identification of a second staff person noted in the progress notes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32513 Based on observation, interview, and record review, the facility failed to ensure insulin pens were dated when opened for seven of 13 residents (Residents #8, #53, #49, #33, #55, #34, and #11) who were administered insulin in the facility. The facility failed also failed to ensure five vials of influenza vaccines were not expired in two of two medication rooms. Review of an undated facility policy titled, Labeling Drugs and Medications, showed all drugs and biologicals must be properly labeled and legible at all times. Review of an undated facility policy titled, Medications, Storage of, showed no discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing pharmacy or destroyed in accordance with established guidelines. 1. Observation and interview on 08/21/24, at 1:36 P.M., of the Magnolia medication room with Licensed Practical Nurse (LPN) #6 showed two boxes containing vials of influenza vaccine that were noted to have an expiration date of 06/30/24. LPN #6 confirmed that the vials were expired and should have been removed from the refrigerator. Observation and interview on 08/22/24, at 4:50 A.M., of the Dogwood/Willow medication room with LPN #5 showed three boxes containing vials of influenza vaccine that were noted to have an expiration date of 06/30/24 on the box. LPN #5 confirmed that the vials were expired and should have been removed from the refrigerator. On 08/21/24, at 1:53 P.M., the Administrator said the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and the unit nurses were responsible for ensuring expired medications were properly disposed of. 2. Observation and interview of the Dogwood medication cart on 08/22/24, at 4:43 A.M., with LPN #5 showed the following: -An opened and undated Novolin R Flex Pen for Resident #8; -An opened and undated Degludec insulin pen and Ozempic flex pen for Resident #53; -An opened and undated Novolog insulin pen and Tresiba insulin pen for Resident #49. -LPN #5 confirmed all the insulin pens and the Ozempic were open and undated. The LPN said the pens should have been dated with an open date. Observation and interview of the [NAME] medication cart on 08/22/24, at 4:57 A.M., with LPN #1 showed the following: -An opened and undated Humalog insulin pen for Resident #33; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An opened and undated Degludec insulin pen for Resident #55; -An opened and undated Novolog insulin pen for Resident #34; -An opened and undated Novolog insulin pen for Resident #11; -LPN #1 confirmed that the insulin pens had been opened and should have been dated when opened on the label. During an interview on 08/22/24, at 7:53 A.M., the Director of Nursing (DON) said the nurses were responsible for ensuring insulin pens were dated with open dates.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 11599 Based on observation, interview, and record review, the facility failed to maintain food at a palatable temperature on one of three halls (300 hall) when six on the hall (Residents #17, #18, #21, #29, #33, and #38) complained of cold food on the hall of 27 residents. Review of the facility's policy titled Food Temperatures, dated May 2015, showed the following guidance: -Temperatures of hot foods should be maintained at no less than 140.0 degrees Fahrenheit (F) during meal service; -Hot food should be at least 120 degrees F when served to the resident. 1. Review of Resident #21's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an Assessment Reference Date (ARD) of 05/07/24, showed the resident was moderately cognitively impaired. During an interview on 08/20/24, at 11:41 A.M., the resident said most times the food is adequate, but it can be cold. He/she ate his/her meals in the dining room. 2. Review of Resident #18's quarterly MDS, with an ARD of 06/12/24, showed the resident was moderately cognitively impaired. During an interview on 08/20/24, at 1:40 P.M., the resident said the food is often cold which doesn't make sense since the kitchen is right there. The resident said he/she ate his/her meals in the dining room. 3. Review of Resident #29's re-entry MDS, with an ARD of 07/08/24, showed the resident was severely cognitively impaired. During an interview on 08/20/24, at 4:06 P.M., the resident, along with his/her family member said the food was cold. The resident received meals in his/her room and was often assisted by family member. 4. Review of Resident #38's quarterly MDS, with an ARD of 04/04/24, showed the resident was cognitively intact. During an interview on 08/20/24, at 4:19 P.M., the resident said the food is cold and he/she ate meals both in the dining room and in his/her room. 5. Review of Resident #33's quarterly MDS, with an ARD of 05/16/24, showed the resident was cognitively intact. During an interview on 08/20/24, at 4:25 P.M., the resident said the food can be cold sometimes and he/she ate his/her meals in the dining room at the table right next to the serving window. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #17's quarterly MDS, with an ARD of 06/20/24, showed the resident was cognitively intact. During an interview on 08/20/24, at 5:03 P.M., the resident said he/she did not understand how the food could get cold from the kitchen directly to the table. The resident said he/she ate his/her meals in the dining room and in his/her room. 8. During a group interview on 08/22/24, at 9:00 A.M., with six residents (Resident #1, #18, #19, #21, #34, and #50), chosen by the facility as alert and oriented and regularly attended the monthly Resident Council meetings, the residents said the food was served cold on the 100 and 300 halls. 9. During an interview and record review on 08/23/24, at 11:10 A.M., the Dietary Manager (DM) said three insulated carts leave the kitchen at the same time for the 100, 200, and 300 hall kitchenettes. The dietary staff member who was to serve the meal transports the cart. The food temperatures are taken prior to placing the food in the food carts and on the steam table prior to meal service on each unit. Review of the food temperature logs showed appropriate temperatures from the kitchen. 10. During observation and test tray of the 300 hall meal service on 08/23/24, at 11:50 A.M., showed 13 residents seated in the dining room. The steam table was observed on and lids covered two steam table wells (one contained fish fillets and one contained onion rings). A container of coleslaw was observed on an ice bath. Food temperatures of the hot food were taken by the dietary staff member and measured 135.0 degrees F. After all the resident meals had been served in the dining room and resident rooms, a test tray was obtained and the DM took the food temperatures at 12:30 P.M. The fried fish fillet with cream sauce was 103.0 degrees F. The fish was cold and unpalatable when tasted. The onion rings were 127.0 degrees F. The onion rings were soft, marginally warm, and difficult to chew. 11. During an interview and observation on 08/23/24, at 12:45 P.M., the DM said it must be the steamer bay. It had been fixed within the past two months. The DM took the temperature of the steamer bay which held the fish fillets and it registered 117.0 degrees F. The DM said that's too low. The DM said he had not looked at the temperature log prior to the meal service on the 300 hall and was unaware the steamer bay was not functioning properly. He/she had no additional monitoring system beyond taking food temperatures prior to service from the kitchenette.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 11599 Based on observation and interview, the facility failed to maintain ceiling vents to ensure condensation and/or peeling paint did not drop from the vent onto the food preparation area. This had the potential to affect all 65 residents of the facility who received their meals from the facility kitchen. 1. During the initial tour of the kitchen on 08/20/24, at 9:00 A.M., with the Dietary Manager (DM), three ceiling vents were observed to have rust, dust, and peeling paint on and around the vents. One vent, located in front of the freezer, was observed to be falling from the ceiling. Another vent, located above the edge of the food preparation table, had condensation dripping from the edges of the vent, landing in front of the food preparation table. The drips were confirmed by the DM and [NAME] #1. They both confirmed there was a potential for the condensation and/or peeling paint to fall into food being moved from the stove to the preparation table and vice versa. During an interview on 08/23/24, at 1:20 P.M., the Maintenance Director (MD) said that he was responsible for the maintenance of the ceiling vents and that he was aware of their condition, but had not fixed the concerns. During an interview on 08/23/24, at 2:02 P.M., the Administrator said they did not have a policy for monitoring the ceiling vents in the kitchen.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) for one resident of one resident (Resident #216) reviewed for EBP, out of a total sample of 22, who had had a peripherally inserted central catheter (PICC line - a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) and received antibiotics. Review of the facility's policy titled, Enhanced Barrier Precautions, dated March 2024, showed the following: -The purpose of the policy is to prevent broader transmission of MDRO (multi-drug resistant organisms) and to help protect patients with chronic wounds and indwelling devices; -EBP (enhanced barrier precautions) should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed. Review of the EBP-Enhanced Barrier Precautions in-service, dated April 2024, provided by the Administrator showed the following: -Staff will notice a new dot on the name tags by residents' doors; -EBP is indicated for residents with infection or colonization with a CDC (Centers for Disease Control) targeted MDRO when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. (The inservice did not address EBP for high-contact care such as showering/bathing and toileting, use of gown and gloves for high contact cares, or where the PPE was located.) 1. Review of Resident #216's Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), showed the following: -admitted [DATE]; -Diagnoses included bacteremia (the presence of bacteria in the blood stream). Review of the resident's admission Minimum Data Set (MDS - federally mandated assessment instrument completed by facility staff), located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 08/23/24, showed the resident was cognitively intact. Observation on 08/20/24, at 2:58 P.M., showed the resident showed the resident had a PICC line in her right arm. Licensed Practical Nurse (LPN) #1 washed his/her hands and disconnected the intravenous (IV) antibiotic from the resident's PICC line. LPN #1 did not wear a gown or gloves during the high-contact care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265853	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joplin Gardens	2810 South Jackson Avenue Joplin, MO 64804

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/02/24, at 3:00 P.M., LPN #1 said he/she had not received any training or in-services on EBP when administering or removing IV antibiotics from a PICC line. LPN #1 said there was no readily accessible PPE (personal protective equipment) to use when administering IV antibiotics to the resident. During an interview on 08/21/24, at 2:20 P.M., the resident said nursing staff had not been using gowns or gloves when administering his/her IV antibiotics since admission to the facility and the Certified Nurse Aides (CNAs) had been not been utilizing protective equipment when assisting his/her with showers or high-contact cares. During an interview on 08/21/24, at 2:30 P.M., CNA #1 said he/she had not received any training or in-services on EBP. During an interview on 08/21/24, at 3:00 P.M., the Infection Preventionist (IP) said he/she had talked to the charge nurses and administration about EBP. There was a dot next to a resident's name on the name plate if staff needed to use EBP. The PPE was in a three-drawer dresser located in the lounge area on the unit. During an interview on 08/21/24, at 3:05 P.M., the Director of Nursing (DON) and the Regional Quality Assurance (QA) nurse were informed of the lack of EBP during the resident's IV care and the staff's lack of knowledge on EBP requirements. The DON said they had training for all staff twice. During an interview on 08/22/24, at 3:50 P.M., LPN #1 said he/she did not think he/she needed to wear precautions for IV administration, but was aware of it for indwelling urinary catheters.