

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265873	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Union Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1080 Marie Lane Union, MO 63084	

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** 37131</b></p> <p>Based on observation, interview and record review, facility staff failed to ensure one resident (Resident #3) out of 18 sampled residents who required continuous oxygen received continuous oxygen as ordered by the physician. Facility staff failed to store oxygen tubing and nebulizer masks in a manner to prevent respiratory infection for two residents (Resident #3 and #52) out of 18 sampled residents. The facility census was 52.</p> <p>1. Review of the facility's Oxygen Therapy Policy, undated, showed all oxygen and nasal cannula tubing should be stored in a plastic bag, that is attached to oxygen concentrator, or E-tank (portable oxygen tank), when not in use.</p> <p>Review of the facility's Nebulizer Treatment policy, undated, showed staff should store nebulizer cannula and tubing in a plastic bag at bedside, with the resident's name and date the equipment was changed.</p> <p>2. Review of Resident #3 Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/17/24, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Required moderate assist from staff for bathing, dressing, personal hygiene, bed mobility, transfers and ambulation in wheelchair;</li> <li>-Did not use oxygen;</li> <li>-Diagnosis of Dementia, asthma and respiratory failure.</li> </ul> <p>Review of the resident's Physician Order Sheet (POS), dated June 2024, showed physician orders:</p> <ul style="list-style-type: none"> <li>-Oxygen at two Liters Per Minute (LPM) per nasal cannula continuously, keep oxygen saturation above 92%, every shift for shortness of breath;</li> <li>-Budesonide Inhalation Suspension 0.5 milligrams (mg)/2 milliliters (ml), one vial inhale orally via nebulizer every 12 hours for 14 days.</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
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan, dated 06/17/24, showed the care plan did not address the resident oxygen use and nebulizer use.</p> <p>Review of the resident's nurse's note, dated 5/23/24, showed Registered Nurse (RN) I documented the resident with diminished and coarse lung sounds. X-ray results state pneumonia and bronchitis.</p> <p>Review of the resident's face sheet, undated, showed staff documented the resident had a new diagnosis of pneumonia on 05/26/2024.</p> <p>Observation on 06/17/24 at 2:32 P.M., showed the resident in his/her room. The resident wore oxygen via nasal cannula from an oxygen concentrator. Observation showed an oxygen tank sat on the back of the resident's wheelchair with an unbagged and uncovered nasal cannula wrapped around the tank.</p> <p>Observation 06/18/24 at 8:06 A.M., showed the resident not in his/her room. The resident's oxygen concentrator is on and the oxygen tubing and cannula laid directly on the resident's bed pad and sheets. The tubing is not bagged or covered.</p> <p>Observation on 06/18/24 at 8:52 A.M., showed the resident in his/her wheelchair, in his/her room. The resident wore oxygen from the tank on the back of his/her wheelchair. Certified Nurse Aide (CNA) B entered the resident's room to assist the resident to bed. The CNA assisted the resident from the wheelchair to the bed. The resident continued to wear oxygen tubing from the tank on the back of the wheelchair. The CNA picked up the oxygen tubing and nasal cannula from the resident's bed and placed the nasal cannula and oxygen tubing on the bedside table. The CNA then took the oxygen tubing from the tank off of the resident and placed it over the handle of the wheelchair. The CNA moved the wheelchair across room, placed the call light over the resident's lap and left the room. The CNA did not bag or cover the oxygen tubing or nasal cannula over the wheelchair handle or the tubing on the bedside table. The CNA did not place the nasal cannula from the concentrator on the resident before he/she left the room.</p> <p>Observation on 06/19/24 at 9:23 A.M., showed the resident in his/her bed with the nasal cannula from the concentrator in his/her nose, with wheelchair out of reach. The oxygen tank on the back of the wheelchair, has the oxygen tubing and nasal cannula hung over the handle, the tubing and nasal cannula are not bagged or covered. The nasal cannula hung an inch from the floor. Licensed Practical Nurse (LPN) N entered the resident's room and checked the resident's oxygen saturation. The resident has a nebulizer mask on his/her nightstand out of reach, it is not bagged or covered. No bags observed in the resident's room for oxygen tubing or nebulizer mask. The LPN left the resident's room and did not place the resident's oxygen tubing or nebulizer mask in a bag.</p> <p>Observation on 06/19/24 at 11:07 A.M., showed CNA K assisted the resident out of bed and into a wheelchair. The CNA placed the resident's oxygen tubing and nasal cannula on the sheet of the resident's bed. The resident asked to use the restroom. The CNA assisted the resident to the restroom without his/her oxygen. The CNA placed the resident in a new wheelchair without an oxygen tank, and propelled the resident out of his/her room. The CNA left the oxygen tubing from concentrator on the resident's bed, not bagged or covered and the oxygen tank tubing over the other wheelchair not bagged or covered. The CNA propelled the resident passed the nurse's station where LPN N sat and into the dining room with activities and left the resident without his/her oxygen. The resident repeatedly opened his/her mouth, yawned and took multiple deep breaths.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/19/24 at 11:26 A.M., the resident said he/she feels short of breath, but he/she is not able to run down to his/her room to get his/her oxygen.</p> <p>Observation on 06/19/24 at 11:32 A.M., showed the resident propelled himself/herself in his/her wheelchair to another dining room table. The resident took deep breaths, opened his/her mouth wide and gasped for air multiple times.</p> <p>Observation on 06/19/24 at 11:37 A.M., showed LPN N entered the dining room and asked the resident where is his/her oxygen. The LPN said to the resident, he/she is supposed to be on continuous oxygen and the resident's hands are really cold. The LPN left the dining room, returned with an oxygen tank and placed the resident on oxygen.</p> <p>During an interview on 06/19/24 11:42 A.M., CNA K said he/she did not know the resident received continuous oxygen. The CNA said he/she thought oxygen was only given in the resident's room. The CNA said information doesn't get passed down to the aides very well.</p> <p>Observation on 06/20/24 at 7:41 A.M., showed CNA K propelled the resident down the 300 hall with the oxygen tank on the back of the resident's wheelchair. Oxygen tubing and nasal cannula hung over the oxygen tank. The resident did not have oxygen in place.</p> <p>Observation on 06/20/24 at 10:05 A.M., showed the resident in bed, with nasal cannula from concentrator in his/her nostrils. Over 10 feet of oxygen tubing laid directly on the floor, with debris around the tubing. A nebulizer mask laid on the nightstand not bagged or covered.</p> <p>Observation on 06/20/24 at 10:09 A.M., showed Restorative Aide (RA) E switched the oxygen tank on the resident's old wheelchair to the resident's new wheelchair in the hallway, outside of the resident's room. The RA then took the wheelchair with the oxygen tank, back into the resident's room and the left the resident's room. The wheelchair is out of reach of the resident. The oxygen tubing is not bagged or covered.</p> <p>During an interview on 06/20/24 at 1:05 P.M., the RA said there should be plastic bags on the concentrators or tanks and staff are supposed to put the oxygen tubing in the plastic bag. The RA said he/she wasn't thinking, because there wasn't a plastic bag on the tank. The RA said he/she didn't think to get a plastic bag, normally he/she would go get a bag and label it, then put the tubing in it. The RA said not putting the nasal cannula in a bag creates the risk of infection. The RA said the resident has had a respiratory infection, but he/she doesn't know any details. The RA said nebulizer masks should have a plastic bag, not sure why it wasn't bagged, but he/she didn't notice it. The RA said excess oxygen tubing is not supposed to be on the floor, it needs to be picked up. The RA said he/she did notice all of the resident's excess tubing on the floor, and he/she probably should have picked it up.</p> <p>Observation on 06/20/24 at 11:32 A.M., showed the resident in bed with his/her call light on. The resident had oxygen on via concentrator and nasal cannula in the resident's nostrils. CNA K entered the resident's room and took the nasal cannula out of the resident's nose and placed the nasal cannula directly on the sheet of the resident's bed. The back of the resident's pants are wet. The sheet the CNA placed the nasal cannula on had pieces of debris and had wet spots. The CNA propelled the resident out of room and left the resident's nasal cannula on the dirty sheets and the nebulizer mask on the end table not bagged or covered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/20/24 at 11:49 A.M., CNA K said he/she doesn't even know what he/she is supposed to do with oxygen tubing. The CNA said he/she also doesn't know what to do with nebulizer masks either. The CNA said he/she just tries to keep it off the floor. The CNA said he/she doesn't bag or cover oxygen tubing or nebulizer masks at all, there isn't even a bag in the resident's room.</p> <p>During an interview on 06/20/24 at 1:00 P.M., the Director of Nursing (DON) said the resident used to have a bag in his/her room for oxygen tubing. The DON said he/she doesn't know what happened to it.</p> <p>3. Review of Resident #52's Significant MDS, dated [DATE], showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Dependent on staff for dressing, bed mobility, transfers and ambulation in wheelchair;</li> <li>-Required maximal assist from staff for bathing and personal hygiene;</li> <li>-Frequent incontinence of bowel and bladder;</li> <li>-Did not use oxygen.</li> </ul> <p>Review of the resident's POS, dated June of 2024, showed physician orders:</p> <ul style="list-style-type: none"> <li>-Oxygen at two LPM via nasal cannula every 24 hours as needed for shortness of breath;</li> <li>-Ipratropium-Albuterol Inhalation Solution 0.5-2.5 MG/3 ML, 3 ML inhale orally four times a day for Pneumonia for five days.</li> </ul> <p>Review of the resident's nurse's notes, dated 06/19/24, showed staff documented the resident received antibiotics for pneumonia.</p> <p>Review of the resident's care plan, dated 06/18/24, showed staff documented the resident has oxygen therapy due to ineffective gas exchange.</p> <p>Observation 06/18/24 at 8:20 A.M., showed the resident in a reclined wheelchair in the dining room. Observation showed the resident's oxygen tubing and nasal cannula from the concentrator are on the resident's bed, not bagged or covered.</p> <p>Observation on 06/18/24 at 9:54 A.M., showed the resident's Broda chair with an oxygen tank on the back of the chair. The oxygen tubing and nasal cannula to the tank hung over the tank and not bagged or covered.</p> <p>Observation on 06/19/24 at 9:34 A.M., showed the resident's reclined wheelchair in the residents room with an oxygen tank on the back of the wheelchair. Observation showed the oxygen tubing and nasal cannula hung over the oxygen tank not bagged, or covered. The resident's nebulizer mask is out of the resident's reach on the bedside table and is not bagged, or covered. The nebulizer is not on and it had liquid in the container.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/19/24 at 11:53 A.M., showed the residents the oxygen tubing and nasal cannula from concentrator hung over the bed by the headboard and the cannula touched the frame of the bed. Observation showed the tubing and nasal cannula not bagged or covered. CNA K entered the room and removed the nebulizer mask from the resident and placed the nebulizer mask and machine back on the nightstand. The CNA did not bag or cover the nebulizer mask, or oxygen tubing on the resident's bed.</p> <p>4. During an interview on 06/20/24 at 1:11 P.M., LPN N said oxygen tubing should be rolled up and placed on a higher table so its not on the floor. The LPN said he/she thinks the nebulizer mask should be put up on the machine. The LPN said excess oxygen tubing should not be on floor and if it touches the floor staff should get a new one. The LPN said if oxygen tubing on the tanks is not in use, it should be off the floor and wrapped around the tank. The LPN said putting oxygen cannulas on a resident's sheet could contaminate it. There would be a risk of infection if it gets dirty and the resident breaths it in. The LPN said he/she did know if oxygen tubing should be stored in a bag when not in use. The LPN said he/she knew nebulizer masks should be bagged. The LPN said he/she does not know why the residents did not have bags for their oxygen and nebulizer tubing and masks. The LPN said he/she did see Resident #3's oxygen tubing on the floor yesterday, he/she picked it up and placed on the table. The LPN said he/she didn't think to replace the oxygen tubing, he/she was busy.</p> <p>During an interview on 06/20/24 at 2:46 P.M., the DON said oxygen tubing should be kept off the floor and maintained in bags for coverage. The DON said he/she wants staff to curl up the oxygen tubing and ensure it is not on the floor, if a bag is not available. The DON said the staff can put the oxygen tubing on the bedside table and go get a bag. The DON said he/she expects staff to do the same thing for nebulizer masks and oxygen tubing for oxygen tanks. The DON said if oxygen tubing is on floor, staff need to roll it up and place on the bedside table, or bed, staff don't have to get new tubing unless its the nasal cannula touching the floor. The DON said he/she does not know why there is not bags in the resident rooms for oxygen tubing and nebulizer masks. The DON said there is a problem with keeping the bags in the resident rooms. The DON said he/she would have to look up Resident #3's order for oxygen. The DON said if a resident is on continuous oxygen, staff would have to remove the nasal cannula for changing clothes or transfers, but for the majority of the time the resident should be on oxygen. The DON said he/she expects the use of oxygen to be on a resident's care plan.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>37131</p> <p>Based on observation, interview, and record review, facility staff failed to store medications in a safe manner when staff failed to ensure expired medications and supplies were not stored with current resident medications, and failed to ensure all medications and treatments were labeled in two out of four medication carts. Additionally, staff failed to ensure medications were not lose in one medication cart. The facility census was 52.</p> <p>1. Review of the facility's Storage of Medications, dated April of 2007, showed drugs and biologicals shall be stored in packaging, containers or other dispensing systems in which they are received. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean safe and sanitary manner. Drug containers that have missing, incomplete, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Drugs shall be stored in an orderly manner in carts. Each resident's medications shall be assigned to a cubicle, drawer or holding area to prevent the possibility mixing medications of several residents.</p> <p>2. Observation on 06/18/24 at 3:13 P.M., showed the 200 hall medication cart contained:</p> <ul style="list-style-type: none"> <li>-One bag of 24 adhesive tape remover pads with an expiration date of of 11/2022;</li> <li>-Three tubes of Diclofenac Sodium 1% topical gel (used to relieve pain from arthritis) with the label removed;</li> <li>-One red rubber urethral catheter with an expiration date of 4/25/24;</li> <li>-One Eucerin topical cream with an expiration date of 10/20/22;</li> <li>-One Urea 20 intensive hydrating cream (lotion) unable to read label script or expiration date and one tube with an expiration date of 04/2024;</li> <li>-Three laxative 10 milligram (MG) suppository without a label script;</li> <li>-14 Acetaminophen 650 mg suppositories laying in drawer not in original container;</li> <li>-Three Albuterol sulfate/ Ipratropium Bromide (helps control symptoms of lung diseases, such as asthma, chronic bronchitis and emphysema) .0.5mg-3mg per 3 milliliters (ml) tubes without a label;</li> <li>-One bottle of vitamin C 250 MG, with an expiration date of 1/2024;</li> <li>-One bottle of Alcohol-free liquid skin prep with an expiration date of 01/19/2024;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Two vials of Haldol (antipsychotic medication) 5 mg per ml, with an expiration date of 05/24 and without a label;</p> <p>-Two tubes of Diclofenac Sodium 1% topical Gel stored in a bag with two different resident's names;</p> <p>-Two boxes of omnifix (tape ideal for dressing retention on joints) with an expiration date of 03/2024;</p> <p>-Roll of omnifix without a box without an expiration date;</p> <p>During an interview on 06/19/24 at 10:27 A.M., RN I said he/she doesn't check the medication cart often enough for expired medications, the facility needs to institute a policy for that. The RN said if a medication is missing a label or is unreadable staff should call the pharmacy for a new label. The RN said there should be dividers between residents medications and residents creams are in separate bags. The RN said he/she was not aware that two different resident's creams were stored in the same bag, they should not be. The RN said he/she never puts open dates on inhalers, he/she doesn't think it changes the expiration date. The RN said medications should stay in the original box, until used, he/she does not know why they medications are out of their box in the medication cart. The RN said to his/her knowledge you don't have to put an open date on eye drops.</p> <p>3. Observation on 06/18/24 at 4:23 P.M., of 100/300 medication cart contained:</p> <p>-One Fluticasone Propionate/Salmeterol Diskus inhalation powder (prescription medication used to treat asthma and chronic obstructive pulmonary disease) 250-50 Micrograms (MCG) open, opened and without an open date;</p> <p>-One Trelegy (prescription medication used to treat asthma and chronic obstructive pulmonary disease) 100 MCG/62.5 MCG/25 MCG opened and without an open date;</p> <p>-One Fluticasone/Salmeterol AER 250/50 opened and without an open date;</p> <p>-One Trelegy 100 MCG/62.5 MCG/25 MCG opened and without an open date;</p> <p>-One Breo Ellipta inhaler (combination medication inhaler for the treatment of chronic obstructive pulmonary disease) 100-25 opened and without an open date;</p> <p>-One Anoro Ellipta AER (combination medication inhaler for the treatment of chronic obstructive pulmonary disease) 62.5-25 opened and without an open date;</p> <p>-One Latanoprost Solution .005 % (treats high pressure inside the eye and helps treat glaucoma) opened and without an open date;</p> <p>-27 unidentified loose pills in the bottom of the medication care drawers.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/19/24 at 4:39 P.M., CMT Q said there is not a schedule to clean out expired medications in the carts. The CMT said staff are supposed to put open dates on eye drops and inhalers, he/she tells all new staff and they don't listen to him/her. The CMT said he/she has gone to management and they do not do anything about it. The CMT said staff should destroy medications that the script has been torn off, or fell off of. The CMT said prescription creams should have dividers to keep them from touching each other. The CMT said Albuterol should remain in the original box with the script until used, or staff wouldn't know whose they are. The suppositories should remain in the original box until used. The CMT said resident medication cards are packed in the drawer and pills will fall out when staff push them in the drawer.</p>		

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<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>33477</p> <p>Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietician or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 53.</p> <p>Review of the facility provided policies, showed the records did not contain a policy related to the qualifications for Director of Food and Nutrition Services.</p> <p>Review of the dietary manager's (DM) personnel records showed a hire date for the DM position listed as 01/04/24. Review showed the records did not contain documentation of prior dietary manager experience in a nursing facility and certification or other education required for the director of nutritional services position.</p> <p>During an interview on 06/19/24 at 8:05 A.M., the DM said he/she had been the DM for about a year, and he/she did not have prior experience as a dietary manager in a nursing facility and he/she did not have a degree or certification related to food service management. The DM said he/she started certification classes through the facility's consultant registered dietician (RD) in December 2023, but only had two or three classes before the RD had to stop the classes for unknown reasons. The DM said the RD only works part-time and the facility did not have any certified or clinically qualified nutritional staff employed full-time.</p> <p>During an interview on 06/19/24 at 9:03 A.M., the administrator said, although the DM had been the interim DM since the previous DM left last year, he/she did not officially appointed the DM as the manager until 01/04/24. The administrator said the DM began certification classes with the facility's part-time consultant RD, but the RD had to postpone the classes due to his/her own staffing issues. The administrator said he/she placed ads to find a qualified DM upon the advisement of the RD, but they had not been able to hire a qualified DM to date. The administrator said he/she knew that the DM did not have the qualifications required for the position and the facility did not have any certified or clinically qualified nutritional staff employed full-time.</p>		