

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>46555</p> <p>Based on record review and interview, the facility failed to ensure resident funds were placed in an account separate from the facility operating account. The facility did not provide residents with refunds of their personal funds from the operating account in a timely manner for six residents (Residents #15, #30, #41, #204, 307 and #311). The facility also failed to allow residents access to resident funds on an ongoing basis for one resident (Resident #252). This had the potential to affect all residents the facility managed funds for. The facility failed to keep resident funds over \$50.00 for residents that receive Medicaid, in an interest bearing account for one resident (Resident #22). The facility census was 49.</p> <p>1. Record review of the facility maintained Accounts Receivable Aging Report, dated 04/09/24, showed the following residents with personal funds held in the facility operating account.</p> <p>Resident Amount Held in Operating Account</p> <p>#15 \$3,685.00</p> <p>#30 \$1,616.92</p> <p>#41 \$1,019.00</p> <p>#204 \$1,913.22</p> <p>#307 \$1,308.00</p> <p>#311 \$35.00</p> <p>Total \$9,577.14</p> <p>Email correspondence dated 04/10/24 at 3:17 P.M., showed the Owner said he/she was working with the accounting firm to get answers as to why the residents had credit balances.</p> <p>Email correspondence dated 04/24/24 at 5:03 P.M., showed the Owner said he/she was working with the accounting firm to get answers.</p> <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:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Email correspondence dated 04/29/24 at 1:16 P.M., showed the Owner said the credits need to be refunded.</p> <p>2. During an interview on 04/16/24 at 12:13 P.M., Resident #252 said he/she was not able to access his/her funds and would like to purchase footies, dresses and other personal items. Resident #252 also said the last time he/she wanted \$20 but was only given \$10. Resident #252 said he/she does not want to wear the same outfit every day but does not have clothing.</p> <p>During an interview on 04/16/24 at 12:13 P.M., two Housekeepers said they used some of their personal money to purchase underwear for Resident #252 during the past weekend. Both Housekeepers stated the office was low on resident trust petty cash and was waiting for the Owner to bring more cash in to replenish the resident trust petty cash and the past two weeks have been a challenge for residents to get their resident trust money.</p> <p>3. Record review on 04/19/24 at 4:30 P.M., the statement signed by the Temporary Administrator/Business Office Manager showed residents can request funds Monday through Friday, from 8:00 A.M. - 4:00 P.M. and are not able to request or access funds during evenings or weekends.</p> <p>During an interview on 04/12/24 at 1:45 P.M., the Temporary Administrator/Business Office Manager said if a resident wants money, the resident has to fill out a request form that has to go through the back office staff and if approved the resident could then have money. He/She also stated it would usually take no longer than 24 hours. The Temporary Administrator/Business Office Manager said he/she was the only person that could give resident funds and was recently given access to view the residents' account and could give funds only Monday through Friday, from 8:00 A.M. - 4:00 P.M.</p> <p>During an interview on 04/16/24 at 12:13 P.M., the Temporary Administrator/Business Office Manager said he/she would walk through the building from time to time to see if residents want or need any money. He/she stated the Social Services staff had not been at the facility and there was no one there to access the money on evenings or weekends.</p> <p>4. Record review on 04/17/24 at 4:25 P.M., the facility maintained resident trust petty cash log showed Resident #22 had \$200.00 on 04/04/24 in his/her envelope, \$150.00 more than what was allowed. The following transactions were listed.</p> <p>Date Amount Balance</p> <p>None -\$6.00 None</p> <p>04/15/24 -\$10.00 \$184.00</p> <p>Record review on 04/17/24 at 4:25 P.M., the Temporary Administrator/Business Office Manager counted Resident #22's petty cash totaling \$181.00, which is \$150.00 more than what was allowed to keep in petty cash. Resident #22's petty cash envelope was also \$3.00 less than the balance of \$184.00.</p> <p>Record review of the Resident's Personal Funds/Trust Fund Authorization with an Admission Packet date of 09/28/2021, showed All Resident personal funds in excess of \$50.00 are kept in a separate interest bearing account.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/19/24 at 4:30 P.M., the Temporary Administrative/Business Office Manager said he/she did not know why the envelope was short by \$3.00.</p> <p>8. Record review of First Mid Bank &amp; Trust Resident Trust Bank Statements for the period 03/2023 through 03/2024 showed interest was not accrued in the account.</p> <p>Record review of the Resident's Personal Funds/Trust Fund Authorization with an Admission Packet date of 09/28/2021, showed The facility has no duty to invest the month in the Resident's account to earn income other than interest in a passbook or similar account.</p> <p>9. During an interview on 04/16/24 at 10:42 A.M., the Temporary Administrator/Business Office Manager said resident funds are kept in the First Mid Bank and Trust and did not know how interest is paid to each resident.</p> <p>49152</p> <p>U4413</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>46555</p> <p>U4413</p> <p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account by not reconciling each month. The facility failed to maintain the accounting records of resident funds for each transaction and failed to provide resident trust statements quarterly. The facility also commingled resident petty cash with facility petty cash. The facility managed funds for 46 residents. The facility census was 49.</p> <p>1. Record review of the facility maintained bank statements for the period 02/2023 through 03/2024 showed no documentation of reconciliations.</p> <p>During an interview on 04/09/24 at 2:09 P.M., the Owner said resident trust reconciliations were not completed.</p> <p>During an interview on 04/16/24 at 10:42 A.M., the Temporary Administrator/Business Office Manager said he/she balances the books as needed.</p> <p>2. Record review of the facility maintained resident fund petty cash logs showed logs for 09/2022 through 09/19/2023 could not be located.</p> <p>Observation of the resident petty cash count on 04/17/24 at 4:22 P.M., showed the Temporary Administrator/Business Office Manager counted a total of \$176.93.</p> <p>Record review of the facility maintained resident petty cash log on 04/17/24 at 4:22 P.M., showed the balance listed as \$171.98 for a discrepancy of \$4.95.</p> <p>Record review of the Resident's Personal Funds/Trust Fund Authorization with an Admission Packet date of 09/28/21, showed A record of all transactions regarding the Resident's funds shall be maintained by the Facility in accordance with generally accepted accounting principles and The Resident shall have reasonable access, upon request, to the above record and shall receive an itemized quarterly statement of his/her account.</p> <p>During an interview on 04/16/24 at 10:42 A.M., the Temporary Administrator/Business Office Manager said he/she took over as the business office manager in either 06/2023 or 07/2023 and did not know if the previous person kept the resident petty cash logs up to date, did not know if the resident funds forms show which resident received the funds and did not know why there was a difference.</p> <p>3. Record review of the Resident's Personal Funds/Trust Fund Authorization with an Admission Packet date of 09/28/21, showed You will be provided with a quarterly report of all transactions made to your account.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/08/24 at 3:23 P.M., the Owner said resident trust quarterly statements have not been done.</p> <p>During an interview on 04/10/24 at 2:07 P.M., the Temporary Administrator/Business Office Manager said resident trust statements are not provided to the residents and/or the financial representative.</p> <p>4. Record review of the facility maintained resident petty cash log on 04/16/24 at 10:42 A.M., showed facility staff transferred resident funds in the resident petty cash to the facility petty cash box.</p> <p>Date Amount</p> <p>10/09/23 \$400.00</p> <p>02/09/24 \$500.00</p> <p>During an interview on 04/17/24 at 4:22 P.M., the Temporary Administrator/Business Office Manager said the \$400.00 transfer from resident petty cash to facility petty cash was completed because money was needed in the facility petty cash box. He/She also said he/she could not remember why the \$500.00 transfer to facility petty cash happened and no receipts or forms were provided showing the transfers.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>46555</p> <p>U4413</p> <p>Based on record review and interview, the facility failed to provide notification when the resident's trust account reached \$200 less than the Supplemental Security Income (SSI) resource for one resident (Resident #22). The facility managed funds for 46 residents of 49 residents.</p> <p>1. Record review of the facility maintained Trust Transaction History for the period 01/01/24 through 04/04/24, dated 04/04/24, showed Resident #22 had the following balances.</p> <p>Date Amount</p> <p>02/15/24 \$7,989.45</p> <p>02/16/24 \$6,592.05</p> <p>02/23/24 \$6,582.05</p> <p>03/01/24 \$8,420.05</p> <p>03/05/24 \$7,012.65</p> <p>03/11/24 \$6,974.65</p> <p>04/03/24 \$7,084.55</p> <p>04/04/24 \$6,884.55</p> <p>2. Record review of the facility maintained Trust Transaction History for Resident #22 showed his/her account reached at least \$200 less than the SSI resource limit of \$5,726.00 for 02/15/24 through 04/04/24.</p> <p>3. Record review of the facility maintained Resident's Personal Funds/Trust Fund Authorization, with an Admission Packet date of 09/28/2021, shows If the Resident receives Medicaid benefits, the facility shall notify the Resident when the amount in her/her account reaches Two Hundred Dollars (\$200.00) less than the Social Security Income (SSI) resource limit for one person.</p> <p>4. During an interview on 04/10/24 at 2:13 P.M., the Temporary Administrator/Business Office Manager said he/she is supposed to write a list of which residents to notify if they need to spend-down, but this has not been done. The Temporary Administrator/Business Office Manager said the back office may check the resident's spend-down amount but did not know. The Temporary Administrator/Business Office Manager also said he/she did not have access to view the resident account balance until just now. Resident notices have not been sent out since no resident had that amount of money until now.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During an interview on 04/16/24 at 10:42 A.M., the Temporary Administrator/Business Office Manager said he/she calls the resident if the resident needs to spend-down but could not give dates and/or times.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>46555</p> <p>U4413</p> <p>Based on record review and interview, the facility failed to maintain a surety bond sufficient to ensure the protection of resident funds. The facility census was 49.</p> <p>Review of the facility maintained Resident Trust Bank Statements for the period 04/2023 through 03/2024, showed an average monthly balance of \$11,894.63.</p> <p>Review of the facility maintained Accounts Receivable (A/R) Aging Report, dated 04/08/24, showed the facility held a balance of resident funds in the amount of \$9,577.14.</p> <p>Review on 04/25/24, of the Department of Health and Senior Services approved bond list showed the facility had a \$1,000.00 approved bond, making the bond insufficient by \$30,500.00.</p> <p>During an interview on 04/16/24 at 10:42 A.M., the Temporary Administrator/Business Office Manager said she thought the bond was determined by taking 30% of the total money managed but did not know for sure.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Temporary Administrator/Business Office Manager said she would expect the bond to be sufficient to cover the resident funds.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46460</p> <p>Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) to two residents (Residents #203 and #204) out of two sampled residents who were discharged from Medicare Part A services with benefit days remaining. The facility census was 49.</p> <p>The facility did not provide a policy for SNF ABN or NOMNC forms.</p> <p>1. Review of Resident #203's medical record showed:</p> <ul style="list-style-type: none"> <li>- The resident discharged from Medicare Part A services on 11/23/23;</li> <li>- The resident remained in the facility;</li> <li>- The facility failed to issue a SNF ABN and NOMNC to the resident.</li> </ul> <p>2. Review of Resident #204's medical record showed:</p> <ul style="list-style-type: none"> <li>- The resident discharged from Medicare Part A services on 10/04/23;</li> <li>- The resident remained in the facility;</li> <li>- The facility failed to issue a SNF ABN and NOMNC to the resident.</li> </ul> <p>During an interview on 04/03/24 at 4:45 P.M., Physical Therapy Assistant (PTA) A said he/she searched for SNF ABN and NOMNC forms and didn't find any. He/She even asked other managerial/office staff and they couldn't find anything.</p> <p>During an interview on 04/17/24 at 4:24 P.M., the Social Services Designee (SSD) said he/she didn't do any sort of documentation regarding the SNF ABN and NOMNC forms when a resident discharged from therapy with days left. He/She was not sure who was responsible for that documentation.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing (DON) said they would expect the SNF ABN and NOMNC forms to be completed and provided to and signed by the resident and/or the resident's representative when a resident was discharged from therapy with days remaining.</p> <p>During an interview on 04/23/24 at 3:43 P.M., the Regional Director of Therapy said Resident #203 and Resident #204 discharged from Medicare Part A services with benefit days remaining. The residents had reached their maximum potential and were discharged by the therapy team. Neither was a resident-initiated discharge.</p> <p>46555</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 49.</p> <p>The facility did not provide a policy regarding the environment.</p> <p>Observation on 04/02/24 from 10:09 A.M. to 3:49 P.M., showed:</p> <ul style="list-style-type: none"> <li>- A musty and foul odor of urine and fecal material on the 100 and 200 Halls;</li> <li>- In room [ROOM NUMBER], the drywall behind both beds had scratches and holes. Two bottom drawers in the bathroom dresser were broken. The vent cover in the bathroom ceiling hung down 1.5 inches (in.) A small, clear medication cup with an unidentified yellow liquid sat on top of a dresser;</li> <li>- A strong urine smell in room [ROOM NUMBER];</li> <li>- The floors in rooms [ROOM NUMBERS] were very sticky;</li> <li>- The floor in room [ROOM NUMBER] sticky with particles of food and dirt scattered, and no threshold between the room and the hall flooring;</li> <li>- The 100 Hall floor dirty and sticky with food particles and an approximate two in. by two in. dried black substance;</li> <li>- The 200 Hall floor sticky with debris, and a three in. by three in. dried pink colored substance on the floor outside of room [ROOM NUMBER];</li> <li>- room [ROOM NUMBER] with dirt and debris throughout the floor of the room, a urinal with a dark yellow dried substance sat on top of clothing items in the floor to the left of the door;</li> <li>- Approximately 10 in. long cracks in the laminate floor in the middle of the hall between rooms [ROOM NUMBERS].</li> </ul> <p>Observation on 04/03/24 from 8:15 A.M. to 6:30 P.M., showed:</p> <ul style="list-style-type: none"> <li>- A musty and foul odor of urine and fecal material on the 100 and 200 Halls;</li> <li>- The 200 Hall floor sticky, with a three in. by three in. dried pink-colored substance on the floor outside of room [ROOM NUMBER];</li> <li>- An approximately three foot (ft.) by one ft. brown area from a spill on the floor between rooms [ROOM NUMBERS];</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- Thresholds missing on the doorways of rooms [ROOM NUMBER];</li> <li>- An old hospital bracelet, crumbs, and larger pieces of food in the floor of room [ROOM NUMBER];</li> <li>- room [ROOM NUMBER] with scratches and holes in the drywall behind both beds in the room. Two bottom drawers in the bathroom dresser not on the hinges and at a 45 degree angle, and the vent cover in the bathroom ceiling hung down 1.5 in. from the ceiling. A small, clear medicine cup with an unidentified yellow liquid sat on top of the dresser at 10:15 A.M. Registered Nurse (RN) B picked up and smelled the unidentified yellow liquid and said it smelled like alcohol, and put the medicine cup back on top of the dresser. The medicine cup still sat on the dresser at 4:25 P.M.;</li> <li>- The courtyard with a broken chair and hundreds of cigarette butts around the perimeter of the courtyard and around the drain grate;</li> <li>- An oxygen concentrator, that was used for multiple residents, sat in the dining room with 1/4 in. of debris/lint lining both filters on each each side of the concentrator.</li> </ul> <p>Observation on 04/04/24 from 8:33 A.M. to 1:53 P.M., showed:</p> <ul style="list-style-type: none"> <li>- A musty and foul odor of urine and fecal material on the 100 and 200 Halls;</li> <li>- The oxygen concentrator used for multiple residents sat in the dining room with 1/4 in. of debris/lint lining both filters on each each side of the concentrator;</li> <li>- A bent metal cover stuck out from the air conditioner located to the left of the entrance to the courtyard, a chair with no seat in the middle of the courtyard, metal bars hung from a broken [NAME], multiple smashed clear plastic cups, plastic wrappers, and various debris throughout the courtyard, and hundreds of cigarette butts around the perimeter of the courtyard and around the drain grate;</li> <li>- room [ROOM NUMBER] with a black cable hanging from above the window to the wall opposite of the closet; red markings on the wall under each light; a green substance smeared across the wall above the light switch; a clear plastic cup under the edge of the closet near the door; a pink plastic straw and disposable gloves under a chair in the corner to the left from the bedroom entrance; dirt and debris throughout the bedroom and bathroom floor; a metal knife, fork, and spoon on the back of the toilet in the bathroom; plastic food wrappers, a plastic bottle, and a plastic fork in an opened paper towel dispenser; plastic food wrappers, an empty soda can, and heath shake cartons sat in the window ledge; and a box of oatmeal cream pies sat on top of the bathroom mirror;</li> <li>- At 10:51 A.M. and again at 4:20 P.M., the small clear medicine cup with a yellow unidentified liquid sat on top of the dresser of room [ROOM NUMBER] since first observed on 04/03/24 at 10:15 A.M.;</li> <li>- Fecal material on the toilet seat and floor by the toilet in room [ROOM NUMBER] at 10:46 A.M., and at 4:00 P.M.</li> </ul> <p>Observation on 04/05/24 from 8:17 A.M. to 10:09 A.M., showed:</p> <ul style="list-style-type: none"> <li>- A musty and foul odor of urine and fecal material on the 100 and 200 Halls;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- A three in. by three in. dried pink colored substance outside of room [ROOM NUMBER] on the floor.</p> <p>Observations on 04/09/24 at 8:10 A.M., 04/10/24 at 8:14 A.M., 04/12/24 at 8:15 A.M., and 04/17/24 at 8:35 A.M., showed a musty and foul odor of urine and fecal material on the 100 and 200 Halls.</p> <p>Observation on 04/19/24 from 11:01 A.M. to 1:15 P.M., showed:</p> <ul style="list-style-type: none"> <li>- A musty and foul odor of urine and fecal material on the 100 and 200 Halls;</li> <li>- A broken ceiling tile hung sideways above the laundry room entrance in front of room [ROOM NUMBER];</li> <li>- room [ROOM NUMBER] with dirt and debris throughout the floor in the room and bathroom, one square ft. area of a sticky orange substance in the floor in front of the closet next to the bedroom entrance, and a ceiling tile hung sideways in the bathroom;</li> <li>- room [ROOM NUMBER] with a broken window blind and scratches in the paint and paint peeled from the floor;</li> <li>- room [ROOM NUMBER] with paint peeling from the floor, a missing threshold, and debris covered a resident's oxygen concentrator;</li> <li>- room [ROOM NUMBER] with a missing threshold, paint peeled from the floor with a half circle groove in the tile by the bedroom door from the door cutting into the floor, and a broken corner of tile along the left area around the door frame to the entrance of the room;</li> <li>- room [ROOM NUMBER] with a missing threshold;</li> <li>- room [ROOM NUMBER] with a missing threshold and scratches in the paint on the bottom outside of the door;</li> <li>- The hallway in front of room [ROOM NUMBER] with missing baseboard at the left corner of the room's entrance;</li> <li>- room [ROOM NUMBER] with damaged and buckled flooring in front of the bathroom, broken window blinds, missing door handle from the closet next to the bathroom, and a loose frame around the window unit air conditioner;</li> <li>- room [ROOM NUMBER] with chipped and broken tile at the door entrance and around the door frame, and scratches and indentations in the door frame;</li> <li>- room [ROOM NUMBER] with black marks and indentations in the wall next to the room entrance and a broken window blind;</li> <li>- room [ROOM NUMBER] with scratches and holes in the drywall behind both beds in the room. Two bottom drawers in the bathroom dresser not on the hinges and at a 45 degree angle, and the vent cover in the bathroom ceiling hung down 1.5 in. from the ceiling;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- The floor very sticky and paint peeling from tile all throughout the 400 Hall;</li> <li>- A missing threshold between the dining room and the 400 Hall;</li> <li>- Quarter and dime size chips in the corner of the flooring tile located in the 300 Hall between the nurses station and the theater room;</li> <li>- Three approximately three in. cracks in the flooring around the threshold of the 300 Hall;</li> <li>- The shower room located near the nurses station with a stick of deodorant and an opened box of gloves lay on the sink, a metal sink stopper in the floor behind the door, a black mold-like substance on the wall above the baseboard to the left of the shower, and a large discolored area around the ceiling vent;</li> <li>- The shower room on the 100 Hall nearest the 300 Hallway entrance with a disposable brief lay on the sink, dirt and debris in the floor and the shower floor, paint peeled from the floor, a half-full shampoo bottle in the floor under a shower chair, dirt and debris on the ceiling vents along with peeled paint around the square vent, and an unpainted area near the toilet;</li> <li>- The shower room on the 100 Hall with dirt and debris throughout the floor, a sippy cup sat on the sink, unpainted drywall next to and across from the toilet, two towels on the back of the toilet, a foam square approximately two ft. by two ft. by two in. thick sat between the toilet and the wall, a gallon plastic jug with approximately one in. of pink liquid in front of the toilet, a spray bottle with approximately one in. of clear liquid sat on the grab bar next to the toilet, a clear plastic cup sat on the grab bar in the shower with approximately one in. of pink liquid, a metal hatch hung open from the ceiling, and a black mold-like substance around the sprinkler head;</li> <li>- A circular white pill with an M on it in the floor outside room [ROOM NUMBER];</li> <li>- Two missing sections of the handrail on the left side of the 200 Hallway from the direction of the 100 Hallway.</li> </ul> <p>Review of the Resident Council Meeting Minutes, dated March 2024, showed:</p> <ul style="list-style-type: none"> <li>- Residents voiced concerns their rooms were not getting fully cleaned and their beds were not being made;</li> <li>- Both residents that resided in room [ROOM NUMBER] had concerns of the flooring coming up in their room.</li> </ul> <p>During an interview on 04/11/24 at 10:00 A.M., Housekeeping Staff (HS) L said he/she did the ordering for housekeeping. He/She ordered once a month and the invoices were sent to the back office to be paid. There had been multiple times in the past the bill had not been paid and they had missed orders. Housekeeping would have to ration supplies during those times. He/she did not feel like housekeeping could adequately do their jobs during those times due to the limited supplies.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview 04/11/24 at 11:50 A.M., HS L and HS O said the housekeeping staffing hours were cut in January and again on 03/01/24 and 03/10/24. Since, that time, the housekeeping staff had been unable to complete everything that needed to be done. They just hired a laundry person last week. They had been without laundry help since February. HS L said the owner wanted him/her to clean and do the laundry by himself/herself, but it was not doable. HS L said he/she was able to talk the owner into letting him/her keep HS O on staff. While they were without a laundry person, they cut up towels to use for washcloths at one point. HS L and HS O said they were told by the owner to not clean the window sills, air units, or dust furniture, and to only sweep and mop. They were told to only mop with water in the hallways that have painted floors, because the chemicals they used reacted with the paint due to the floors being painted with wall paint because it was cheaper than concrete paint. HS L looked at his/her supply orders and said 07/28/23 until 08/10/23, and again 02/15/24 02/27/24, they went without chemicals for cleaning and laundry due to the bill not being paid. The last time the bill was \$30,000, for the cleaning chemicals and the washers and dryers were rented. They were told by the rental company they were going to come get the washers and dryers unless a payment was made. HS L said the laundry was not set up as a separate clean/dirty side, but the owner called them when the survey started and told them to set it up that way.</p> <p>During an interview on 04/11/24 at 3:50 P.M., HS L said nursing staff were supposed to clean the oxygen concentrators and change out the tubing.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing (DON) said the RNs were expected to clean and maintain the oxygen concentrators, but wasn't sure how often. The Administrator said it was expected that all floors and surfaces would be free from spills and liquids and that the Maintenance Supervisor would be contacted via text if something needed to be done. It would be written in a book after completed. The jobs were completed as soon as possible and based on the need and importance.</p> <p>49152</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46460</p> <p>Based on observation, interview, and record review, the facility failed to assess the use of a lap tray to determine if it was a restraint, failed to document the lap tray on the care plan, failed to identify a medical symptom that supported the use of the lap tray, failed to document the least restrictive use for the lap tray, and failed to document an ongoing re-evaluation for the use of the lap tray for one resident (Resident #16) out of one sampled resident with a restraint. The facility census was 49.</p> <p>Review of the facility's policy titled, Restraints - Definitions, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, which restricts freedom of movement or normal access to one's body;</li> <li>- Physical restraints include, but are not limited to, lap cushions and lap trays the resident cannot remove easily.</li> </ul> <p>Review of the facility's policy titled, Restraints - Consent, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Consent must be obtained from the resident's family member or responsible party before applying a restraint;</li> <li>- Obtaining informed consent includes instructing the resident and family member about alternatives to the restraint, what potential negative outcomes there may be, and the right to refuse the restraint;</li> <li>- A Restraint Consent form must be filled out and signed for each type of restraint and for each episode of restraint use;</li> <li>- In order for the resident and family member to be fully informed, the unit nurse must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration, including using a restraint, not using a restraint, and alternatives to restraint use;</li> <li>- Whenever restraint is considered, the unit nurse must explain to the resident and family member how the use of restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being;</li> <li>- In the case of a resident who is incapable of making a decision about the restraint, the legal surrogate or representative may exercise this right based on the same information that would have been provided to the resident.</li> </ul> <p>Review of the facility's policy titled, Restraints - Criteria, dated 02/23/23, showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- The facility will ensure that the resident is free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms;</li> <li>- Before any restraint is applied, a restraint assessment must be completed which includes evaluation of balance, strength, gait, transfer, and safety;</li> <li>- The underlying causes of medical symptoms must be investigated and interventions implemented to eliminate those causes. Evaluation must be done to determine if these symptoms are caused by a failure to meet the resident's individual needs; use rehabilitative/restorative care; provide meaningful activities; and manipulate the resident's environment, including seating;</li> <li>- If underlying causes of medical symptoms cannot be eliminated, alternative measures must be tried before a restraint is used;</li> <li>- If alternatives are unsuccessful, the least restrictive form of restraint must be applied.</li> </ul> <p>Review of the facility's policy titled, Restraints - Program, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- A restraint will be used only after other alternatives have failed;</li> <li>- A restraint assessment will be completed before any restraint is applied;</li> <li>- The underlying causes of medical symptoms will be investigated, and interventions will be implemented to eliminate those causes;</li> <li>- If underlying causes of medical symptoms cannot be eliminated, the facility will try alternative measures before the restraint is used;</li> <li>- If alternatives are unsuccessful, the least restrictive form of restraint will be applied;</li> <li>- A physician's order will be obtained for restraint use, stating the medical symptoms requiring the restraint, what type of restraint is to be used, and when the restraint is to be used;</li> <li>- The physician's order will include instructions to check the restraint every 30 minutes, and to release it every two hours for 10 minutes. These instructions will be documented in the Treatment Administration Record (TAR) and the Nursing Assistant Care sheet;</li> <li>- Restraint use will be reevaluated weekly or as soon as the staff has determined that a change in the resident's condition has occurred;</li> <li>- The restraint will be discontinued as soon as possible;</li> <li>- During restraint use, the resident will be regularly monitored for potential negative outcomes and to make sure all of the resident's needs are met;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Restraint use will be addressed on the Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by the facility) assessments, Resident Assessment Protocols, and in the care plan;</li> <li>- Care plan interventions will include measures to minimize or eliminate the medical symptoms requiring restraint use;</li> <li>- Interventions will include programs to prevent functional declines, such as exercise and restorative programs for transfer, gait, and balance;</li> <li>- The Restraints Committee membership consists of the Director of Nursing (DON) and representatives from the Restorative Nursing (nursing care designed to improve or maintain the functional ability of residents), MDS, and Quality Assurance departments. They will meet monthly and evaluate the restraint use of all residents in the facility;</li> <li>- The Quality Assurance (QA) nurse will track the facility's restraint use by month, day, location, and unit;</li> <li>- The QA nurse will perform monthly audits of the facility's restraint use and practices to ensure that medical reason for restraint is documented, families and residents are instructed about alternatives to restraint use and potential negative outcomes; informed consents are obtained and signed; alternatives to restraint use are attempted; appropriate physician's order is in the chart and in treatment record; restraint is the least restrictive and applied for the least amount of time; restraint is checked every 30 minutes and released every two hours for 10 minutes as ordered; toileting needs are monitored; nutrition and hydration needs are monitored; restraint care plan is completed;</li> <li>- The Staff Education department will ensure that staff is educated about the facility restraint program through orientation and regular in-services and staff education on restraints includes instructions on restraint regulations, risks, and alternatives.</li> </ul> <p>Review of Resident #16's April 2024 Physician's Order Sheet (POS), showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), hemiparesis (muscle weakness or partial paralysis on one side of the body) and hemiplegia (complete paralysis) following a stroke;</li> <li>- No order for a lap tray.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Severe cognitive impairment;</li> <li>- Impairment on one side of the upper extremities;</li> <li>- Supervision or touching assistance for eating;</li> <li>- Partial to moderate assist for sit to stand and transfers;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- No restraint use.</li> </ul> <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> <li>- No assessment for lap tray to determine if used as a restraint;</li> <li>- No documentation of alternatives tried prior to a lap tray use;</li> <li>- No documentation of the least restrictive use for a lap tray;</li> <li>- No documentation of ongoing re-evaluations for the use of a lap tray;</li> <li>- No documentation of consent for restraint use.</li> </ul> <p>Review of the resident's Occupational Therapy (OT) note, dated 04/08/24, showed:</p> <ul style="list-style-type: none"> <li>- OT educated nursing staff on the resident's discharge and recommendations for a toilet schedule, rest schedule out of chair, and considering a Broda chair (a specialized reclining chair for positioning on wheels) with lateral (the side) support as an alternative to a lap tray on a geri chair (a reclining chair on wheels). Nursing expressed understanding of education but said the resident's behavior was a limiting factor.</li> </ul> <p>Review of the resident's OT Discharge Summary, dated 04/08/24, showed:</p> <ul style="list-style-type: none"> <li>- Facility provided a geri chair with an overall decrease in falls with an added lap tray. Due to a continued lean in the geri chair, therapy was recommending a Broda chair with lateral supports. However, per the administrator, the Broda chair was not being considered at this time and said a physician order will be obtained for a lap tray to not be considered a restraint. Right lateral support that was in the Broda chair after the switch to a geri chair was not able to be located. OT educated on the use of pillows as needed for the right side lean.</li> </ul> <p>Review of the resident's care plan, revised on 04/05/24, did not address the lap tray or restraint use.</p> <p>Review of the resident's progress notes showed:</p> <ul style="list-style-type: none"> <li>- Wheelchair with tray attached per skilled evaluation, dated 03/14/24;</li> <li>- Geri chair with food tray attached per skilled evaluation, dated 04/03/24;</li> <li>- Broda chair with meal tray for meals per skilled evaluation, dated 04/04/24 and 04/05/24.</li> </ul> <p>Observations of the resident showed:</p> <ul style="list-style-type: none"> <li>- On 04/03/24 at 9:58 A.M., the resident sat in a geri chair with a tray attached. When asked to remove the tray, the resident pressed against some screws on the tray and said, It's stuck, and was unable to remove it;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 04/04/24 at 12:48 P.M., the resident sat in a geri chair with tray attached in the dining area by the door to the courtyard, slumped over the right side of the chair with his/her arm dangling and almost touching floor;</li> <li>- On 04/09/24 at 11:30 A.M., the resident stood with no assistance over his/her geri chair at the bedside;</li> <li>- On 04/17/24 at 10:27 A.M., the resident sat in a geri chair in the room with a tray attached and was unable to remove tray when asked;</li> <li>- On 04/19/24 at 9:38 A.M., the resident sat near the nurses station in a geri chair with a tray attached;</li> <li>- On 04/19/24 at 10:11 A.M., the resident sat near the nurses station in a geri chair with a tray attached;</li> <li>- On 04/19/24 at 10:57 A.M., the resident sat in front of the closed door of room [ROOM NUMBER] in a geri chair with a tray attached, his/her head lay on the tray and eyes closed;</li> <li>- On 04/19/24 at 4:45 P.M., the resident sat in a geri chair in the room with a tray attached.</li> </ul> <p>During an interview on 04/19/24 at 10:00 A.M., the DON said therapy had worked with the resident, but wasn't making progress. She knew the tray was considered a restraint. The resident should only have it for meals and should not have it attached at any other time.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they would expect a resident with a restraint to have documentation regarding the restraint use, such as documentation of other attempted interventions, rationale for use, including medical symptoms, an order for the restraint, consent from the guardian or the resident representative, care planning, and on-going re-evaluation for necessity of the restraint.</p> <p>During a telephone interview on 04/24/24 at 4:24 P.M., the Regional Director of Therapy said they had tried different chairs for the resident. The resident had a fall history and had cervical flexion (head bent forward toward the chest) while sitting in his/her chair. The resident was discharged from OT due to non-compliance with the plan of treatment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for transfer, and failed to notify a representative of the Office of the State Long-Term Care Ombudsman for five residents (Resident #6, #16, #18, #35, and #36) out of 13 sampled residents and one resident (Resident #43) outside the sample. The facility's census was 49.</p> <p>Review of the facility's policy titled, Discharges, undated, showed the Social Services department will notify the resident and family of the discharge in accordance with federal regulations.</p> <p>1. Review of Resident #6's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 12/19/23, and readmitted to the facility on [DATE];</li> <li>- Transferred to the hospital on 02/16/24, and readmitted to the facility on [DATE];</li> <li>- No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer;</li> <li>- No documentation of transfer/discharge notice given to the Ombudsman.</li> </ul> <p>2. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 03/10/24, and readmitted to the facility on [DATE];</li> <li>- No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer;</li> <li>- No documentation of transfer/discharge notice given to the Ombudsman.</li> </ul> <p>3. Review of Resident #18's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 04/15/24, and did not readmit to the facility;</li> <li>- No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer;</li> <li>- No documentation of transfer/discharge notice given to the Ombudsman.</li> </ul> <p>4. Review of Resident #35's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 03/08/24, and readmitted to the facility on [DATE];</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer;</p> <p>- No documentation of transfer/discharge notice given to the Ombudsman.</p> <p>5. Review of Resident #36's medical record showed:</p> <p>- Transferred to the hospital on 04/05/24 and readmitted to the facility on [DATE];</p> <p>- No documentation that the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer;</p> <p>- No documentation of transfer/discharge notice given to the Ombudsman.</p> <p>6. Review of Resident #43's medical record showed:</p> <p>- Transferred to the hospital on 09/19/23, and readmitted to the facility on [DATE];</p> <p>- Transferred to the hospital on 12/03/23, and readmitted to the facility on [DATE];</p> <p>- No documentation the resident or resident representative was informed in writing of the transfer/discharge to the hospital at the time of transfer;</p> <p>- No documentation of transfer/discharge notice given to the Ombudsman.</p> <p>During an interview on 04/09/24 at 11:26 A.M., the Director of Nursing (DON) said they looked for transfer and bed hold documentation, and they didn't have any. They weren't doing that documentation.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they would expect staff to notify the resident or resident representative in writing the reason for transfer and to send a copy to the Ombudsman.</p> <p>46460</p> <p>49152</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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> 39360</p> <p>Based on interview and record review, the facility failed to inform the resident and/or legal representative in writing of their bed hold policy at the time of transfer to the hospital for four residents (Residents #6, #16, #35, and #36) out of 13 sampled residents and one resident (Resident #43) outside the sample. The facility's census was 49.</p> <p>Review of the facility's policy titled, Discharges, undated, showed the Social Services department will provide the resident and family with the facility's bed hold and readmission policies.</p> <p>1. Review of Resident #6's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 12/19/23, and readmitted to the facility on [DATE];</li> <li>- Transferred to the hospital on 02/16/24, and readmitted to the facility on [DATE];</li> <li>- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer.</li> </ul> <p>2. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 03/10/24, and readmitted to the facility on [DATE];</li> <li>- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer.</li> </ul> <p>3. Review of Resident #35's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 03/08/24, and readmitted to the facility on [DATE];</li> <li>- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer.</li> </ul> <p>4. Review of Resident #36's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 04/05/24, and readmitted to the facility on [DATE];</li> <li>- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer.</li> </ul> <p>5. Review of Resident #43's medical record showed:</p> <ul style="list-style-type: none"> <li>- Transferred to the hospital on 09/19/23, and readmitted to the facility on [DATE];</li> <li>- Transferred to the hospital on 12/03/23, and readmitted to the facility on [DATE];</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>- No documentation the resident or resident representative was informed in writing of the facility bed hold policy at the time of transfer.</p> <p>During an interview on 04/05/24 at 11:17 A.M., the Administrator said they didn't do written bed hold policies. They just did them verbally.</p> <p>During an interview on 04/09/24 at 11:26 A.M., the Director of Nursing (DON) said they looked for transfer and bed hold documentation, and they didn't have any. They weren't doing that documentation.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they expect staff to inform the resident or resident representative in writing of the bed hold policy.</p> <p>46460</p> <p>49152</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS - a federally mandated assessment completed by the facility) within the required time frames for 10 residents (Residents #1, #2, #6, #16, #26, #32, #33, #35, #36, and #38) out of 13 sampled residents and two residents (Residents #8 and #20) outside the sample. The facility census was 49.</p> <p>Review of the facility's policy titled, MDS Coordinator - Job Description, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Tracks and scheduled required resident assessments per state and federal requirements;</li> <li>- Completes all MDS assessments and Care Area Trigger Summaries;</li> <li>- Checks the facility's census daily and completes Discharge and Entry Tracking forms as needed;</li> <li>- Monitors documentation in the facility to ensure consistency and compliance with state and federal requirements;</li> <li>- Writes all chronic nursing care plans for all residents in the facility, and monitors acute nursing care plans;</li> <li>- Monitors all of the facility's resident assessments and care plans to ensure they are completed in a timely manner, are completed appropriately, meet state and federal regulations, and meet standards of practice and clinical guidelines;</li> <li>- Transmits completed MDS assessments to the state in compliance with state and federal regulations.</li> </ul> <p>Review of the Resident Assessment Instrument (RAI) Manual showed:</p> <ul style="list-style-type: none"> <li>- For the Admission assessment, the MDS completion date must be no later than 13 days after the entry date;</li> <li>- For the Admission assessment, the Care Area Assessment (CAA) completion date must be no later than 13 days after the entry date.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A comprehensive admission MDS assessment with CAA completion date of 01/29/24, and MDS completion date of 01/29/24;</li> <li>- No CAAs completed within 14 days of admission;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- No comprehensive admission MDS assessment within 14 days of admission.</li> </ul> <p>2. Review of Resident #2's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A comprehensive admission MDS assessment with CAA completion date of 03/16/24, and MDS completion date of 03/16/24;</li> <li>- No CAAs completed within 14 days of admission;</li> <li>- No comprehensive admission MDS assessment within 14 days of admission.</li> </ul> <p>3. Review of Resident #6's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A comprehensive admission MDS assessment with CAA completion date of 02/01/24, and MDS completion date of 02/01/24;</li> <li>- No CAAs completed within 14 days of admission;</li> <li>- No comprehensive admission MDS assessment within 14 days of admission.</li> </ul> <p>4. Review of Resident #8's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A comprehensive admission MDS assessment with CAA completion date of 01/29/24, and MDS completion date of 01/29/24;</li> <li>- No CAAs completed within 14 days of admission;</li> <li>- No comprehensive admission MDS assessment within 14 days of admission.</li> </ul> <p>5. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A comprehensive admission MDS assessment with CAA completion date of 03/08/24, and MDS completion date of 03/08/24;</li> <li>- No CAAs completed within 14 days of admission;</li> <li>- No comprehensive admission MDS assessment within 14 days of admission.</li> </ul> <p>6. Review of Resident #20's medical record showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 02/27/23, and MDS completion date of 02/27/23;</p> <p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>7. Review of Resident #26's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 03/23/24, and MDS completion date of 03/23/24;</p> <p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>8. Review of Resident #32's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 04/13/23, and MDS completion date of 04/13/23;</p> <p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>9. Review of Resident #33's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 01/25/23, and MDS completion date of 01/25/23;</p> <p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>10. Review of Resident #35's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 01/29/24, and MDS completion date of 01/29/24;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>11. Review of Resident #36's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 01/25/23, and MDS completion date of 01/23/23;</p> <p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>12. Review of Resident #38's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- A comprehensive admission MDS assessment with CAA completion date of 04/10/23, and MDS completion date of 04/10/23;</p> <p>- No CAAs completed within 14 days of admission;</p> <p>- No comprehensive admission MDS assessment within 14 days of admission.</p> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS Coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments were very far behind. RN AG said he/she had to code a lot of items as not assessed because the information was not there. RN AG said he/she had staff from nursing and the Social Services Designee (SSD) assist with the interviews so he/she could complete what was possible. He/She followed the RAI manual.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator said she would expect the MDS assessments to be completed accurately and timely per the RAI Manual and reflect the current status of the resident. She was aware the services of the previous MDS Coordinator had been paused, and there was currently no MDS Coordinator for the facility.</p> <p>46460</p> <p>46555</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46460</p> <p>Based on interview and record review, the facility failed to complete a quarterly Minimum Data Set (MDS - a federally mandated assessment completed by the facility) within the required timeframe for seven residents (Residents #2, #18, #32, #33, #38, #40, and #42) out of 13 sampled residents. The facility's census was 49.</p> <p>Review of the facility's policy titled, MDS Coordinator - Job Description, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Tracks and schedules required resident assessments per state and federal requirements;</li> <li>- Completes all MDS assessments and Care Area Trigger Summaries;</li> <li>- Checks the facility's census daily and completes Discharge and Entry Tracking forms as needed;</li> <li>- Monitors documentation in the facility to ensure consistency and compliance with state and federal requirements;</li> <li>- Writes all chronic nursing care plans for all residents in the facility, and monitors acute nursing care plans;</li> <li>- Monitors all of the facility's resident assessments and care plans to ensure that they are completed in a timely manner, are completed appropriately, meet state and federal regulations, and meet standards of practice and clinical guidelines;</li> <li>- Transmits completed MDS assessments to the state in compliance with state and federal regulations.</li> </ul> <p>Review of the Resident Assessment Instrument (RAI) Manual showed:</p> <ul style="list-style-type: none"> <li>- The Assessment Reference Date (ARD) of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent Omnibus Budget Reconciliation Act (OBRA - Nursing Home Reform Act of 1987, which improved the quality of care in nursing homes over the last twenty years by setting federal standards of how care should be provided to residents) assessment (ARD of previous OBRA assessment (Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment) + 92 calendar days);</li> <li>- The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.</li> </ul> <p>1. Review of Resident #2's medical record showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- An admission MDS assessment with completion date of 12/29/23;</li> <li>- A quarterly MDS assessment, dated 03/29/24, in progress;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>2. Review of Resident #18's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A significant change MDS assessment with completion date of 12/11/23;</li> <li>- A quarterly MDS assessment with a completion date of 03/24/24;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>3. Review of Resident #32's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- An admission MDS assessment with completion date of 11/21/23;</li> <li>- A quarterly MDS assessment with a completion date of 03/19/24;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>4. Review of Resident #33's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A quarterly MDS assessment with a completion date of 09/30/23;</li> <li>- A quarterly MDS assessment with a completion date of 01/29/24;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>5. Review of Resident #38's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A quarterly MDS assessment with a completion date of 11/15/23;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- A quarterly MDS assessment, dated 02/15/24, in progress;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>6. Review of Resident #40's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- A quarterly MDS assessment with a completion date of 12/15/23;</li> <li>- A quarterly MDS assessment with a completion date of 03/30/24;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>7. Review of Resident #42's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- An admission MDS assessment with a completion date of 10/17/23;</li> <li>- A quarterly MDS assessment with a completion date of 01/29/24;</li> <li>- The facility failed to complete a quarterly MDS assessment within 92 days of the prior MDS assessment.</li> </ul> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS Coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments were very far behind. RN AG said he/she had to code a lot of items as not assessed because the information was not there. RN AG said he/she had staff from nursing and the Social Services Designee (SSD) assist with the interviews so he/she could complete what was possible. He/She followed the RAI manual.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator said she would expect the MDS assessments to be completed accurately and timely per the RAI Manual and reflect the current status of the resident. She was aware the services of the previous MDS Coordinator had been paused, and there was currently no MDS Coordinator for the facility.</p> <p>46555</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46460</p> <p>Based on interview and record review, the facility failed to electronically transmit Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility) assessments in a timely manner and in accordance with guidelines for ten residents (Residents #6, #16, #18, #32, #33, #35, #36, #38, #40, and #42) of 13 sampled residents. The facility's census was 49.</p> <p>Review of the facility's policy titled, MDS Coordinator - Job Description, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Tracks and scheduled required resident assessments per state and federal requirements;</li> <li>- Completes all MDS assessments and Care Area Trigger Summaries;</li> <li>- Checks the facility's census daily and completes Discharge and Entry Tracking forms as needed;</li> <li>- Monitors documentation in the facility to ensure consistency and compliance with state and federal requirements;</li> <li>- Writes all chronic nursing care plans for all residents in the facility, and monitors acute nursing care plans;</li> <li>- Monitors all of the facility's resident assessments and care plans to ensure they are completed in a timely manner, are completed appropriately, meet state and federal regulations, and meet standards of practice and clinical guidelines;</li> <li>- Transmits completed MDS assessments to the state in compliance with state and federal regulations.</li> </ul> <p>Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual for assessment transmission showed the following:</p> <ul style="list-style-type: none"> <li>- Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date;</li> <li>- Entry tracking records must be transmitted electronically no later than the entry date + 14 days;</li> <li>- All other MDS assessments must be submitted within 14 days of the MDS completion date.</li> </ul> <p>1. Review of Resident #6's medical record showed:</p> <ul style="list-style-type: none"> <li>- A discharge - return anticipated MDS, dated [DATE], and completed 02/01/24. The discharge - return anticipated MDS transmitted and accepted on 03/15/24;</li> <li>- The facility failed to ensure the discharge - return anticipated MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- A comprehensive admission MDS assessment, dated 12/26/23, and completed 02/01/24. Care plan decisions for the comprehensive admission MDS assessment completed 02/01/24. The comprehensive admission MDS assessment transmitted and accepted 03/15/24;</li> <li>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date;</li> <li>- An entry MDS tracking record, dated 02/17/24, and completed 03/29/24. The entry MDS tracking record transmitted and accepted 04/02/24;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date.</li> </ul> <p>2. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 12/16/23, and completed 01/08/24;</li> <li>- The entry MDS tracking record transmitted and accepted 01/30/24;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date.</li> </ul> <p>3. Review of Resident #18's medical record showed:</p> <ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 11/01/22, and completed 05/02/23. The entry MDS tracking record transmitted and accepted 05/18/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A comprehensive admission MDS assessment, dated 11/07/22, and completed 01/25/23. Care plan decisions for the comprehensive admission MDS assessment completed 01/25/23. The comprehensive admission MDS assessment transmitted and accepted 02/15/23;</li> <li>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date;</li> <li>- A quarterly MDS assessment, dated 02/07/23, and completed 02/27/23. The quarterly MDS assessment transmitted and accepted 03/27/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- A discharge - return anticipated MDS, dated [DATE], and completed 03/27/24. The discharge - return anticipated MDS not yet transmitted and accepted;</li> <li>- The facility failed to ensure the discharge - return anticipated MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 08/01/23, and completed 03/27/24. The entry MDS tracking record not yet transmitted and accepted;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A quarterly MDS assessment, dated 11/03/23, and completed 11/03/23. The quarterly MDS assessment transmitted and accepted 12/12/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date.</li> </ul> <p>4. Review of Resident #32's medical record showed:</p> <ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 03/22/23, and completed 03/23/23. The entry MDS tracking record transmitted and accepted 04/06/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A comprehensive admission MDS assessment, dated 03/28/23, and completed 04/13/23. Care plan decisions for the comprehensive admission MDS assessment completed 04/13/23. The comprehensive admission MDS assessment transmitted and accepted 05/15/23;</li> <li>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date;</li> <li>- A quarterly MDS assessment, dated 06/28/23, and completed 06/28/23. The quarterly MDS assessment transmitted and accepted 07/26/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- A quarterly MDS assessment, dated 09/28/23, and completed 09/28/23. The quarterly MDS assessment transmitted and accepted 11/15/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- A discharge - return anticipated MDS, dated [DATE], and completed 11/02/23. The discharge - return anticipated MDS transmitted and accepted 12/12/23;</li> <li>- The facility failed to ensure the discharge - return anticipated MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- An entry MDS tracking record, dated 11/08/23, and completed 11/08/23. The entry MDS tracking record transmitted and accepted 12/12/23;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A comprehensive admission MDS assessment, dated 11/21/23, and completed 11/21/23. Care plan decisions for the comprehensive admission MDS assessment completed 11/21/23. The comprehensive admission MDS assessment transmitted and accepted 12/12/23;</li> <li>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date.</li> <li>5. Review of Resident #33's medical record showed: <ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 10/06/22, and completed 12/28/22. The entry MDS tracking record transmitted and accepted 01/31/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- An entry MDS tracking record, dated 11/04/22, and completed 12/28/22. The entry MDS tracking record transmitted and accepted 02/15/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A quarterly MDS assessment, dated 01/10/23, and completed 02/27/23. The quarterly MDS assessment transmitted and accepted 03/27/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- A quarterly MDS assessment, dated 04/06/23, and completed 04/18/23. The quarterly MDS assessment transmitted and accepted 05/15/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- A comprehensive significant change MDS assessment, dated 06/30/23, and completed 06/30/23. Care plan decisions for the comprehensive significant change MDS assessment completed 06/30/23. The comprehensive significant change MDS assessment transmitted and accepted 07/26/23;</li> <li>- The facility failed to ensure the comprehensive significant change MDS assessment was transmitted electronically within 14 days of the care plan completion date;</li> <li>- A quarterly MDS assessment, dated 09/30/23, and completed 09/30/23. The quarterly MDS assessment transmitted and accepted 11/15/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date.</li> </ul> </li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Review of Resident #35's medical record showed:</p> <ul style="list-style-type: none"> <li>- A quarterly MDS assessment, dated 03/25/24, and completed 04/02/24;</li> <li>- The quarterly MDS assessment not yet transmitted and accepted;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date.</li> </ul> <p>7. Review of Resident #36's medical record showed:</p> <ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 10/22/22, and completed 11/14/22. The entry MDS tracking record transmitted and accepted 01/31/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A comprehensive admission MDS assessment, dated 11/01/22, and completed 01/23/23. Care plan decisions for the comprehensive admission MDS assessment completed 01/25/23. The comprehensive admission MDS assessment transmitted and accepted 02/15/23;</li> <li>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date;</li> <li>- A quarterly MDS assessment, dated 02/01/23, and completed 02/27/23. The quarterly MDS assessment transmitted and accepted 03/27/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- A quarterly MDS assessment, dated 10/27/23, and completed 10/27/23. The quarterly MDS assessment transmitted and accepted 11/13/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date.</li> </ul> <p>8. Review of Resident #38's medical record showed:</p> <ul style="list-style-type: none"> <li>- An entry MDS tracking record, dated 02/13/23, and completed 02/24/23. The entry MDS tracking record transmitted and accepted 03/27/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A quarterly MDS assessment, dated 11/15/23, and completed 11/15/23. The quarterly MDS assessment transmitted and accepted 12/12/23;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date.</p> <p>9. Review of Resident #40's medical record showed:</p> <p>- An entry MDS tracking record, dated 09/01/23, and completed 09/01/23. The entry MDS tracking record transmitted and accepted 10/18/23;</p> <p>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</p> <p>- A comprehensive admission MDS assessment, dated 09/14/23, and completed 09/14/23. Care plan decisions for the comprehensive admission MDS assessment completed 09/14/23. The comprehensive admission MDS assessment transmitted and accepted 10/18/23;</p> <p>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date;</p> <p>- A discharge - return anticipated MDS, dated [DATE], and completed 10/04/23. The discharge - return anticipated MDS transmitted and accepted 11/15/23;</p> <p>- The facility failed to ensure the discharge - return anticipated MDS assessment was transmitted electronically within 14 days of the MDS completion date;</p> <p>- An entry MDS tracking record, dated 10/07/23, and completed 10/07/23. The entry MDS tracking record transmitted and accepted 12/12/23;</p> <p>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</p> <p>- A discharge - return anticipated MDS, dated [DATE], and completed 02/01/24. The discharge - return anticipated MDS transmitted and accepted 03/16/24;</p> <p>- The facility failed to ensure the discharge - return anticipated MDS assessment was transmitted electronically within 14 days of the MDS completion date;</p> <p>- An entry MDS tracking record, dated 10/27/23, and completed 01/01/24. The entry MDS tracking record transmitted and accepted 01/01/24;</p> <p>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date.</p> <p>10. Review of Resident #42's medical record showed:</p> <p>- An entry MDS tracking record, dated 02/23/23, and completed 02/24/23. The entry MDS tracking record transmitted and accepted 03/27/23;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A quarterly MDS assessment, dated 07/19/23, and completed 07/19/23. The quarterly MDS assessment transmitted and accepted 08/04/23;</li> <li>- The facility failed to ensure the quarterly MDS assessment was transmitted electronically within 14 days of the MDS completion date;</li> <li>- An entry MDS tracking record, dated 10/04/23, and completed 10/04/23. The entry MDS tracking record transmitted and accepted 11/15/23;</li> <li>- The facility failed to ensure the entry MDS tracking record was transmitted electronically within 14 days of the entry date;</li> <li>- A comprehensive admission MDS assessment, dated 10/17/23, and completed 10/17/23. Care plan decisions for the comprehensive admission MDS assessment completed 10/17/23. The comprehensive admission MDS assessment transmitted and accepted 11/13/23;</li> <li>- The facility failed to ensure the comprehensive admission MDS assessment was transmitted electronically within 14 days of the care plan completion date.</li> </ul> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS Coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments were very far behind. RN AG said he/she had to code a lot of items as not assessed because the information was not there. RN AG said he/she had staff from nursing and the Social Services Designee (SSD) assist with the interviews so he/she could complete what was possible. He/She followed the RAI manual.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator said she would expect the MDS assessments to be completed accurately and timely per the RAI Manual and reflect the current status of the resident. She was aware the services of the previous MDS Coordinator had been paused, and there was currently no MDS Coordinator for the facility.</p> <p>46555</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46460</p> <p>Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for five residents (Residents #6, #16, #18, #36, and #42) out of 13 sampled residents. The facility's census was 49.</p> <p>Review of the facility's policy titled, MDS Coordinator-Job Description, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Tracks and schedules required resident assessments per state and federal requirements;</li> <li>- Completes all MDS assessments and Care Area Trigger Summaries;</li> <li>- Checks the facility's census daily and completes Discharge and Entry Tracking forms as needed;</li> <li>- Monitors documentation in the facility to ensure consistency and compliance with state and federal requirements;</li> <li>- Monitors all of the facility's resident assessments and care plans to ensure they are completed in a timely manner, are completed appropriately, meet state and federal regulations, and meet standards of practice and clinical guidelines;</li> <li>- Transmits completed MDS assessments to the state in compliance with state and federal regulations.</li> </ul> <p>Review of the Resident Assessment Instrument (RAI) Manual, dated October 2023, showed:</p> <ul style="list-style-type: none"> <li>- Code that best describes the setting the resident was in immediately preceding this admission/entry or reentry;</li> <li>- Code the MDS the if the Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder to determine the level of care needed) Level II screening determined the resident has a serious mental illness and/or intellectual disability (ID)/developmental disability (DD) or related condition.</li> </ul> <p>1. Review of Resident #6's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and altered mental status (change in mental function that stems from illnesses, disorders and injuries affecting your brain);</li> <li>- Level II PASARR completed on 03/05/21, showed the resident had serious mental illness;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The resident discharged to the hospital on 12/19/23, and readmitted to the facility on [DATE].</p> <p>Review of the resident's MDS entry tracking record, dated 12/21/23, showed:</p> <ul style="list-style-type: none"> <li>- Entered from a skilled nursing facility, not the hospital, upon readmission;</li> <li>- The facility failed to code the resident's MDS accurately.</li> </ul> <p>Review of the resident's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Did not have a serious mental illness;</li> <li>- The facility failed to code the resident's MDS accurately.</li> </ul> <p>2. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder, hemiparesis (muscle weakness or partial paralysis on one side of the body) and hemiplegia (complete paralysis) following a stroke;</li> <li>- Progress note, dated 03/14/24, showed the resident used a wheelchair with a tray attached per a skilled evaluation.</li> </ul> <p>Review of the resident's quarterly MDS assessment, dated 03/19/24, showed:</p> <ul style="list-style-type: none"> <li>- No restraint used in the seven-day look back period;</li> <li>- The facility failed to code the resident's MDS accurately.</li> </ul> <p>During an interview on 04/19/24 at 10:00 A.M., the Director of Nursing (DON) said the lap tray was considered a restraint.</p> <p>3. Review of Resident #18's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Diagnoses of severe protein-calorie malnutrition, aphasia (loss of ability to understand or express speech caused by brain damage), bipolar disorder (a mental disorder that causes unusual shifts in mood), cerebrovascular disease (damage to the brain from interrupted blood supply), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), anemia (low blood levels of iron), neuromuscular dysfunction of the bladder (lack of bladder control due to nerve damage), gastrostomy status (G-tube - a tube placed in the stomach for nutrition and medication administration), insomnia (difficulty sleeping), hyperlipidemia (high level of fat particles in the blood), and multiple pressure ulcers (damage to the skin and/or underlying tissue as a result of pressure);</p> <p>- An order for Flagyl (an antibiotic medication) 500 milligram (mg) give two tablets by mouth one time a day every Monday, Wednesday, and Friday for wound care. Crush the tablets and sprinkle over silvadene (a wound dressing) on the wound beds, dated 02/29/24.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>- No diagnoses of GERD, aphasia, and cerebrovascular disease;</p> <p>- Did not receive antibiotics;</p> <p>- The facility failed to code the resident's MDS accurately.</p> <p>4. Review of Resident #36's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of major depressive disorder (MDD - long-term loss of pleasure or interest in life), generalized anxiety, pain, hemiplegia and hemiparesis, atherosclerotic heart disease (chronic condition where the heart does not pump blood as well it should), chronic embolism and thrombosis of unspecified deep veins in bilateral legs (blood clots in legs), pulmonary embolism (PE - blood clot in one or both lungs), and aphasia;</p> <p>- No diagnosis of GERD.</p> <p>Review of the resident's Physician's Order Sheet (POS), undated, showed:</p> <p>- An order for Reglan (medication used to treat heartburn caused by GERD) 5 mg three times a day via G-tube for GERD, dated 10/11/23;</p> <p>- An order for famotidine (medication used to treat heartburn caused by GERD) 20 mg one tablet via G-tube two times a day for acid reflux, dated 10/11/23.</p> <p>Review of the resident's quarterly MDS assessment, dated 01/27/24, showed:</p> <p>- No diagnoses of PE and GERD;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The facility failed to code the resident's MDS accurately.</p> <p>5. Review of Resident #42's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of malignant neoplasm of connective and soft tissue, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), GERD, high blood pressure, chronic pain, and other genetic-related intellectual disability.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>- No diagnosis of GERD;</p> <p>- Diagnosis of pneumonia;</p> <p>- The facility failed to code the resident's MDS accurately.</p> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS Coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments were very far behind. RN AG said he/she had to code a lot of items as not assessed because the information was not there. RN AG said he/she had staff from nursing and the Social Services Designee (SSD) assist with the interviews so he/she could complete what was possible. He/She followed the RAI manual.</p> <p>49152</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on interview and record review, the facility failed to provide a Level I Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder to determine the level of care needed) for two residents (Resident #2 and #26) out of 13 sampled residents. The facility's census was 49.</p> <p>The facility did not provide a PASARR policy.</p> <p>1. Review of Resident #2's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of major depressive disorder (long-term loss of pleasure or interest in life), anxiety disorder (persistent worry and fear about everyday situations) and schizophrenia (a disorder that affects one's ability to think, feel and behave clearly);</li> <li>- No level I PASARR.</li> </ul> <p>2. Review of Resident #26's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of schizophrenia, anxiety disorder and dementia (thinking and social symptoms that interfere with daily functioning);</li> <li>- No level I PASARR.</li> </ul> <p>During an interview on 4/11/24 at 2:23 P.M., the Director of Nursing (DON) said she was unable to find a PASARR for Resident #2 and Resident #26. She would expect all residents to be screened before admission to the facility. These two residents had admitted from a previous facility that closed emergently and should have been screened if the appropriate paperwork was not able to be located after admission.</p> <p>42699</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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> 42699</p> <p>Based on interview and record review, the facility failed to implement a baseline care plan (the minimum healthcare information necessary to properly care for a resident) upon admission with specific interventions for five residents (Resident #1, #2, #6, #18, and #32) out of 13 sampled residents. The facility census was 49.</p> <p>The facility failed to provide a policy related to baseline care plans.</p> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of diabetes mellitus (a condition that affects the way the body processes blood sugar), high blood pressure, and high cholesterol.</li> </ul> <p>Review of the resident's baseline care plan, dated 01/24/24, showed:</p> <ul style="list-style-type: none"> <li>- Not completed within 48 hours of admission;</li> <li>- No documentation the resident and/or the representative received a written summary of the baseline care plan.</li> </ul> <p>2. Review of Resident #2's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of major depressive disorder (long-term loss of pleasure or interest in life), anxiety disorder (persistent worry and fear about everyday situations) schizophrenia (a disorder that affects one's ability to think, feel and behave clearly), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and atherosclerosis of native arteries of bilateral legs (buildup of plaque in the walls of arteries causing obstructed blood flow).</li> </ul> <p>Review of the resident's baseline care plan, dated 01/06/24, showed:</p> <ul style="list-style-type: none"> <li>- Not completed within 48 hours of admission;</li> <li>- No documentation the resident and/or the representative received a written summary of the baseline care plan.</li> </ul> <p>3. Review of Resident #6's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>- Diagnoses of schizophrenia, COPD, and anxiety disorder.</p> <p>Review of the resident's baseline care plan, dated 01/24/24, showed:</p> <p>- Not completed within 48 hours of admission;</p> <p>- No documentation the resident and/or the representative received a written summary of the baseline care plan.</p> <p>4. Review of Resident #18's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of severe protein-calorie malnutrition, aphasia (loss of ability to understand or express speech caused by brain damage), bipolar disorder (a mental disorder that causes unusual shifts in mood), cerebrovascular disease (damage to the brain from interrupted blood supply), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), anemia (low blood levels of iron), neuromuscular dysfunction of the bladder (lack of bladder control due to nerve damage), gastrostomy status (G-tube - a tube placed in the stomach for nutrition and medication administration), insomnia (difficulty sleeping), and multiple pressure ulcers (damage to the skin and/or underlying tissue as a result of pressure);</p> <p>- No documentation of a baseline care plan;</p> <p>- No documentation the resident and/or representative received a written summary of the baseline care plan.</p> <p>5. Review of Resident #32's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of bipolar disorder, suicidal ideations (thinking about or planning suicide), and mild intellectual disabilities;</p> <p>- No documentation of a baseline care plan;</p> <p>- No documentation the resident and/or the representative received a written summary of the baseline care plan.</p> <p>During an interview on 04/10/24 at 3:35 P.M., Registered Nurse (RN) E said he/she did not receive much of an orientation and was not sure exactly what was required for a new admission.</p> <p>During an interview on 04/01/23 at 3:45 P.M., the Director of Nursing (DON) said nursing staff was responsible for the care plan and she would expect an baseline care plan to be completed within 48 hours of the resident's admission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 04/19/2024 at 3:44 P.M., the Administrator said she would expect the baseline care plans to be completed within 10 days of admission, but preferred within three days of the resident's admission. The Administrator was unaware the baseline care plans should completed within 48 hours of admission, be signed by the resident and/or the representative, and available for review for all new admissions.</p> <p>46555</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans with specific interventions to meet individual needs for three residents (Resident #1, #6, and #16) out of 13 sampled residents and one resident (Resident #29) outside the sample. The facility's census was 49.</p> <p>Review of the facility's policy titled, Care Planning - Interdisciplinary Team, reviewed 02/21, showed:</p> <ul style="list-style-type: none"> <li>- Every resident will be assessed using the Minimum Data Set (MDS - a federally mandated assessment completed by the facility) according to the guidelines set forth in the Resident Assessment Instrument (RAI) Manual;</li> <li>- Purpose is to assess each resident's strengths, weaknesses, and care needs and to use this assessment data to develop a comprehensive plan of care (POC) for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible;</li> <li>- Upon completion of comprehensive assessments, Care Area Assessments (CAAs) will be triggered to flag areas of concern that may need addressed in the POC for that resident;</li> <li>- CAA documentation will be done following guidelines in the RAI Manual and will state whether or not a care plan is needed to address the triggered area and the rationale for arriving at this decision;</li> <li>- While CAAs identify common areas of concerns, the POC is not to be limited to the triggered areas. The comprehensive POC must address all care issues that are relevant to the individual, whether or not they are specifically covered in the MDS/CAA process.</li> </ul> <p>Review of the facility policy titled, Restraints - Program, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Care plan interventions will include measures to minimize or eliminate the medical symptoms requiring restraint use;</li> <li>- Interventions will include programs to prevent functional declines, such as exercise and restorative programs for transfer, gait, and balance.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of diabetes (group of diseases that result in too much sugar in the blood) and gastroesophageal reflux disease (GERD - digestive disease in which stomach acid or bile irritates the food pipe lining);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- An admission MDS, dated [DATE], with functional abilities, urinary incontinence, nutritional status and pressure ulcer/injury as triggered CAAs that would be addressed on the care plan;</p> <p>- Care plan did not address the CAAs.</p> <p>2. Review of Resident #6's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), gastroesophageal reflux disease GERD, and hyperlipidemia (high cholesterol);</p> <p>- An admission MDS, dated [DATE], with cognitive loss/dementia, functional abilities, urinary incontinence, falls, fluid maintenance, psychotropic drug use, and pain as triggered CAAs that would be addressed on the care plan;</p> <p>- A comprehensive care plan initiated 04/06/24, with only one focus area of current functional performance addressed, with interventions listed as independent transfer and set up help only, and no goals listed;</p> <p>- Care plan did not address the CAAs.</p> <p>3. Review of Resident #16's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), hemiparesis (muscle weakness or partial paralysis on one side of the body) and hemiplegia (complete paralysis) following a stroke;</p> <p>- A quarterly MDS assessment, dated 03/19/24, does not address restraints;</p> <p>- A comprehensive care plan, revised 04/05/24, did not address the lap tray/restraint use.</p> <p>Observations of the resident showed:</p> <p>- On 04/03/24 at 9:58 A.M., the resident sat in a geri (a wheeled chair that reclines) chair with a tray attached. The resident pressed against some screws on the tray, said It's stuck, and was unable to remove it;</p> <p>- On 04/04/24 at 12:48 P.M., the resident sat in a geri chair with a tray attached in the dining area by the door to the courtyard, slumped over the right side of the chair with his/her arm dangling and almost touched floor;</p> <p>- On 04/09/24 at 11:30 A.M., the resident stood with no assistance over his/her geri chair at bedside;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 04/17/24 at 10:27 A.M., the resident sat in a geri chair in his/her room with a tray attached and was unable to remove the tray;</p> <p>- On 04/19/24 at 9:38 A.M., and 10:11 A.M., the resident sat near the nurses station in a geri chair with a tray attached;</p> <p>- On 04/19/24 at 10:57 A.M., the resident sat in front of the closed door of room [ROOM NUMBER] in a geri chair with a tray attached, and his/her head lay on the tray and eyes closed;</p> <p>- On 04/19/24 at 4:45 P.M., the resident sat in a geri chair in his/her room with a tray attached.</p> <p>During an interview on 04/19/24 at 10:00 A.M., the Director of Nursing (DON) said the lap tray was considered a restraint. Resident #16 should only have it for meals, but should not have it on at any other time.</p> <p>4. Review of Resident #29's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of dementia with behavioral disturbance, altered mental status, and pain;</p> <p>- An admission MDS assessment, dated 12/29/23, showed a dementia diagnosis and urinary incontinence, falls, pressure ulcer, and psychotropic drug use as triggered CAAs that would be addressed on the care plan;</p> <p>- Resident with no comprehensive care plan.</p> <p>During an interview on 04/10/24 at 1:57 P.M., the Assistant Director of Nursing (ADON) said they didn't have many dementia residents, but they should have appropriate interventions and activities so they can participate.</p> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS and care plan coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments and care plans were very far behind or had not been completed. RN AG said he/she gathered what information he/she could, but many items in the assessments had to be left blank. This affected the care plan as there were no triggers from the assessments.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said the MDS Coordinator or Social Services Designee (SSD) created the care plans, and they should revise the care plans as needed. The care plans should accurately reflect the condition of the resident.</p> <p>46460</p> <p>46555</p> <p>49152</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42699</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan in seven days after completion of the comprehensive assessment and no more than 21 days after admission to properly care for six residents (Resident #18, #32, #33, #36, #40, and #42) out of 13 sampled residents. The facility census was 49.</p> <p>The facility did not provide a policy.</p> <p>1. Record review of Resident #18's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/17/22, showed the following:</p> <ul style="list-style-type: none"> <li>- admitted to the facility on [DATE];</li> <li>- Diagnoses of severe protein-calorie malnutrition, aphasia (loss of ability to understand or express speech caused by brain damage), bipolar disorder (a mental disorder that causes unusual shifts in mood), cerebrovascular disease (damage to the brain from interrupted blood supply), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), anemia (low blood levels of iron), neuromuscular dysfunction of bladder (lack of bladder control due to nerve damage), gastrostomy status (g-tube, a tube placed in the stomach for nutrition and medication administration), insomnia (difficulty sleeping), and multiple pressure ulcers (damage to the skin and/or underlying tissue as a result of pressure).</li> </ul> <p>Review of the resident's medical record showed a care plan with a start date of 11/15/22 and completion date of 02/05/23.</p> <p>2. Record review of Resident #32's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- admitted to the facility on [DATE];</li> <li>- Diagnoses of bipolar disorder, suicidal ideations (thinking about or planning suicide), and mild intellectual disabilities.</li> </ul> <p>Review of the resident's medical record showed a care plan with a start date of 3/23/23 and completion date of 4/19/23.</p> <p>3. Record review of Resident #33's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- admitted to the facility on [DATE];</li> <li>- Diagnoses of bipolar disorder, dysphasia following cerebral infarction (swallowing disorder following a stroke), and asthma (a condition in which a person's airways become inflamed, narrow and swell.)</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed a care plan with a start date of 12/31/23 and completion date of 01/18/24.</p> <p>4. Record review of Resident #36's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- admitted to the facility on [DATE];</li> <li>- Diagnoses of major depressive disorder (MDD, long-term loss of pleasure or interest in life), generalized anxiety (persistent worry and fear about everyday situations), pain, hemiplegia and hemiparesis (paralysis and lack of sensation of one side of the body), atherosclerotic heart disease (chronic condition where the heart does not pump blood as well it should), chronic embolism and thrombosis of unspecified deep veins in bilateral legs (blood clots in both legs), pulmonary embolism (blood clot in one or both lungs), and aphasia.</li> </ul> <p>Review of Resident #36's medical record showed a care plan with a start date of 03/22/23 and completion date of 03/27/23.</p> <p>5. Record review of Resident #40's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- admitted to the facility on [DATE];</li> <li>- Diagnoses of hypertension (high blood pressure), chronic viral hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), paraplegia (paralysis of the legs and lower body), pressure ulcer of other site stage IV (full thickness tissue loss with exposed bone, tendon or muscle.)</li> </ul> <p>Review of Resident #40's medical record showed a care plan with a start date of 03/16/24 and completion date of 4/2/24.</p> <p>6. Record review of Resident #42's admission MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- admitted to the facility on [DATE];</li> <li>- Diagnoses of malignant neoplasm (cancer) of connective and soft tissue, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), GERD, hypertension (high blood pressure), chronic pain, and other genetic related intellectual disability.</li> </ul> <p>Review of Resident #42's medical record showed a care plan with a start date of 03/22/23 and completion date of 04/03/23.</p> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS and care plan coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments and care plans were very far behind or had not been completed. RN AG said he/she gathered what information he/she could, but many items in the assessments had to be left blank. This affected the care plan as there were no triggers from the assessments.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing said they would expect care plans to be created and updated in a timely manner per the RAI Manual and reflect the current status of the resident. They would expect the MDS coordinator or the Social Service Director to complete the revisions. They said the care plans should be revised as needed.</p> <p>46555</p> <p>49152</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on observation, record review and interview, the facility failed to follow physician's orders for five residents (Residents #16, #18, #26, #33, and #40) out of 13 sampled residents and one resident (Resident #12) outside the sample. The facility census was 49.</p> <p>The facility did not provide a policy.</p> <p>1. Review of Resident #12's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of moderate protein calorie malnutrition (a type of malnutrition that the diet is deficient in both protein and calories), anxiety, schizophrenia (a mental disorder that causes a person to interpret reality abnormally and can include hallucinations and delusions and could impair daily function), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and diabetes due to underlying condition of hyperglycemia (glucose building up in the blood);</li> <li>- An order dated 04/03/24 for Jevity (a supplemental or sole-source nutrition) 237 milliliters (mL) three times a day. May substitute Isosource HN (complete high nutrition tube-feeding formula) 1.2 if Jevity not available;</li> <li>- An order dated 04/03/24 for Isosource HN 1.2 500 mL three times a day, 100 mL free water flush (fwf) before and after feeding;</li> <li>- An order dated 04/03/24 for Jevity 1.2 bolus two cartons=570 calories four times a day. May substitute Isosource;</li> <li>- An order dated 08/31/23 to flush gastrostomy tube with 100 mL of water three times a day and at bedtime. Flush tube with 50 mL of water before and after tube feeding to equal 100 mL.</li> </ul> <p>Review of the resident's Medication Administration Record (MAR), dated April 2024, showed:</p> <ul style="list-style-type: none"> <li>- Registered Nurse (RN) C documented Jevity 1.2 bolus two bottles = 570 calories administered on 04/04/24 at 12:00 P.M.</li> </ul> <p>Observation of the medication pass for the resident on 04/04/24 at 11:50 A.M. showed:</p> <ul style="list-style-type: none"> <li>- RN C administered two bottles of Glucerna (therapeutic nutrition) by g-tube;</li> <li>- RN C failed to flush g-tube after administering tube feeding.</li> </ul> <p>During an interview on 04/04/24 at 12:15, RN C said he/she thought the Glucerna was Jevity so that's why he/she used it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (persistently depressed mood or loss of interest in activities), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations);</li> <li>- An order for Trintellix oral tablet (antidepressant) 10 milligrams (mg), give one tablet by mouth one time a day, dated 12/16/23.</li> </ul> <p>Review of the resident's MAR, dated March 2024, showed the resident did not receive the medication on 03/22/24, 03/25/24, 03/27/24, 03/28/24, 03/29/24, and 03/30/24.</p> <p>Review of the resident's MAR, dated April 2024, showed the resident did not receive the medication from 04/01/24 through 04/18/24.</p> <p>Review of the resident's progress notes showed:</p> <ul style="list-style-type: none"> <li>- On 03/22/24, on order;</li> <li>- On 03/25/24, medication on reorder;</li> <li>- On 03/27/24, 03/28/24, and 03/29/24, on order;</li> <li>- On 03/30/24, medication unavailable;</li> <li>- On 04/01/24 and 04/02/24, on order;</li> <li>- On 04/03/24 and 04/04/24, medication on hold by pharmacy;</li> <li>- On 04/05/24, 04/06/24, and 04/07/24 on order;</li> <li>- On 04/08/24 and 04/09/24, medication on hold by pharmacy;</li> <li>- On 04/10/24, 04/11/24, and 04/12/24 on order;</li> <li>- On 04/13/24, medication reordered by pharmacy;</li> <li>- On 04/14/24, medication unavailable, reordered;</li> <li>- On 04/15/24, medication unavailable. Medication reordered by pharmacy;</li> <li>- On 04/16/24, no reason given;</li> <li>- On 04/17/24, medication unavailable. Medication on reorder;</li> <li>- On 04/18/24, medication unavailable.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/24 at 11:06 A.M., the pharmacy staff said a prior payment authorization needed completed to dispense the medication. The pharmacy staff tried multiple times to contact the nursing home, but no one ever answered. Multiple phone calls were made, and messages were sent on 03/17/24 and 03/29/24. The pharmacy has tried to contact the owner, who was the prior Administrator. The pharmacy has a messaging board, and the owner has been on every message thread ever sent. The only reason the resident got the medication on 04/19/24 is because the pharmacy found out the resident was no longer on Medicare Part A, but was now on Medicaid. Since changing to Medicaid, the pharmacy could bill for the medication and dispense it. The resident got taken off Medicare Part A on 04/07/24 and the pharmacy wasn't notified until 04/19/24.</p> <p>3. Review of Resident #18's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of severe protein-calorie malnutrition, aphasia (loss of ability to understand or express speech caused by brain damage), bipolar disorder, cerebrovascular disease (damage to the brain from interrupted blood supply), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), gastrostomy status, and multiple pressure ulcers (damage to the skin and/or underlying tissue as a result of pressure);</li> <li>- No order for suction;</li> <li>- No documented use of suction or assessment for use of suction;</li> <li>- Current care plan showed resident requires suction as needed and to maintain suction at bedside and document use.</li> </ul> <p>Observations of the resident showed:</p> <ul style="list-style-type: none"> <li>- On 04/02/24 at 1:38 P.M., suction canister with 250 milliliters (mLs) of yellow substance in it with tubing and oral suction device attached. All equipment undated;</li> <li>- On 04/09/24 at 8:45 A.M., suction canister with 450 mLs of yellow substance and brown-green chunks in it with tubing and oral suction device attached. All equipment undated;</li> <li>- On 04/17/24 at 10:30 A.M., suction canister with 450 mLs of yellow substance and brown-green chunks in it with tubing and oral suction device attached. All equipment undated.</li> </ul> <p>During an interview on 04/19/24 at 3:44 P.M., the DON and Administrator said they would expect there to be an order for suctioning. Staff should assess if resident needs to be suctioned and expect them to do it at least when staff go in the room to turn or clean up the resident.</p> <p>4. Review of Resident #26's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Diagnoses of protein calorie malnutrition, anxiety and schizophrenia;</p> <p>- An order dated 02/17/24 for fortified foods and health shakes twice daily with meals;</p> <p>- An order dated 04/02/24 for mirtazapine (a drug used to treat depression that can help with weight loss) 7.5 milligrams (mg), by mouth, at bedtime for weight loss.</p> <p>Review of a list of residents that were to be given fortified foods and health shakes with meals showed Resident #26 was not on the list.</p> <p>5. Review of Resident #33's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of bipolar disorder, dysphasia following cerebral infarction (swallowing disorder following a stroke), and asthma (a condition in which a person's airways become inflamed, narrow and swell);</p> <p>- A current order dated 02/08/24 for Boost health shakes with meals for protein deficiency three times daily (TID) with each meal;</p> <p>- A current order dated 08/28/23 for Ensure (a nutritional drink) three times a day for prophylaxis to be thickened to nectar thickness;</p> <p>- An order dated 11/09/22 for continuous oxygen via nasal cannula at 2L to keep SpO2 at 92%.</p> <p>Observation of the resident showed:</p> <p>- On 04/03/24 at 6:00 P.M., resident ate his/her meal with no health shake provided;</p> <p>- On 04/04/24 at 1:15 P.M., resident ate his/her meal with no health shake provided;</p> <p>- On 04/02/024 at 2:00 P.M., resident sat in wheel chair in room not wearing oxygen;</p> <p>- On 04/04/24 at 1:15 P.M., resident in dining room not wearing oxygen;</p> <p>- On 04/09/24 at 1:18 P.M., resident in wheel chair in room not wearing oxygen.</p> <p>Interviews with the resident showed:</p> <p>- On 04/09/24 at 1:18 P.M., he/she said staff remove his/her oxygen at meal times and don't put it back on him/her until they put him/her back in bed;</p> <p>- On 04/19/24 at 11:48 A.M., the resident said he/she no longer receives any kind of health shake. He/She used to receive them sometimes, but not at every meal.</p> <p>Review of a list of residents that were to be given fortified foods and health shakes with meals showed the resident on the list for shakes to be given twice a day.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/09/24 at 4:05 P.M., Dietary Staff N said the list that showed which residents received health shakes was current and was updated as the dietician or physician changed the orders. He/She said the only health shakes they had to give residents were from their food vendor. No Boost or Ensure shakes were provided to residents.</p> <p>6. Review of Resident #40's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of hypertension (high blood pressure), chronic viral hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), paraplegia (paralysis of the legs and lower body), and pressure ulcer of other site stage IV (full thickness tissue loss with exposed bone, tendon or muscle);</li> <li>- An order for wound vac at 125 millimeters of mercury (mmHg) continuous suction to right hip. Cleanse area. Lightly pack wounds with white foam cover with black granufoam, apply drape. Dressing to be changed Monday-Wednesday-Friday, order start date 03/15/24 and end date 04/19/24;</li> <li>-No alternative dressing order.</li> </ul> <p>Review of the resident's Treatment Administration Record (TAR), dated April 2024, showed wound vac order charted as completed by RN AB on 04/12/24 and 04/15/24.</p> <p>Observations of Resident #40 showed:</p> <ul style="list-style-type: none"> <li>- On 04/02/24 at 2:19 P.M., the resident sat in wheelchair holding the wound vac, which was beeping and displayed tubing occluded;</li> <li>- On 04/16/24 at 1:20 P.M., the resident sat in wheelchair with the wound vac sitting beside the bed turned off and not connected to the resident.</li> </ul> <p>During an interview on 04/02/24 at 2:19 P.M., Resident #40 said the wound vac does not work all the time. Sometimes the battery dies and sometimes the machine beeps saying the seal is bad or the tubing is kinked. Wound care does the dressings on Wednesdays, but the facility is supposed to do them on Monday and Friday. There isn't a good seal mostly when facility staff do the dressing changes and sometimes they do not have the supplies to do the dressing changes.</p> <p>During an interview on 4/15/24 at 4:20 P.M., RN G said they run out of wound vac supplies for the resident and staff have had to do the alternate dressing multiple times due to not having wound vac canisters or appropriate supplies to change it.</p> <p>During an interview on 04/16/24 at 1:20 P.M., Resident #40 said the wound vac has not been on since this past Friday (04/12/24). RN B tried to change it last Friday, but it did not work since the seal was bad. The wound vac does not work as well as when wound care does the dressing changes. Another nurse was going to try today, but told them to hold off since wound care would do it tomorrow. The facility staff have to do an alternative dressing a lot due to lack of supplies or them not being able to do the wound vac right.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they would expect residents to receive diets, supplements, oxygen, and other items according to physician orders. Nursing should have the appropriate competencies to provide specialized care.</p> <p>46555</p> <p>49152</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>39360</p> <p>Based on interview and record review, the facility failed to complete a comprehensive discharge summary for one resident (Resident #50) out of two discharged residents. The facility's census was 49.</p> <p>Review of the facility's policy titled, Discharge, undated, showed:</p> <ul style="list-style-type: none"> <li>- After the discharge care conference, the unit nurse will write a Discharge Summary that includes an overview of the resident's stay and a final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative that includes identification and demographic information, customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnosis and health condition, dental and nutritional status, skin condition, activity pursuit, medications, special treatments and procedures, and discharge potential;</li> <li>- The unit nurse will review and explain the Discharge Summary for the resident and family, and document this in the nursing notes.</li> </ul> <p>Review of Resident #50's closed medical record showed:</p> <ul style="list-style-type: none"> <li>- Resident discharged to another facility on 01/05/24;</li> <li>- No documentation of a discharge summary.</li> </ul> <p>During an interview on 04/19/24 at 11:00 AM, the Director of Nursing (DON) said she was unable to find the discharge summary.</p> <p>During an interview on 04/19/24 at 11:15 AM, the Assistant Director of Nursing (ADON) said staff had failed to chart the recapitulation of stay.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they would expect a recapitulation to be completed upon discharge.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 - Minimal harm or potential for 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> 46460</p> <p>Based on observation, interview and record review the facility facility to provide needed care and services in accordance with professional standards of practice for one resident (Resident #42) out of one sampled resident receiving chemotherapy services. The facility census was 49.</p> <p>Review of the facility policy, Intravenous Therapy, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- A physician's order is required for intravenous (IV) therapy and must state route, type of solutions and additives, flow, rate, and time of administration, type and frequency of flushes, start date, and stop date;</li> <li>- Registered Nurses (RNs) who have had IV training or certification are the only staff members authorized to change IV dressings, maintain IV sites, set up or change any settings on transfusion pumps, and remove an IV;</li> <li>- Dressings are applied sterile with transparent dressing and tape, use sterile or non-sterile clean gloves during dressing changes, replace dressings when damp, loose, or soiled, and date, time, and initial the dressing when it is applied or changed, and also document in resident's chart;</li> <li>- Refer to the pump's manufacturer instructions in the policy and procedure manual, instruct staff members to inform RN whenever the pump alarm sounds or when resident must be moved or needs a procedure that would require the tubing or pump to be disconnected;</li> <li>- Instruct staff members they must not disconnect or reconnect any tubing from the pump, change any settings on the pump, turn the pump alarm off, or turn the pump on or off;</li> <li>- Label all bags and tubing with date, time, and initials;</li> <li>- Monitoring and documentation include checking the resident, site, dressing, tubing, bag, and pump every four hours;</li> <li>- Monitor for redness, swelling, warmth, pain, fever, bag and tubing intact, pump running correctly, type of fluids and medications are as ordered, flow and rate as ordered, and dressing intact, free of blood or drainage;</li> <li>- If there are signs of infiltration or infection, stop and remove the IV immediately, and notify the physician;</li> <li>- Keep strict intake and output on any resident receiving IV medications, a log of fluid administration must be included in the resident's medication administration record (MAR), at the end of shift record exactly how much of the IV medication the resident received, and add these amounts for totals at the end of night shift.</li> </ul> <p>Review of the facility policy, Medication Administration, undated, showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The facility will provide pharmaceutical services, including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident;</p> <p>- If unit nurse is unfamiliar with the medication, the nurse should look it up in the drug handbook on the medication cart, call the pharmacist and/or physician for clarification, and look for the manufacturer guidelines at the nurses' station if it is a recently released medication.</p> <p>The facility did not have a policy regarding resident's who received chemotherapy.</p> <p>Review of the Yondelis (a chemotherapy drug) prescribing information showed if the medication leaks into the tissues around your infusion site, it can cause damage and death of tissue cells around the infusion site. You may need to have surgery to remove any dead tissue. Tell your healthcare provider right away if you see any Yondelis leaking out of your vein or around the catheter during your infusion, or if you notice any redness, swelling, itching, or discomfort at the infusion site at any time. For contact with skin, take off contaminated clothing &amp; shoes immediately and wash off with soap and water. Small Spills- Moisten a towel, cover the spill, pick up the spill or use a HEPA vacuum.</p> <p>Review of the resident's care plan, last reviewed 03/22/23, did not identify or address that the resident received chemotherapy through a port or give any direction on how to care for the resident after he/she returned from the infusion center.</p> <p>Review of the residents undated Physician's Order Sheet showed:</p> <p>- admitted to the facility on [DATE];</p> <p>- Diagnoses of malignant neoplasm (cancer) of connective and soft tissue, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure), chronic pain, and other genetic related intellectual disability;</p> <p>- An order dated 04/04/24 and ended on 04/05/24 for Trabectedin Intravenous Solution Reconstituted (a chemotherapy medication) use 2.3 mg intravenously one time only for 2.3 mg per 500 ml saline infusion over 24 hours related to malignant neoplasm of connective and soft tissue, unspecified for one day continuous infusion as started. Do not adjust. Observe for any side effects. Contact 911 and send to hospital for any adverse reactions;</p> <p>- No orders for when resident was to go to infusion center.</p> <p>- No additional orders regarding additional chemotherapy treatment.</p> <p>Observation on 04/04/24 at 1:36 P.M., showed Resident #42 in dining room with a portable infusion pump.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/04/24 at 1:36 P.M., Resident #42 said he/she goes to the infusion center every 21 days and comes back with an infusion pump that runs for 24 hours. He/She goes back to the infusion center the next day and they disconnect it. He/she said the appointment is around noon tomorrow. The facility sends a nurse aide with him/her, and the facility helps with transport to and from the infusion center.</p> <p>Observation on 04/05/24 at 8:04 A.M. showed Resident #42 sitting on the side of the bed. The resident's infusion pump was off and tape was wrapped around where the tubing would connect to the machine. The resident's left chest port was accessed with an undated/unlabeled dressing.</p> <p>Observation on 04/05/24 at 9:55 A.M. showed the resident in dining room with infusion pump off and not running.</p> <p>During an interview on 04/05/24 at 8:40 A.M., Resident #42 said the infusion pump started beeping at 4:00 A.M., and he/she called the nurse to look at it. The nurse was going to look into it and get back with him/her. Usually when the pump is running, it will say how much longer the infusion should last and he/she should have around 12 hours left. Some of the infusion had leaked and got on his/her sweatshirt and hands.</p> <p>During an interview on 04/05/24 at 8:44 A.M., the Director of Nursing (DON) said she did not know about the resident's infusion pump issue but will look at it right away.</p> <p>During an interview on 04/05/24 at 9:23 A.M., RN A from the infusion center said the resident has had issues before where the port was completely deaccessed (needle comes out) under the dressing with the medication leaking around the site. The resident was soaked, and the infusion pump was beeping. The facility has not notified the infusion center yet about the incident at 4:00 A.M. The medication the resident is on is called Yondelis, and if the infusion pump was leaking around the port site, the RN would expect facility staff to clamp the tubing.</p> <p>During an interview on 04/05/24 at 9:26 A.M., RN B from the infusion center said if a resident was starting a medication that required an infusion pump to run while away from the infusion center, then the resident would be educated verbally and print a resource on how to manage the infusion pump if issues arise. He/she would educate how to manage the line to contain the medication and clamp off the line. The medication the resident is on is a hardcore medication. If the medication is leaking from tubing or around the port site, or the port site needle becomes deaccessed, then would try to aspirate as much as possible and clamp tubing to minimize the damage. The resident should take two showers if any gets on skin. There is a drug reference book as some medications require an antidote treatment and a spill kit. The antidote is given by the oncologist, but a spill kit can be sent with the resident to help manage a spill or leak if it happens. There is a 24-hour emergency number the infusion center gives everyone in case there are issues or concerns like a pump malfunction. Nobody has called from the facility about the resident.</p> <p>During an interview on 04/05/24 at 10:10 A.M. RN B from the infusion center said the facility is not answering their phone calls. He/She was trying to get a hold of the facility to see if the resident could come in earlier for an appointment. The facility should have a spill kit if any chemotherapy leaked. The facility should have called if the pump was beeping and if the medication has leaked and gotten on any skin. The facility staff should give the resident a shower and get them here as soon as possible. The shower will help flush the medication from the skin as much as possible.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/05/24 at 10:30 A.M., RN E said the resident's infusion center appointment is at 1:00 P.M. and a Certified Nursing Assistant (CNA) will go with him/her. The night nurse called and left a message at the infusion center, but no one has called back. RN E has not tried to contact the infusion center. As far as he/she knows, there are no issues with the resident's infusion. He/She has not assessed the resident. The RN has not received any training regarding the chemotherapy or the infusion pump. He/She does not know anything about a spill kit.</p> <p>During an interview on 04/05/24 at 10:49 A.M., the Assistant Director of Nursing (ADON) said as far as she knows they have a protocol for how they address the resident's chemotherapy, but she does not know what the protocol is. The resident goes to the doctor and they start the chemotherapy and it runs for a day. The resident goes back and then a couple days later goes for labs. She does not know if they have a spill kit. If there are issues with the chemo, the staff are supposed to call the ADON or DON immediately anytime, day or night</p> <p>During an interview on 04/05/24 at 10:55 A.M., CNA H said there has not been any training on chemotherapy or how to care for someone receiving chemotherapy. The resident has been receiving the medication for a long time now. The resident had an issue a few months ago with the chemotherapy leaking from the port. The nurse changed the dressing. The CNA drove the resident to the infusion center to get it fixed. If he/she sees an issue with the pump, he/she reports it to the nurse. He/She does not know anything about a spill kit.</p> <p>During an interview on 04/05/24 at 11:20 A.M., the DON said there was no education or training regarding the chemo. They did not originally have orders for it, but she called the doctor and got them. She also put in orders if anything is wrong with the chemo, they are to send the resident to the ER. The DON said they do not have a spill kit or anything regarding what to do if it malfunctions or leaks. If the pump was leaking, she would clean it and ensure skin isn't red and then send the resident to the ER. When checking the tubing this morning, it looked like the night nurse tried to reattach the tubing and then put tape over it. She did not see anything on the resident's skin. When asking if staff understood what to do, the DON said, It's not something the nurses here know how to do.</p> <p>During an interview on 04/05/24 at 11:54, RN E said he/she called the doctor's office that manages the resident's chemotherapy and was told it was ok to address the pump issue at the scheduled appointment time.</p> <p>During an interview on 04/15/24 at 4:19 P.M., RN G said on 04/05/24 around 4:00 A.M. the resident's pump was alarming. The pump said tubing occluded (blocked off), which is unusual and had not happened before. Usually the pump has no issues and lasts until the resident goes back to the infusion center to get the infusion pump taken off. He/she tried to troubleshoot the infusion pump but could not fix it. He/she did not apply any tape or anything but that does not mean someone else didn't. He/She silenced the pump and called the emergency number provided in the orders to see what they wanted him/her to do. They did not answer so he/she left a voicemail and let the DON and ADON know about the issue. He/she then passed the information along to the dayshift nurse. He/she has never received training on how to manage or care for the infusion pump or chemotherapy medication infusing. He/she does not know about a spill kit.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the DON would expect training and education to be done so that staff can competently and appropriately take care of residents receiving chemotherapy. There is a lot of training and in-services going to be done this year.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/19/24 at 3:44 P.M., the Administrator would expect medications to be administered per physician orders and the manufacturer guidelines. Training and education should be done in the future so staff are competent to take care of people getting chemotherapy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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**</b> 46460</p> <p>Based on interview, and record review, the facility failed to ensure the Registered Dietician's (RD) recommendations for weight loss were provided to the physician which affected one resident (Resident #16) out of 13 sampled residents. The facility census was 49.</p> <p>Review of the facility policy titled, Weight Loss, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- The facility will ensure that each resident maintains acceptable parameters of body weight, unless the resident's clinical condition demonstrates that this is not possible;</li> <li>- The charge nurse will ensure that each resident is weighed monthly or more frequently if ordered by the physician or deemed necessary for the resident's clinical condition;</li> <li>- Ensure that all residents with unplanned weight loss are monitored by the physician and dietician;</li> <li>- Monitor the charts of all residents with unplanned weight loss to ensure that interventions and documentation are appropriate;</li> <li>- Calculate weight losses and notify the resident's physician and dietician if there has been a 5 percent (%) weight loss in one month, 7.5% weight loss in 3 months, and 100% weight loss in 6 months;</li> <li>- Inform the resident and family member of the weight loss;</li> <li>- Document in the resident's chart that the physician, dietician, resident, and family member were notified;</li> <li>- Schedule the resident to be weighed weekly or more frequently as ordered by the resident's physician or dietician.</li> </ul> <p>1. Review of Resident #16's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of mild protein calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), dementia (group of thinking and social symptoms that interferes with daily functioning), and gastroesophageal reflux disease (GERD - digestive disease in which stomach acid or bile irritates the food pipe lining);</li> <li>- At risk of malnutrition, per the admission Mini Nutrition Evaluation, dated 01/11/24.</li> </ul> <p>Review of the resident's weights showed:</p> <ul style="list-style-type: none"> <li>- On 12/19/23, the resident weighed 134.4 pounds (#);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>	<ul style="list-style-type: none"> <li>- On 01/10/24, the resident weighed 128.2#;</li> <li>- On 02/02/24, the resident weighed 138.6#;</li> <li>- On 03/03/24, the resident weighed 114.8#, which is a 14.58 percent (%) loss in three months;</li> <li>- On 04/09/24, the resident weighed 126.2#.</li> </ul> <p>Review of the resident's height showed:</p> <ul style="list-style-type: none"> <li>- On 12/21/23, 67.0 inches;</li> <li>- On 01/11/24, 61.0 inches;</li> <li>- On 01/11/24, 62.0 inches.</li> </ul> <p>Review of the resident's care plan, revised on 04/05/24, showed:</p> <ul style="list-style-type: none"> <li>- Resident is nutritionally at risk related to malnutrition, foot ulcer, multiple comorbidities/medications;</li> <li>- Resident will consume &gt;75% two of three meals/day through next review;</li> <li>- Give the resident supplements/snacks as ordered. Alert nurse/dietician if not consuming on a routine basis;</li> <li>- Labs as ordered. Report results to physician and ensure dietician is aware;</li> <li>- Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss;</li> <li>- Monitor and record food intake at each meal;</li> <li>- Offer substitutes if resident consumes less than 50% of meal. Regular diet.</li> </ul> <p>Review of the RD note, dated 12/24/23, showed:</p> <ul style="list-style-type: none"> <li>- Regular diet with regular texture and liquid consistency;</li> <li>- Most recent weight 134.4# on 12/19/23. No height in electronic medical record (EMR) for resident;</li> <li>- Skin- left foot 5th toe;</li> <li>- Continue to encourage adequate by mouth (PO) intake at meals;</li> <li>- Recommend provide double protein to aid in wound healing;</li> <li>- Recommend enter height in EMR for resident.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>Review of the RD note, dated 01/30/24, showed:</p> <ul style="list-style-type: none"> <li>- Regular diet with regular texture and liquid consistency. Intake variable over the past month, likely inadequate overall;</li> <li>- Most recent weight 128.2# on 01/10/24. Admission weight of 134.4#, indicating loss of 6.2# (4.6%) times one month, mild for time frame;</li> <li>- Skin- left foot 5th toe;</li> <li>- Continue to encourage adequate PO intake at meals;</li> <li>- Recommend provide health shake twice daily with meals to aid in PO intake and wound healing.</li> </ul> <p>Review of the RD note, dated 02/29/24, showed:</p> <ul style="list-style-type: none"> <li>- Regular diet with regular texture and liquid consistency. Intake continues to be varied at meals, likely inadequate overall. Consuming less than 50% of most meals;</li> <li>- Most recent weight 138.6# on 02/02/24; Body mass index (BMI - an indicator of obesity and underweight) 25.3. Weight stable times one month since admission;</li> <li>- Skin- left foot 5th toe;</li> <li>- Continue to encourage adequate PO intake at meals;</li> <li>- Continue current supplement regimen;</li> <li>- No new recommendations at this time.</li> </ul> <p>Review of the RD note, dated 03/31/24, showed:</p> <ul style="list-style-type: none"> <li>- Regular diet with regular texture and liquid consistency. Intake improved over the past month, consuming &gt;75% of most meals. Receives health shake twice daily (BID) with meals;</li> <li>- Most recent weight 114.8# on 03/05/24; BMI 21. Weight of 139# on 02/02/24, indicating loss of 24# (17.3%) times one month, severe for time frame;</li> <li>- Skin- vascular wound to left foot 5th toe;</li> <li>- Recommend weekly weights to better establish baseline weight;</li> <li>- Recommend 30 milliliters (ml) of Prostat (liquid protein supplement) twice daily to aid in wound healing;</li> <li>- Continue to encourage adequate PO intake at meals;</li> <li>- Continue current supplement regimen.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>Review of the RD note, dated 04/17/24, showed:</p> <ul style="list-style-type: none"> <li>- Regular diet with regular texture and liquid consistency. Limited documentation of intake available. Receives health shake BID with meals;</li> <li>- Most recent weight 126.2# on 4/9/24; BMI 23.1. Weight of 114.8# on 03/05/24 suggesting gain of 11.4# (9.9%) x 1 month. RD not concerned with weight gain as resident BMI remains normal for age;</li> <li>- Skin- vascular wound to left foot 5th toe;</li> <li>- Recommend 30 ml Prostat BID to aid in wound healing;</li> <li>- Continue to encourage adequate PO intake at meals.</li> </ul> <p>Review of the resident's physician orders showed:</p> <ul style="list-style-type: none"> <li>- Regular diet, Regular texture, Regular/Thin consistency, dated 12/18/23;</li> <li>- Weight monthly, every day shift every month starting on the 2nd for one day, dated 12/16/23;</li> <li>- Health shake two times a day with meals, dated 02/02/24;</li> <li>- No order for double protein, per RD recommendation, dated 12/24/23;</li> <li>- No order for weekly weights, per RD recommendation, dated 03/31/24;</li> <li>- No order for Prostat twice daily to aid in wound healing, per RD recommendations, dated 03/31/24 and 04/17/24.</li> </ul> <p>During an interview on 04/10/24 at 10:32 A.M., the Director of Nursing (DON) said they are having a morning meeting on the computer. She does walking rounds. They talk about wounds, falls, psychotropics, weight loss, and they have in-services planned for the entire year. They are not having weekly weight meetings yet. They are hoping to do education and have mandatory meetings. When the dietician comes, she talks to the dietary manager about changes, and then it should be communicated with nursing management if new orders are needed. She would expect dietician recommendations to be implemented as physician orders for residents. The DON has not yet seen a dietician report in the three weeks she's been here. The dietician is on the calendar to come on 04/17/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>42699</p> <p>Based on interview and record review, the facility failed to ensure there was a sufficient number of nursing personnel to provide care and respond to each resident's basic and individual needs required by the resident's diagnoses, medical condition, or plan of care. This had the potential to affect all residents in the facility. The facility census was 49.</p> <p>Review of the Facility Assessment (an assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies), dated 08/30/22, showed:</p> <ul style="list-style-type: none"> <li>- Facility assessment not reviewed since 2022 when the facility opened and had a census of two residents;</li> <li>- Direct Care Staffing desired showed one Registered Nurse (RN), two Licensed Practical Nurses (LPN) and one Certified Nursing Assistant (CNA) for the two residents.</li> </ul> <p>Review of Resident Council Minutes from January 2024 through March 2024 showed:</p> <ul style="list-style-type: none"> <li>- Clothing is not being washed and returned in a timely manner;</li> <li>- Rooms are not being fully cleaned;</li> <li>- Beds are not being made;</li> <li>- CNAs are not checking on residents enough at night.</li> </ul> <p>Review of resident care needs showed:</p> <ul style="list-style-type: none"> <li>- 10 residents dependent on staff for transfers that required the use of a hooyer lift;</li> <li>- Nine residents that required partial to moderate assistance of 1-2 staff for transfers.</li> </ul> <p>Review of the medical diagnoses (dx) of the 49 residents present during the on-site survey showed:</p> <ul style="list-style-type: none"> <li>- Twenty-two residents had dx of schizophrenia (disorder that affects a person's ability to think, feel and behave clearly);</li> <li>- Eleven residents had a dx of bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs);</li> <li>- Seventeen residents had a dx of anxiety (intense, excessive and persistent worry and fear about every day situations);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- Twenty-two residents had a dx of depression (loss of pleasure or interest in activities for long periods of time);</li> <li>- Seven residents had a dx of schizoaffective disorder (mental health condition including a combination of schizophrenia and a mood disorder like depression or bipolar);</li> <li>- Three residents had a dx of history of suicide attempt/suicidal ideations (thoughts);</li> <li>- One resident had a dx of agoraphobia (fear of places and situations that might cause panic, helplessness or embarrassment);</li> <li>- One resident had a dx of neurocognitive disorder with Lewy bodies (type of dementia which affects chemicals in the brain and can lead to problems with thinking, movement, behavior and mood);</li> <li>- One resident had a dx of personality disorder (condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems);</li> <li>- One resident had a dx of antisocial personality disorder (mental health condition characterized by disregard for other people);</li> <li>- One resident had a dx of borderline personality disorder (mental health disorder characterized by unstable moods behavior and relationships);</li> <li>- One resident had a dx of post traumatic stress disorder (PTSD - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event);</li> <li>- One resident had a dx of psychosis (mental disorder characterized by disconnection from reality);</li> <li>- One resident had a dx of disruptive mood dysregulation disorder (condition that causes chronic intense irritability and frequent temper outbursts that are out of proportion for the situation).</li> </ul> <p>Review of the facility schedule and employee timepunches for March 2024 showed:</p> <ul style="list-style-type: none"> <li>- On 03/07/24 from 9:11 P.M.-6:39 A.M., the facility had one RN and one CNA in the building with a census of 48;</li> <li>- On 03/15/24 from 8:12 P.M.-11:00 P.M. and from 1:00 A.M.-6:43 A.M., the facility had one RN and one CNA in the building with a census of 49;</li> <li>- On 03/20/24 from 9:00 P.M.-6:30 A.M., the facility had one RN and one CNA in the building with a census of 50;</li> <li>- On 03/30/24 from 8:35 P.M.-9:50 P.M., and from 5:36 A.M.-6:45 A.M., the facility had one RN and one CNA in the building with a census of 50;</li> <li>- On 03/31/24 from 8:07 A.M.-6:49 P.M., the facility had one LPN, 1 Certified Medication Technician (CMT) and 1 CNA in the building with a census of 50.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility schedule and employee timepunches for 04/01/24 through 04/19/24, showed:</p> <ul style="list-style-type: none"> <li>- On 04/03/24 from 8:49 P.M.-6:26 A.M., the facility had one RN and one CNA in the building with a census of 49;</li> <li>- On 04/04/24 from 9:12 P.M.-6:53 A.M., the facility had one RN and one CNA in the building with a census of 49.</li> </ul> <p>During an interview on 04/02/24 at 2:00 P.M., Resident #33 said the facility does not have enough staff. He/She said it takes two staff to get him/her up or put him/her in bed and they will often have long wait times due to not having staff available to assist. They will often wait forty-five minutes to an hour for the call light to be answered. They will also have to wait for their medications and receive them late.</p> <p>During an interview on 04/03/24 at 10:40 A.M., Resident #31 said the facility does not have enough staff at night. He/She is independent and can do for himself/herself, but at night there are only two people sometimes, which is not enough, especially if there was an emergency.</p> <p>During an interview on 04/11/24 at 9:45 A.M., CNA I said he/she used to work night shift and there have been multiple nights during his/her course of employment that there was only one nurse and one CNA for the building. He/She felt it could be dangerous to only have two staff in the building. If a medical emergency occurred, the nurse on duty would have to leave the floor and deal with the emergency, and one CNA cannot watch the rest of the building until the emergency has been dealt with. It also takes two people to assist residents in a mechanical lift transfer and that cannot be done until the day shift staff get here.</p> <p>During an interview on 04/11/24 at 11:50 A.M., Housekeeping L and Housekeeping O said the owner cut all housekeeping hours 03/01/24 and had previously cut hours in January. Housekeeping L said the owner expected him/her to clean the facility and do the laundry by himself/herself and it was not doable. The owner allowed two staff to continue to work, but the laundry got behind and staff were cutting up towels to use for washcloths at one point. Housekeeping said they tried to come up with a cleaning schedule, but the owner told them to not clean the window sills, air units, or dust furniture, and to only sweep and mop. They are told to only mop with water in the hallways that have painted floors due to the way the chemicals react with the paint. They do the best they can with what they have to keep the facility clean and laundry done for the residents. The facility has had a lot of agency staff and they sometimes pass out clothes to the wrong residents. Housekeeping previously had five employees and that has been cut down to two full time and one part time person to manage the building.</p> <p>During an interview on 04/11/24 at 12:40 P.M., CMT D said there are plenty of times when staff calls in and there won't be a nurse on the floor. There are often times running with only one CNA at night. The facility also has a lot of residents with behavioral issues which require more staff to meet their needs should they become agitated or aggressive. Behavioral residents sometimes require a one-on-one sitter, and that is not possible if there are only two people in the building at night.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/12/24 at 11:20 A.M., Resident #252 said he/she did not feel the facility had enough staff to meet resident needs. He/She will help other residents back to their rooms after meals. He/She knows he/she is not supposed to help assist other residents, but someone has to help them.</p> <p>During an interview on 04/15/24 at 4:20 P.M., RN G said staffing usually sucks at night and there is usually only him/her and one CNA in the building, sometimes two CNAs. RN G said the facility does not provide any training or orientation upon hire and with staffing being short, it makes him/her afraid for his/her license.</p> <p>During an interview on 04/19/24 at 1:15 P.M., the Director of Nursing (DON) said he/she had worked in the facility approximately a month and has now taken over the schedule. The DON would expect with a census over 40 to have a minimum of two nurses and three CNAs during the day shift and one nurse and two CNAs during the night shift, as they work 12 hour shifts. The facility utilizes agency staff when needed for call-ins and this has to go through the owner first so the opening can be approved and posted with the agency.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the DON and Administrator said they would expect for the facility to have the appropriate staffing numbers to adequately provide for resident care and meet resident needs. The Administrator said she would expect the facility assessment to reflect the resident population and their needs to ensure adequate staffing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42699</p> <p>Based on interview and record review, the facility failed to ensure two Certified Nurse Assistants (CNAs) (CNA K and CNA R) out of two sampled CNAs received 12 hours of training annually. The facility census was 49.</p> <p>The facility failed to provide a policy regarding annual training.</p> <p>Review of the facility assessment, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Facility assessment not reviewed since 2022 when the facility opened and had a census of two residents;</li> <li>- Staff competencies and annual training requirements per regulatory authority and/or facility policy to include: Abuse, Neglect, Exploitation and Misappropriation, Advance Directives, Behavioral Health, Communication, Compliance and Ethics, Cardiopulmonary Resuscitation (CPR), Dementia Care Management, Equipment and assistive device training, Infection Control, Emergency Preparedness, Facility policies and procedures, Resident Rights, Assessing Nutritional Needs and Meeting the needs of individuals with Mental Illness/Intellectual Disability/Developmental Delays.</li> </ul> <p>1. Review of CNA K's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of [DATE];</li> <li>- No documentation of in-services done in relation to facility assessment and annual review.</li> </ul> <p>2. Review of CNA R's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of [DATE];</li> <li>- No documentation of in-services done in relation to facility assessment and annual review.</li> </ul> <p>During an interview on [DATE] at 3:30 P.M., CNA K said he/she had not received any annual trainings on abuse/neglect, Alzheimer's, dementia or behavioral health. Employee signed a paper upon hire regarding abuse, but no orientation or training was done. In-services were done from time to time, but he/she did not remember abuse/neglect in-service.</p> <p>During an interview on [DATE] at 3:44 P.M., the Administrator and Director of Nursing (DON) said they would expect CNAs receiving in-services to have the length of the in-services documented. The DON said they were compiling a list of in-services and trainings that need to be done, as it was not being done. The Administrator said she would expect the facility assessment to reflect the resident population and their needs and for annual trainings to reflect the facility assessment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46460</p> <p>Based on interview and record review, the facility failed to ensure a resident diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care to ensure services to promote the resident's highest level of functioning and psychosocial needs for three residents (Residents #20, #29 and #45) outside the sample with dementia. The facility census was 49.</p> <p>The facility did not provide a dementia policy.</p> <p>1. Review of Resident #20's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnosis of dementia with behavioral disturbance (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 01/06/24, showed:</p> <ul style="list-style-type: none"> <li>- Diagnosis of dementia;</li> <li>- Severe cognitive impairment.</li> </ul> <p>Review of the resident's care plan, last reviewed 12/19/23, showed:</p> <ul style="list-style-type: none"> <li>- Did not address dementia;</li> <li>- Did not address specific problems, interventions, or goals for dementia care;</li> <li>- Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia.</li> </ul> <p>Observations of the resident showed:</p> <ul style="list-style-type: none"> <li>- On 04/02/24 at 2:09 P.M., the resident lay in bed with eyes closed and a blanket covering his/her lower extremities;</li> <li>- On 04/03/24 at 8:07 A.M., the resident lay in bed with eyes closed and a blanket covering his/her lower extremities;</li> <li>- On 04/03/24 at 6:48 P.M., the resident lay in bed with eyes closed and visitors at bedside;</li> <li>- On 04/04/24 at 9:26 A.M., the resident lay in bed with eyes closed and a blanket covering his/her lower extremities.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #29's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnosis of dementia with behavioral disturbance;</li> <li>- Severe cognitive impairment;</li> <li>- No comprehensive care plan.</li> </ul> <p>Review of the resident's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Diagnosis of dementia;</li> <li>- Cognitive status not assessed.</li> </ul> <p>Observations of the resident showed:</p> <ul style="list-style-type: none"> <li>- On 04/02/24 at 1:49 P.M., the resident lay in bed with a blanket covering his/her head;</li> <li>- On 04/03/24 at 8:57 A.M., the resident lay in bed and did not respond to verbal stimuli;</li> <li>- On 04/03/24 at 9:48 A.M., the resident lay in bed with a shirt covering his/her face.</li> </ul> <p>3. Review of Resident #45's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Moderate cognitive impairment;</li> <li>- Diagnosis of dementia with agitation.</li> </ul> <p>Review of the resident's annual MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Diagnosis of dementia;</li> <li>- No cognitive impairment.</li> </ul> <p>Review of the resident's care plan, last reviewed 12/19/23, showed:</p> <ul style="list-style-type: none"> <li>- Did not address dementia;</li> <li>- Did not address specific problems, interventions, or goals for dementia care;</li> <li>- Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia.</li> </ul> <p>Observations of the resident showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 04/02/24 at 1:47 P.M., the resident sat in a chair in the dining room wearing sunglasses;</p> <p>- On 04/03/24 at 8:29 A.M., the resident sat in a chair in 100/200 hallway by the nurse's station;</p> <p>-On 04/03/24 at 6:48 P.M., the resident outside smoking a cigarette;</p> <p>-On 04/04/24 at 9:16 A.M., the resident in dining area waiting to go out and smoke.</p> <p>During an interview on 04/10/24 at 1:57 P.M., the Assistant Director of Nursing (ADON) said they didn't have many dementia residents, but they should have appropriate interventions and activities for residents diagnosed with dementia.</p> <p>During an interview on 04/18/24 at 3:33 P.M., RN AG said he/she was the MDS Coordinator 03/01/24 through 04/10/24. RN AG said when he/she started in March 2024 the MDS Assessments were very far behind. RN AG said he/she had to code a lot of items as not assessed because the information was not there. RN AG said he/she had staff from nursing and the Social Services Designee (SSD) assist with the interviews so he/she could complete what was possible. He/She followed the RAI manual.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing (DON) said they would expect a resident with dementia to have a personalized care plan to ensure his or her highest practicable physical, mental, and psychosocial well-being.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>49152</p> <p>Based on observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately administered, documented, not expired and reconciled for the facility's Emergency Medication Kit (E-Kit), which had the potential to affect all residents. The facility's census was 49.</p> <p>Review of the facility's policy titled, Medications-Pharmacy, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- The facility will provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident;</li> <li>- Emergency Medications: The unit nurse who uses an emergency medication must break the plastic lock, remove the medication, apply a new lock, document in the emergency medication box log, the date, time, and signature, medication with strength and dose, number of the lock removed and number of the lock applied. The nurse is to fill out a requisition for the medication and send the requisition to the pharmacy to replace the medication. Charge nurse should monitor the log to make sure it is filled out correctly;</li> <li>- Pharmacy Consultant will periodically monitor the log, monitor medications in the box, and replace the entire box.</li> </ul> <p>Review of the facility's policy titled, Medications-Narcotics, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Narcotics must be counted at the beginning and end of every shift by the unit nurse ending the shift and the unit nurse beginning the shift;</li> <li>- Both nurses must sign and date the count log that is in the narcotic book.</li> </ul> <p>Review of the facility's policy titled, Medications-Pharmacy Consultant, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Establish a system of records or receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation;</li> <li>- Monitors the emergency medications box and replaces it when needed.</li> </ul> <p>Review of the facility policy titled, Medication Storage, dated 02/23/23, showed medications will be monitored by the unit nurse, charge nurse, and consultant pharmacist to assure they are not expired, contaminated or unusable.</p> <p>Review of the facility protocol titled, E-Kit, undated, showed:</p> <ul style="list-style-type: none"> <li>- Make sure there is an order for what you are pulling;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>	<ul style="list-style-type: none"> <li>- Call the Director of Nursing (DON) and let them know you're using the E-Kit;</li> <li>- Pull your medication, make sure to keep/note the number of the green tag;</li> <li>- Fill out an E-Kit removal form available in the E-Kit;</li> <li>- Make a copy of the E-Kit form;</li> <li>- One copy goes in the DON mailbox;</li> <li>- Original gets faxed to the pharmacy;</li> <li>- Put the original, after faxing to the pharmacy, in the E-Kit;</li> <li>- Re-seal the E-Kit using a red tag available in the E-Kit;</li> <li>- Note the new red tag number on the E-Kit verification form you should have signed at the beginning of the shift.</li> </ul> <p>Observation on 04/04/24 at 4:45 P.M., of the E-Kit located in the 100/200 Hall Medication Room showed:</p> <ul style="list-style-type: none"> <li>- The narcotic E-Kit not locked with a green or red tag;</li> <li>- The non-narcotic E-Kit not locked with a green or red tag;</li> <li>- No E-Kit removal forms;</li> <li>- No E-Kit Verification forms.</li> </ul> <p>Observation on 04/04/24 at 4:50 P.M., of the E-Kit located in the 100/200 Hall Medication Room showed:</p> <ul style="list-style-type: none"> <li>- Two Fentanyl (medication for moderate/severe pain) 75 micrograms (mcg)/hour (hr) patches expired 01/2024;</li> <li>- Two Fentanyl 37.5 mcg/hr patches expired 02/2024;</li> <li>- Two Fentanyl 100 mcg/hr patches expired 08/2023;</li> <li>- Twenty Pregabalin (nerve pain medication) 50 milligrams (mg) tablets expired 01/30/24;</li> <li>- Four Heparin (anticoagulant) 5000 units/milliliter (ml) 1 ml vial expired 03/2024;</li> <li>- Fifteen amlodipine (blood pressure medication) 5 mg tablets expired 12/01/23;</li> <li>- Fourteen amoxicillin/otassium clavulanate (antibiotic) 875mg/125mg tablets expired 03/24/24;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>	<ul style="list-style-type: none"> <li>- Thirty amoxicillin/potassium clavulanate 500mg/125mg tablets expired 02/08/24;</li> <li>- Fifteen amoxicillin/potassium clavulanate 500mg/125mg tablets expired 03/24/24;</li> <li>- Fifteen atorvastatin (cholesterol lowering medication) 20 mg tablets expired 12/01/23;</li> <li>- Thirty atorvastatin 40 mg expired 12/01/23;</li> <li>- Fifteen amoxicillin (antibiotic) 500 mg capsules expired 12/01/23;</li> <li>- Fifteen amoxicillin 500 mg capsules expired 03/24/24;</li> <li>- Fifteen azithromycin (antibiotic) 250 mg tablets expired 12/01/23;</li> <li>- Thirtten azithromycin 250 mg tablets expired 11/16/23;</li> <li>- Fifteen buspirone (antianxiety medication) 5 mg tablets expired 11/30/23;</li> <li>- Fifteen buspirone 5 mg tablets expired 12/30/23;</li> <li>- Fifteen cefdinir (antibiotic) 300 mg capsules expired 01/31/24;</li> <li>- Fifteen cefadroxil (antibiotic) 500 mg tablets expired 03/24/24;</li> <li>- Fifteen cephalexin (antibiotic) 250 mg capsule expired 10/30/23;</li> <li>- Nine cephalexin 250 mg capsule expired 03/24/24;</li> <li>- Sixteen ciprofloxacin (antibiotic) 250 mg tablets expired 12/01/23;</li> <li>- Nine ciprofloxacin 250 mg tablets expired 03/24/24;</li> <li>- Fifteen clindamycin (antibiotic) 150 mg capsules expired 06/30/23;</li> <li>- Two clindamycin 150 mg capsules expired 02/2/24;</li> <li>- Fifteen divalproex (antiseizure medication) 125 mg capsules expired 12/01/23;</li> <li>- Fifteen divalproex 125 mg delayed release (DR) tablets expired 12/05/23;</li> <li>- Fifteen divalproex 250 mg extended release (ER) tablets expired 12/01/23;</li> <li>- Seven divalproex 25 mg ER tablets expired 12/05/23;</li> <li>- Fifteen doxycycline hyclate (antibiotic) 100 mg capsules expired 10/17/23;</li> <li>- Fifteen doxycycline hyclate (antibiotic) 100 mg capsules expired 10/31/23;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>	<ul style="list-style-type: none"> <li>- Five Eliquis (anticoagulant) 2.5 mg tablets expired 12/01/23;</li> <li>- One Eliquis 2.5 mg tablet expired 03/24/24;</li> <li>- Two enoxaparin (anticoagulant) 30 mg injection injections expired 03/20/24;</li> <li>- Fifteen fluconazole (antifungal) 100 mg tablets expired 11/30/23;</li> <li>- Fifteen furosemide (diuretic) 20 mg tablets expired 12/01/23;</li> <li>- Fifteen furosemide 20 mg tablets expired 12/05/23;</li> <li>- Fifteen gabapentin (nerve pain) 100 mg tablets expired 03/14/24;</li> <li>- Two gentamycin injectable vial 800 mg/20ml vials expired 09/2023;</li> <li>- One Glucagon Hypokit (for low blood sugar) 1 mg/ml kit expired 08/31/23;</li> <li>- Twelve haloperidol (antipsychotic) 2 mg tablets expired 12/01/23;</li> <li>- Fifteen haloperidol 2 mg tablets expired 03/24/24;</li> <li>- Twent-five ipratropium/albuterol nebulizers 0.5 mg/3 mg 3ml unit-dose vials expired 03/2024;</li> <li>- Two lactulose solution (laxative) 10 grams/15 ml cups expired 07/2023;</li> <li>- Eight levofloxacin (antibiotic) 250 mg tablets expired 12/01/23;</li> <li>- Fifteen levofloxacin 250 mg tablets expired 03/24/24;</li> <li>- Fifteen meloxicam (nonsteroidal antiinflammatory) 15 mg tablets expired 09/30/23;</li> <li>- Four metronidazole (antibiotic) 500 mg tablets expired 03/24/24;</li> <li>- Eleven metoprolol tartrate (blood pressure medication) 25 mg tablets expired 12/01/23;</li> <li>- Ten moxifloxacin (antibiotic) 400 mg tablets expired 10/30/23;</li> <li>- Fifteen nitrofurantoin monohydrate (antibiotic) 100 mg tablets expired 03/24/24;</li> <li>- Fifteen ondansetron (nausea) 4 mg tablets expired 03/24/24;</li> <li>- Fourteen pantoprazole sodium (acid reflux) 40 mg tablets expired 12/01/23;</li> <li>- Fifteen penicillin V potassium (VK) (antibiotic) 250 mg tablets expired 07/30/23;</li> <li>- Fifteen penicillin VK 250 mg tablets expired 07/31/23;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>	<ul style="list-style-type: none"> <li>- Fifteen potassium 10 milliequivalents (mEq) tablets expired 12/01/23;</li> <li>- Fifteen prednisone (steroid) 5 mg tablets expired 09/30/23;</li> <li>- Fifteen prednisone 5 mg tablets expired 12/05/23;</li> <li>- Fifteen prednisone 20 mg tablets expired 03/24/24;</li> <li>- Fifteen prochlorperazine (nausea) 5 mg tablets expired 10/30/23;</li> <li>- Fifteen prochlorperazine 5 mg tablets expired 02/28/24;</li> <li>- Fifteen quetiapine 25 mg (antipsychotic) tablets expired 12/01/23;</li> <li>- Eight quetiapine 25 mg tablets expired 12/05/23;</li> <li>- Fifteen risperidone (antipsychotic) 0.25 mg tablets expired on 12/31/23;</li> <li>- Fifteen risperidone 0.25 mg tablets expired on 05/31/23;</li> <li>- Fifteen spironolactone (diuretic) 25 mg tablets expired 12/01/23;</li> <li>- Fifteen sulfamethoxazole/trimethoprim (SMZ/TMP) (antibiotic) 160/800mg tablets expired 02/08/24;</li> <li>- Fifteen SMZ/TMP 160/800mg tablets expired 03/24/24;</li> <li>- Fifteen trazodone (antidepressant/sedative) 50 mg tablets expired 09/30/23;</li> <li>- Fourteen trazodone 50 mg tablets expired 12/05/23;</li> <li>- Fifteen vancomycin (antibiotic) 125 mg capsules expired 05/2023;</li> <li>- Five vitamin K 10mg/ml ampule ampules expired 08/30/23;</li> <li>- Two vitamin K1 10 mg/ml ampule ampules expired 09/01/23;</li> <li>- Fifteen warfarin (blood thinner) 1 mg tablets expired 07/30/23;</li> <li>- Fifteen warfarin 1 mg tablets expired 12/01/23;</li> <li>- Fifteen warfarin sodium 2 mg tablets expired 03/30/23;</li> <li>- Fifteen warfarin sodium 2 mg tablets expired 11/30/23;</li> <li>- Ten Xarelto (anticoagulant) 10 mg tablets expired 12/01/23;</li> <li>- Five Xarelto 10 mg tablets expired 03/24/24.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>During an interview on 04/04/24 at 4:30 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said they would expect for all expired medications to be discarded per the facility policy. They were new to the facility and had only been here two weeks, but it did not appear that the facility had a process or was following the process.</p> <p>Observation on 04/04/24 at 6:30 P.M., showed Registered Nurse (RN) C removed a hydrocodone/acetaminophen (hydro/apap - pain medication) 5-325 mg tablet from the E-Kit and told the Administrator, the DON and the ADON, who were in the medication room, that it was for Resident #12. RN C did not fill out an E-kit form. When the DON said that had to be logged out, the Administrator told the DON to just put it on the supply log so it could be replaced.</p> <p>Observation on 04/04/24 at 6:32 P.M., of the E-Kit Narcotic Count showed:</p> <ul style="list-style-type: none"> <li>- Twenty Tramadol (medication for moderate/severe pain) 50 mg tablets;</li> <li>- Two morphine solution (medication for moderate/severe pain) 20 mg/ml bottles;</li> <li>- Nineteen temazepam (sedative) 15 mg;</li> <li>- Sixteen Oxycontin (medication for moderate/severe pain) 10 mg;</li> <li>- Sixteen oxycodone (medication for moderate/severe pain) 10 mg;</li> <li>- Seventeen oxycodone 5 mg;</li> <li>- Eight hydrocodone/acetaminophen (hydro/aapap) (medication for moderate/severe pain) 5/325 mg;</li> <li>- Seven hydro/apap 10/325 mg;</li> <li>- Twenty hydro/apap 7.5/325 mg;</li> <li>- Nineteen oxycodone/Acetaminophen (oxy/apap) (medication for moderate/severe pain) 5/325 mg;</li> <li>- Eighteen oxy/apap 10/325 mg;</li> <li>- Nine clonazepam (anticonvulsant) 0.5 mg;</li> <li>- Twenty diazepam 2 (seizure/anxiety medication) mg ;</li> <li>- Two Fentanyl (medication for moderate/severe pain) 12 mcg/hr patches;</li> <li>- Two Fentanyl 25 mcg/hr patches;</li> <li>- Two Fentanyl 50 mcg/hr patches;</li> <li>- Fourteen alprazolam (anxiety medication) 0.25 mg.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>During an interview on 04/04/24 at 7:30 P.M., the Administrator said she would expect the E-Kit be monitored for expired medications and discarded per the facility policy. She would expect for narcotic medications to be signed out and reconciled, and non-narcotic medications should be signed out as well. There did not appear to be a process that was being followed.</p> <p>During an interview on 04/04/24 at 7:35 P.M., the DON and ADON said they would expect all medications removed from the E-Kit to have been signed out per the E-Kit instructions. They would expect for the E-Kit narcotics to be counted and reconciled daily. The DON and ADON said there was no way to account for the narcotic medications that had been removed from the E-Kit.</p> <p>During an interview on 04/05/24 at 12:15 P.M., the Pharmacy Consultant said it was his/her understanding the facility should check the E-Kit weekly. The Pharmacy Consultant did not know if the E-Kits were being swapped out weekly. The pharmacy consultant that came to the facility was supposed to be doing medication cart checks, as well as E-Kit checks when they came. He/She said it was not getting done and he/she was starting to check them monthly. Normally, the facility would send the pharmacy an E-Kit notification when they had utilized the kit so that it could be replenished.</p> <p>During an interview on 04/05/24 at 12:22 P.M., the Pharmacy RN confirmed the facility had not received a new E-Kit since the initial delivery. The narcotic kit should have had a quantity of 20 for each medication, other than there were only two Fentanyl patches of each dose and only two 20 ml bottles of morphine. The pharmacy had not received any faxes showing the E-Kit was accessed and narcotics were removed in order to reconcile the kit.</p> <p>After verification of the original E-Kit narcotic counts with the pharmacy, the following narcotics were unable to be accounted for:</p> <ul style="list-style-type: none"> <li>- One temazepam 15 mg tablet;</li> <li>- Four oxycodone 10 mg tablets;</li> <li>- Three oxycodone 5 mg tablets;</li> <li>- Twelve hydro/apap 5-325 mg tablets;</li> <li>- Thirteen hydro/apap 10-325 mg tablets;</li> <li>- One oxy/apap 5-325 mg tablet;</li> <li>- Two oxy/apap 10-325 mg tablets;</li> <li>- Eleven clonazepam 0.5 mg tablets;</li> <li>- Six alprazolam 0.25 mg tablets.</li> </ul> <p>During an interview on 04/05/24 at 2:03 P.M., the Administrator and DON said there was no way at this time to reconcile when and to whom the narcotic medications from the E-Kit were administered.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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** 46460</b></p> <p>Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for two residents (Residents #29 and #43) outside of the sample. This failure had the potential to keep any resident on a psychoactive medication from receiving the lowest possible dosage of medication due to not monitoring if a medication is treating the target symptom. The facility census was 49.</p> <p>The facility did not provide a policy.</p> <p>1. Review of Resident #29's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of dementia with behavioral disturbance and altered mental status;</li> <li>- An order for paroxetine (antidepressant medication) oral tablet 10 milligrams (mg), give one tablet by mouth one time a day related to altered mental status (change in mental function that stems from illnesses, disorders and injuries), dated 12/17/23;</li> <li>- An order for quetiapine (antipsychotic medication) 25 mg tablet, give one tablet by mouth one time a day related to altered mental status, dated 12/17/23;</li> <li>- A behavior note, dated 01/28/24 at 3:15 P.M., with resident spitting on floor. When asked to stop spitting, resident stated that he didn't, then spit again on the floor;</li> <li>- A progress note, dated 04/06/24 at 5:39 A.M., with Medication Regimen Review (MRR). GDR request, see report;</li> <li>- No letter to attending physician regarding GDR request;</li> <li>- No documentation of GDRs attempted;</li> <li>- No documentation of contraindication of medication adjustments.</li> </ul> <p>Observations of Resident #29 showed:</p> <ul style="list-style-type: none"> <li>- On 04/02/24 at 1:49 P.M. in bed with cover over head;</li> <li>- On 04/03/24 at 8:57 A.M. lying in bed on left side. Does not respond to verbal stimuli;</li> <li>- On 04/03/24 at 9:48 A.M. lying in bed with shirt covering face.</li> </ul> <p>2. Review of Resident #43's medical record showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>- An admitted [DATE];</p> <p>- Diagnoses of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), type 2 diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), heart failure (an inability of the heart to pump sufficient blood flow to meet the body's needs), schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), depression (a serious medical illness that negatively affects how you feel, the way you think, and how you act), bipolar (a mental disorder that causes unusual shifts in mood), glaucoma (a disease affecting eye pressure and causing gradual loss of vision), insomnia (difficulty sleeping), and anxiety (persistent worry and fear about everyday situations);</p> <p>- An order for Latuda (antipsychotic medication) 80 mg one tablet daily for schizophrenia, dated 03/15/23;</p> <p>- An order for Latuda 40 mg one tablet daily for schizophrenia, dated 03/15/23;</p> <p>- An order for lorazepam (antianxiety medication) 0.5 mg twice a day for generalized anxiety disorder, dated 07/06/23;</p> <p>- An order for sertraline (antidepressant medication) oral tablet 50 mg one tablet once daily for bipolar disorder, dated 03/15/23;</p> <p>- No documentation of GDRs attempted;</p> <p>- No documentation of contraindications of medication adjustments.</p> <p>Observations of Resident #43 showed:</p> <p>- On 04/02/24 at 2:27 P.M., resident laying on left side in bed with blue mask over face with nasal cannula on underneath mask;</p> <p>- On 04/03/24 at 12:20 P.M., resident paced up and down hall dressed in a suit with blue mask on face;</p> <p>- On 04/04/24 at 3:28 P.M., resident in courtyard wearing the same suit from the day before with mask under his/her chin.</p> <p>During an interview on 04/24/24 at 9:48 A.M., the pharmacist said the process for medication review is to do them monthly and check every resident's medications. As needed medications as well as antipsychotics get looked at monthly. If a resident needs something addressed, then it will be addressed with the monthly medication review. If a resident's condition changes and a medication needs to be addressed, he/she relies on facility staff to reach out with updated resident information. All GDRs are done per CMS regulations. It does not matter if a psychologist or specialist is seeing a resident. The GDR must still be addressed, and the doctor can document whether or not the GDR can be attempted or not.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>During an interview on 04/19/24 at 3:44 P.M., the Director of Nursing (DON) said she would expect all residents to have monthly medication reviews by the pharmacist. If a resident is on a psychotropic medication, then she would expect a GDR attempt or physician documentation indicating why the GDR is contraindicated. She would also expect a resident on a psychotropic medication to have an appropriate diagnosis for the medication.</p> <p>49152</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent (%) or less. There were six errors out of 42 opportunities for error, resulting in an error rate of 14.29%. This practice affected one resident (Resident #36) out of 13 sampled residents and one resident (Resident #12) outside the sample. The facility census was 49.</p> <p>Review of the facility policy titled, Medication Administration, undated, showed:</p> <ul style="list-style-type: none"> <li>- The facility will provide pharmaceutical services, including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident;</li> <li>- Scan the resident's other medication orders to make sure there are no contraindications between the medications;</li> <li>- If unit nurse is unfamiliar with the medication, the nurse should look it up in the drug handbook on the medication cart, call the pharmacist and/or physician for clarification, and look for the manufacturer guidelines at the nurses' station if it is a recently released medication;</li> <li>- Wash hands thoroughly between residents;</li> <li>- Check for any special instructions the medication has for administration, such as flushing gastrostomy tubes (g-tubes - tube inserted through the belly that brings nutrition directly to the stomach), crushing medications with a list of medications it is permissible to crush can be found at the back of the Medication Administration Record (MAR), shaking, rotating patch or injection sites, and giving medications with or between meals;</li> <li>- The unit nurse must watch the resident take the medication, and no medication must ever be left in the resident's room;</li> <li>- Oral medications may be administered to the resident in the dining room if the resident is agreeable, but medications by any other route must not be given in the dining room;</li> <li>- The medication cart should always be locked unless it is in direct view of the unit nurse.</li> </ul> <p>Review of the facility policy titled, Feeding Tubes, undated, showed:</p> <ul style="list-style-type: none"> <li>- Physician orders for a feeding tube must state type and size of tube, feeding formula, total calories per day, amount, rate and frequency of formula, and type, amount, and frequency of flushes;</li> <li>- Flush the tube per physician's orders. The tube should be flushed at least once per shift, before and after bolus administration of formula, and before and after administration of medications;</li> <li>- Check medications and formulas to make sure they are compatible, as certain combinations will cause clotting of formulas;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Medications should be in liquid form if possible. If medication is in tablet form, check that it is permissible to crush it. Dissolve crushed medications in water before administering. Do not crush enteric coated tablets;</p> <p>- To administer medication, stop the feeding and confirm tube placement by either aspirating small amount of gastric content or by injecting 5-10 milliliters (ml) of air into the tube, and listening to air entering the stomach. Flush tube with 30 ml of water unless physician order states otherwise. Administer the medication. Flush with 30 ml of water and continue the feeding.</p> <p>Review of drug information on www.drugs.com showed:</p> <p>- Take desvenlafaxine ER tablets whole; do not divide, crush, chew, or dissolve;</p> <p>- Do not open the hydroxyurea capsule or crush or chew a tablet. Do not use a broken pill. The medicine from a crushed or broken pill can be dangerous if it gets in your eyes, mouth, or nose, or on your skin;</p> <p>- Do not chew, break, or crush Reglan (metoclopramide).</p> <p>1. Review of Resident #12's medical record showed:</p> <p>- An admitted [DATE];</p> <p>- Diagnoses of moderate protein calorie malnutrition (a type of malnutrition that the diet is deficient in both protein and calories), anxiety, schizophrenia (a mental disorder that causes a person to interpret reality abnormally and can include hallucinations and delusions and could impair daily function), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and diabetes due to underlying condition of hyperglycemia (glucose building up in the blood);</p> <p>- An order dated 04/03/24 for Jevity (a supplemental or sole-source nutrition) 237 milliliters (mL) three times a day. May substitute Isosource HN (complete high nutrition tube-feeding formula) 1.2 if Jevity not available;</p> <p>- An order dated 04/03/24 for Isosource HN 1.2 500 mL three times a day, 100 mL free water flush (fwf) before and after feeding;</p> <p>- An order dated 04/03/24 for Jevity 1.2 bolus two cartons=570 calories four times a day. May substitute Isosource;</p> <p>- An order dated 08/31/23 to flush gastrostomy tube with 100 mL of water three times a day and at bedtime. Flush tube with 50 mL of water before and after tube feeding to equal 100 mL;</p> <p>- An order for gabapentin (nerve pain medication) oral capsule 300 milligrams (mg) three times a day for pain, dated 08/31/23.</p> <p>Review of the resident's MAR, dated April 2024, showed Registered Nurse (RN) C documented gabapentin oral capsule 300 mg administered on 04/04/24 at 12:00 P.M.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the medication pass for the resident on 04/04/24 at 11:50 A.M. showed:</p> <ul style="list-style-type: none"> <li>- RN C opened the gabapentin capsule, mixed with 30 ml water, flushed the first 10 ml of water into the g-tube and it came out the other g-tube port onto the bed sheet.</li> </ul> <p>2. Review of Resident #36's Physician Order Sheets (POS), undated, showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of major depressive disorder (MDD - long-term loss of pleasure or interest in life), generalized anxiety (persistent worry and fear about everyday situations), pain, pulmonary embolism (blood clot in one or both lungs), and atherosclerotic heart disease (chronic condition where heart does not pump blood as well it should);</li> <li>- An order for hydroxyurea oral capsule 500 mg one capsule one time a day for chemotherapy, dated 10/11/23;</li> <li>- An order for desvenlafaxine (an antidepressant) extended release (ER) 24 hour 100 mg one tablet via g-tube one time a day for MDD, dated 10/11/23;</li> <li>- An order for Reglan (a gut motility stimulator) oral tablet 5 mg one tablet via g-tube three times a day for gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), dated 10/11/23.</li> </ul> <p>Review of the resident's MAR, dated April 2024, showed:</p> <ul style="list-style-type: none"> <li>- RN B documented desvenlafaxine ER oral tablet 24 hour 100 mg administered on 04/03/24 at A.M. med pass;</li> <li>- RN B documented hydroxyurea oral capsule 500 mg administered on 04/03/24 at 8:00 A.M.;</li> <li>- RN B documented Reglan oral tablet 5 mg administered on 04/03/24 at A.M. med pass.</li> </ul> <p>Observation of medication pass for Resident #36 showed:</p> <ul style="list-style-type: none"> <li>- On 04/03/24 at 9:50 A.M., RN B crushed the desvenlafaxine ER 24 hour release oral tablet, opened the hydroxyurea oral capsule 500 mg, and crushed the Reglan oral tablet 5 mg then mixed the three medications with 30 mL of water and administered through the g-tube. RN B attempted to flush the medications mixed with water through the g-tube, but it frequently became clogged. RN B unclogged the g-tube multiple times before the medications were administered with difficulty over a 12 minute period. RN B failed to flush the g-tube after med pass;</li> <li>- On 04/04/24 at 12:40 P.M., RN C crushed and administered Reglan oral tablet 5 mg with 30 mL of water through the g-tube;</li> <li>- On 04/04/24 at 4:54 P.M., RN C crushed and administered Reglan oral tablet 5 mg with 30 mL of water through g-tube.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/03/24 at 10:09 A.M., RN B said if the medications were ordered, then he/she would crush them and give them. The pharmacy changed some residents' g-tube medications that could not be crushed and given in their tube. He/She didn't know why the pharmacy changed some residents' orders but not others.</p> <p>During an interview on 04/05/24 at 11:17 A.M., the Administrator said she was not sure how nursing staff knew which meds to crush and not crush.</p> <p>During an interview on 04/05/24 at 11:54 A.M., RN E said there was no training for which medications could/couldn't be crushed. There was no list posted anywhere or resources available to see if something could be crushed.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Director of Nursing (DON) and Administrator said they expect staff to administer medications per physician's orders and per medication guidelines. They expect staff to follow facility policy and if they didn't know if something could be crushed or given a different route, then they needed to clarify with the physician or with the pharmacy.</p> <p>During an interview on 04/24/24 at 9:48 A.M., the Pharmacist said if a resident's condition changed and a medication needed to be addressed, he/she relied on facility staff to reach out with the updated resident information. A gabapentin capsule could be opened and given through a g-tube, but if the g-tube was not working correctly or the medication couldn't go through the g-tube without difficulty, then the medication may need to be adjusted. Extended release medications should be changed to a different form if possible when getting medication through a g-tube. Most medications could be crushed but some couldn't and hydroxyurea needed to be handled differently. The pharmacy would most likely need to change the hydroxyurea capsule to a compound form. There is a special transfer device that can be used for hydroxyurea, but it is expensive and most places did not have them.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49152</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were securely stored in accordance with currently accepted practices and facility policy. The facility failed to ensure one resident (Resident #42) out of the 13 sampled residents had a physician's order to keep and self-administer medications at the bedside. The facility failed to ensure medication carts and medication rooms were free from expired medications, which had the potential to affect all residents. The facility failed to properly dispose of an expired medication for one resident (Resident #30) outside of the sample. The facility census was 49.</p> <p>Review of the facility policy titled, Medication Storage, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- Medications must only be accessible to authorized staff and locked when not under the direct supervision of authorized staff;</li> <li>- Medication cart should always be locked unless it is in the direct view of the unit nurse;</li> <li>- No medications should be left unattended in resident rooms;</li> <li>- Medications will be monitored by the unit nurse, charge nurse, and consultant pharmacist to assure they are not expired, contaminated, or unusable.</li> </ul> <p>Review of the facility policy titled, Medication Self-Administration, dated 02/23/23, showed:</p> <ul style="list-style-type: none"> <li>- A resident may only be permitted by the facility to self-administer medications if all the following requirements are met: A) Physician's order approving self-administration, B) Assessment completed by charge nurse that determines resident is capable of taking medications competently and safely as prescribed, C) Resident given instructions on safe medication use and is documented in the resident's record, D) Resident demonstrated ability to take medications competently and safely as prescribed and documented in the resident's record;</li> <li>- Care plan for self-administration of medications to include monitoring the resident's ability;</li> <li>- Unit Nurse will monitor the resident's self-administration frequently and report to the care plan team any changes in the resident's ability to safely self-administer medications.</li> </ul> <p>Observations of the medication and treatment carts showed:</p> <ul style="list-style-type: none"> <li>- On 04/03/24 at 11:10 AM, the medication cart sat unlocked outside the Director of Nursing's (DON) office;</li> <li>- On 04/03/24 at 1:13 P.M., the medication cart sat unattended and unlocked with the computer screen with resident information visible. The medication cart was unattended and unlocked from 1:13 P.M. until 1:17 P.M. , when Registered Nurse (RN) B returned, locked the cart and closed the computer;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- On 04/03/24 at 1:45 P.M., the medication cart sat unlocked outside of room [ROOM NUMBER];</li> <li>- On 04/04/24 at 8:03 A.M., the medication cart sat unlocked outside of room [ROOM NUMBER];</li> <li>- On 04/05/24 at 10:47 A.M., the medication cart sat unlocked outside of room [ROOM NUMBER];</li> <li>- On 04/10/24 at 8:25 A.M., the medication cart sat unlocked and unattended outside room [ROOM NUMBER]. RN B walked from around the corner and locked the cart;</li> <li>- On 04/12/24 at 1:15 P.M., the treatment cart sat unlocked between 300/400 Hall.</li> </ul> <p>Observations of Resident #42's room showed:</p> <ul style="list-style-type: none"> <li>- On 04/02/24 at 1:36 P.M., five different pills in a crushed pill package and one pill outside of the package sat on the bedside table;</li> <li>- On 04/03/24 at 9:45 A.M., two circular orange pills sat on the bedside table;</li> <li>- On 04/04/24 at 8:03 A.M., five circular orange pills sat on the bedside table;</li> <li>- On 04/04/24 at 1:36 P.M., five circular orange pills sat on the bedside table;</li> <li>- On 04/04/24 at 4:55 P.M., four circular orange pills sat on the bedside table.</li> </ul> <p>During an interview on 04/02/24 at 1:36 P.M., Resident #42 said the medications on his/her bedside table were his/her morning medications. The staff did not watch him/her take the medications all the time.</p> <p>During an interview on 04/05/24 at 8:40 A.M., Resident #42 said that he/she took one of the pills yesterday evening. It was normal for him/her to have extra pills at bedside. He/She takes the medication when he/she needs them.</p> <p>During an interview on 04/19/24 at 1:30 P.M., Certified Medication Technician (CMT) AC said all residents should be watched when they took all their medications and no medications should be left at the bedside.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the DON and Administrator said they would expect staff to watch residents take their medication when administering it. They would expect no medications to be left at the bedside and unattended at anytime. There was no process for residents to self-administer medications as no residents should be doing it. Medication carts should be locked at all times when staff were not attending the carts.</p> <p>Observation on 04/04/24 at 4:00 P.M., of the medication refrigerator located at the 300/400 Hall Nurse's Station showed:</p> <ul style="list-style-type: none"> <li>- Ten syringes of Hepatitis A Vaccine 0.5 milliliter (ml) dose labeled to discard after 08/17/23;</li> <li>- Ten syringes of Hepatitis B Vaccine 20 microgram (mcg) dose labeled to discard after 03/21/24;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- One Ventolin HFA Inhaler 2 puffs by mouth every 5 hours as needed labeled to discard after 03/21/24, for Resident #30.</p> <p>Observation on 04/04/24 at 4:15 P.M., of the 100/200 Hall Medication Cart showed a bottle of liquid bandage 30 ml expired 02/2020.</p> <p>Observation on 04/04/24 at 4:22 P.M., of the 100/200 Hall Medication Storage Room showed two unopened boxes of loperamide hydrochloride (antidiarrheal medication) 2 mg tablets #24 in each box, expired 06/2023.</p> <p>During an interview on 04/04/24 at 4:30 P.M., the DON and Assistant Director of Nursing (ADON) said they would expect for all expired medications to be discarded per the facility policy. They would expect the nurses to monitor the medications on the cart at least weekly to ensure they were not expired.</p> <p>During an interview on 04/04/24 at 6:30 P.M., the Administrator said she would expect the medication carts and medication rooms to be monitored for expired medications and discarded per the facility policy.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>46555</p> <p>Based on observation, interview and record review, the facility failed to provide appealing alternative options of similar nutritive value to residents who choose not to eat food that was initially served. The facility census was 49.</p> <p>1. Observations of the white dry erase board hung next to the serving window in the dining room showed:</p> <ul style="list-style-type: none"> <li>- On 04/03/24 at 6:00 P.M., the menu for dinner as flatbread pizza, salad, and a bread stick, with no alternative option;</li> <li>- On 04/04/24 at 12:37 P.M., the menu for lunch as chicken parmesan with pasta, asparagus, and garlic bread, with no alternative option.</li> </ul> <p>Observation on 04/03/24 at 1:14 P.M., showed Resident #27 told staff he/she did not like the meal being served. Staff brought the resident a bowl of cereal with milk in place of the lunch option because there were no other alternatives available.</p> <p>Review of the facility's four week rotating menu showed only the main meal served with no alternative options.</p> <p>During an interview on 04/03/24 at 9:41 A.M., six residents (Resident #48, #46, #32, #13, #31, and #23) in attendance at the Resident Council Meeting said there wasn't a specific alternative food menu available for meals. If a resident was served a meal they did not like, they could get a sandwich of some kind, such as peanut butter and jelly, ham and cheese, grilled cheese, etc.</p> <p>Review of the Resident Council Meeting minutes, dated March 2024, showed the residents requested more food options.</p> <p>During an interview on 04/09/24 at 4:04 P.M., the Dietary Manager (DM) said they did not offer an alternative menu for meals. If a resident didn't like what was served, they could have a bowl of cereal, a cheese sandwich or depending on what they wanted, something else could possibly be made. There was one resident that liked chicken, so they tried to have extra chicken on hand for them, but there were no specific alternative menus available at this time.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator said she expected dietary services to have an alternative food option available in case residents didn't like what was being offered that was of equal nutritional value. She would expect residents to have choices on what they eat or drink.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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> 46555</p> <p>Based on observation and interview, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. The facility failed to ensure that foods are maintained at a safe and appetizing temperature on the steam table according to current Food and Drug Administration (FDA) standards, food is kept covered while waiting to be served, and dietary staff sanitize their hands or change gloves during and after preparing food, wear the appropriate hair restraints while in the kitchen, and have policies and procedures in place for food brought in from outside the facility. These practices had the potential to affect all residents who are served food from the kitchen. The facility census was 49.</p> <p>Review of the FDA 2013 Code Section ,d+[DATE].16 Time/Temperature Control for Safety Food, Hot and Cold Holding, showed that:</p> <p>(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under Section ,d+[DATE].19, and except as specified under paragraph (B) and in paragraph (C) of this section, time/temperature control for safety food shall be maintained;</p> <p>(1) At 57 degrees Celsius (C) (135 degrees Fahrenheit (F)) or above (for hot foods), except that roasts cooked to a temperature and for a time specified in paragraph ,d+[DATE].11(B) or reheated as specified in paragraph ,d+[DATE].11(E) may be held at a temperature of 54 degrees C (130 degrees F) or above; or (2) At 5 degrees C (41 degrees F) or less (for cold foods).</p> <p>The facility did not provide a policy pertaining to the kitchen or dietary services.</p> <p>1. Observation on [DATE] at 10:21 A.M., of the white chest-style freezer showed:</p> <ul style="list-style-type: none"> <li>- A ,d+[DATE] inch buildup of frost/ice on the walls of the freezer;</li> <li>- Five frozen food items in plastic bags or wrapping not labeled or dated.</li> </ul> <p>Observation on [DATE] at 10:22 A.M., of the glass door refrigerator showed:</p> <ul style="list-style-type: none"> <li>- Three heads of unwrapped cabbage sat directly on the shelf;</li> <li>- Three bundles of unwrapped asparagus sat directly on the shelf;</li> <li>- Four large plastic bags of lettuce unlabeled and not dated.</li> </ul> <p>Observation on [DATE] at 10:26 A.M., of the walk-in freezer showed:</p> <ul style="list-style-type: none"> <li>- Food items not labeled or dated, including bags of bread in clear plastic bags and what appeared to be frozen vegetables;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>	<ul style="list-style-type: none"> <li>- An unlabeled opened box with an unidentified object wrapped in plastic sat on the floor of the freezer;</li> <li>- An unopened box sat on the floor against the back wall of the freezer;</li> <li>- Dirt and debris in the floor of the freezer.</li> </ul> <p>Observation on [DATE] at 10:29 A.M., of the dry food storage room showed:</p> <ul style="list-style-type: none"> <li>- A box of frying oil sat on the floor between two metal shelves;</li> <li>- An opened box of grill cleaner sat on top of a box of cooking oil in the floor;</li> <li>- An opened box of six cans of red beans sat on the floor;</li> <li>- A box of paper towels sat on the floor with a box of chips and marshmallows on top of the paper towels;</li> <li>- A box of canned pineapples sat on the floor;</li> <li>- Scattered dirt and debris throughout the room;</li> <li>- Multiple items of popcorn, chips, and canned good items not labeled or dated.</li> </ul> <p>During an interview on [DATE] at 10:30 A.M., the Dietary Manager (DM) said the boxes the food came in had dates on them. The individual cans or items did not have dates. They did not realize that, so the only way to know the best by or expiration dates would be to have the original box the items were shipped in.</p> <p>Observation on [DATE] at 10:18 A.M., of the kitchen showed:</p> <ul style="list-style-type: none"> <li>- The commercial dishwasher with white grime build up on the interior and exterior surfaces and water ran from the back left side of the dishwasher with the dishwasher not in use;</li> <li>- Debris on and around the sink to the right of the dishwasher and food debris on the floor beneath the sink;</li> <li>- Debris and a puddle of purple liquid under the right side of the dishwasher;</li> <li>- Debris on the shelf with spices and drinking pitchers;</li> <li>- A shelf in the center of the kitchen with a large container labeled flour, cornmeal, rice, and sugar with no use by date listed;</li> <li>- Black grime build-up on the back and top of the stove;</li> <li>- Pots, pans, plates in an upright position, bowls in an upright position, and cups stored on open shelves under the serving window with dirt and debris;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>	<ul style="list-style-type: none"> <li>- Pots, pizza pans, baking sheets, and skillets with black carbon buildup;</li> <li>- A toaster on the counter by the serving window covered in debris;</li> <li>- The counter by the serving window with debris;</li> <li>- A crate with dirty rags next to the counter where the coffee machine and drink containers sat;</li> <li>- A fan next to the crate with dirty rags covered in dust and debris;</li> <li>- Dirt and debris throughout the kitchen floor;</li> <li>- Cracks in tiles near the wall by the counter with the coffee machine.</li> </ul> <p>Observation on [DATE] at 10:01 A.M., of the kitchen showed:</p> <ul style="list-style-type: none"> <li>- Maintenance attempted to repair the serving window that didn't close correctly. He/She was not wearing a hair net and used a drill that caused saw dust and debris to fall onto the toaster on the counter. Saw dust and debris also fell on the clean dishes on the counter to the left of the window near the steam table;</li> <li>- Six gallons of whole milk on the bottom shelf of the solid door refrigerator with a best by date of [DATE];</li> <li>- Two drawer style refrigerators located near the stove contained a bag of shredded parmesan cheese dated [DATE], an unlabeled bag of shredded cheese dated [DATE], and a block of undated sliced cheese.</li> </ul> <p>Observation on [DATE] at 3:45 P.M., of the kitchen showed:</p> <ul style="list-style-type: none"> <li>- A plastic container in the refrigerator with glass doors, labeled as cantaloupe, with a prep date of [DATE], and a use by date of [DATE];</li> <li>- Tomatoes and one bundle of unwrapped asparagus sat directly on the shelf of the refrigerator;</li> <li>- Strawberry and chocolate -flavored health shakes in a box with chocolate flavored health with no use by date on the individual products;</li> <li>- An opened bag of charcoal and a container of lighter fluid sat on a crate in the dry goods storage room;</li> <li>- Debris throughout the kitchen floor and walk in freezer floor;</li> <li>- The commercial dishwasher with white grime build up on the interior and exterior surfaces and water ran from the back left side of the dishwasher with the dishwasher not in use;</li> <li>- Debris and a puddle of purple liquid under the right side of the dishwasher;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>	<ul style="list-style-type: none"> <li>- Debris on the shelf with spices and drinking pitchers;</li> <li>- A shelf in the center of the kitchen with a large container labeled flour, cornmeal, rice, and sugar with no use by date listed;</li> <li>- Black grime build-up on the back and top of the stove;</li> <li>- Pots, pans, plates in an upright position, bowls in an upright position, and cups stored on open shelves under the serving window with dirt and debris;</li> <li>- Pots, pizza pans, baking sheets, and skilletts with black carbon buildup;</li> <li>- A toaster on the counter by the serving window covered in debris;</li> <li>- The counter by the serving window with debris;</li> <li>- Dirt and debris throughout the kitchen floor.</li> </ul> <p>Observation on [DATE] at 10:22 A.M., of the dry goods storage showed:</p> <ul style="list-style-type: none"> <li>- A package of chocolate sandwich cookies with an expiration date of [DATE];</li> <li>- A box of pie crust mix with a use by date of [DATE];</li> <li>- Debris throughout floor.</li> </ul> <p>During an interview on [DATE] at 12:00 P.M., the DM and Dietary Staff N said when they received food orders on Thursdays, the DM checked everything in. They put away all the freezer and cold items first. Items should be labeled and dated as they were put away. The dry good items were put into the storage area and were put away as they found time to unbox them. Dietary staff were responsible for cleaning the kitchen. The dishwashers would usually clean and mop their area between the lunch and dinner meals, typically around 3:00 P.M. to 4:00 P.M., each day, and the cooks or DM would clean the remaining area of the kitchen.</p> <p>During an interview on [DATE] at 11:19 A.M., the DM said he/she knew the kitchen was dirty, but they didn't have time to clean it.</p> <p>2. Observations on [DATE] between 12:37 P.M. and 1:14 P.M. showed;</p> <ul style="list-style-type: none"> <li>- The steam table and food temperatures were not taken during that time;</li> <li>- Cook P with a beard, wore a hair restraint around his/her neck not covering his/her beard while at the steam table and serving food;</li> <li>- Dishwasher Q with a mustache, with no hair restraint while filling plastic food containers with dry good products and filling plates for the residents;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 DM with a hair restraint not wrapped around his/her head, and dangling from the bottom of his/her pony tail;</p> <p>- Baking sheet containing dessert, which appeared to be cake, on the counter in individual bowls with no covering;</p> <p>- Dishwasher Q wore gloves to open packages of dry goods (pasta and cereal) to put into plastic storage containers. He/She opened the refrigerators with gloves, opened packages and, wearing the same soiled gloves, touched a clean plate and food that appeared to be slices of cheese, to put on a plate for a resident.</p> <p>Observations on [DATE] at 01:20 P.M. showed:</p> <p>- Room trays going out without temperatures being taken then, or at any time since the last observation;</p> <p>- Cake that had been sitting uncovered on the counter since 12:37 P.M. was put into the hot cart with no covering to be taken to resident rooms.</p> <p>Review of the log file showed there were no logs completed for the steam table temperatures for the last eleven months.</p> <p>During an interview on [DATE] at 10:01 A.M., the DM said they had been checking the temperature of the food on the steam table, but had not been keeping logs because they couldn't find a form that wasn't confusing for the staff. They just started some forms and provided forms for the last three days.</p> <p>During an interview on [DATE] at 2:00 P.M., the Administrator said they do not have a policy regarding outside food being brought into the facility. He/she said if someone were to bring something in, they would label it and put it in the refrigerator in the kitchen.</p> <p>During an interview on [DATE] at 4:05 P.M., the DM said when they had less residents they used to keep outside food brought in for residents on a tray on the bottom shelf of the refrigerator. He/she said now they have limited room and are at capacity, so they don't accept resident food. He/she did not know of any residents having their own refrigerators and did not know of any unit refrigerators that are used for resident food.</p> <p>During an interview on [DATE] at 12:00 P.M., the DM said staff should wash their hands or change their gloves between tasks and wear hair restraints.</p> <p>During an interview on [DATE] at 11:30 A.M., Resident #40 said sometimes staff will check any outside food they bring in, but he/she stated there was not a specific person or schedule when food would be checked to make sure it's still ok to eat.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>During an interview on [DATE] at 3:44 P.M., the Administrator said she would expect food to be stored up off the floor, labeled, and dated. She would expect clean dishes to be stored in an enclosed area free from dirt and debris. She would expect food to be covered and dated when stored or waiting to be served. She would expect kitchen equipment to be maintained in working order and free from calcium build up and debris. She would expect floors and surfaces to be free from spills, dirt and debris. She would expect cleaning agents and chemicals to be stored separate from food. She would expect pots, pans, and cooking sheets to be free from carbon and grime build up. She would expect freezers to be free of ice buildup and expired food to be discarded. The Administrator said she would expect staff to wear hair restraints while in the kitchen. She would expect staff to change their gloves after touching equipment or surfaces before touching food. She would expect food temperature to be checked each meal and temperature logs maintained. She would expect food to be covered when being transported or sitting on the counter waiting to be served.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>46555</p> <p>Based on observation and interview, the facility failed to ensure the dumpsters were closed at all times and maintained to keep pests out and to keep the garbage contained in the dumpster. The facility census was 49.</p> <p>The facility did not provide a garbage policy.</p> <p>Observations of two dumpsters, both with two lids, on the back left side of the facility showed:</p> <ul style="list-style-type: none"> <li>- On 04/04/24 at 10:01 A.M., the dumpster on the left with the left lid opened;</li> <li>- On 04/09/24 at 9:31 A.M., and 04/19/24 at 9:34 A.M., all of the dumpster lids opened with visible cardboard boxes and other miscellaneous items;</li> <li>- On 04/16/24 at 11:00 A.M., only one dumpster present with the lid up on the right side of the dumpster.</li> </ul> <p>During an interview on 04/09/24 at 4:04 P.M., the Dietary Manager (DM) said the trash dumpster lids should be closed after staff discard trash and other miscellaneous items. He/She told staff to close them but nursing staff took trash out and left them open.</p> <p>During an interview on 04/16/24 at 10:09 A.M., Housekeeper L said housekeeping empties trash, and at times the dumpsters get too full to close them. The dumpsters used to be emptied more frequently but now they only get emptied a couple days a week which wasn't often enough. There were times the trash would fly out of the dumpsters and be all over the back parking lot because they were unable to close the lids.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing said they would expect the trash dumpster lids to be closed after staff discard trash and other miscellaneous items.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>46460</p> <p>Based on interview and record review, the facility failed to ensure the facility assessment (an assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies) was complete and reviewed annually. The facility census was 49.</p> <p>The facility did not provide a facility assessment policy.</p> <p>Review of the facility assessment, dated 08/30/22, showed:</p> <ul style="list-style-type: none"> <li>- The census of two residents;</li> <li>- The facility assessment not updated to reflect the current resident census and needs;</li> <li>- The facility assessment not reviewed annually;</li> <li>- No documentation the Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committee reviewed the facility assessment.</li> </ul> <p>During an interview on 04/19/24 at 3:45 P.M., the Administrator said she would expect the facility assessment to reflect the resident population and their needs and for it to be updated annually.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>46460</p> <p>Based on interview and record review, the facility failed to develop a Quality Assurance and Performance Improvement Plan (QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved.) The facility census was 49.</p> <p>Review showed the facility did not have a QAPI plan containing the necessary policies and protocols describing how they will identify and correct their quality deficiencies, track and measure performance, and establish goals and thresholds for performance measurement.</p> <p>During an interview on 04/17/24 at 4:30 P.M., the Regional Nurse said he/she was unable to find any documentation that the facility had a QAPI Plan. He/She did not believe the facility had been doing anything related to QAPI.</p> <p>During an interview on 04/19/24 at 3:45 P.M., the Administrator said she would expect the facility to implement a QAPI Program and Plan with policies and procedures for data collection and monitoring.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>46460</p> <p>Based on interview and record review, the facility failed to ensure the Quality Assurance/Quality Assurance Performance Improvement (QAA/QAPI) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The facility census was 49.</p> <p>The facility did not provide a policy for a QAPI Plan or Performance Improvement Plans (PIPs).</p> <p>Review showed no documentation the facility maintained the minimum required documentation for a QAPI plan or PIPs.</p> <p>During an interview on 04/17/24 at 4:30 P.M., the Regional Nurse said he/she was unable to find any documentation that the facility had a QAPI Plan or PIPs in place. He/She did not believe the facility had been doing anything related to QAPI.</p> <p>During an interview on 04/19/24 at 3:45 P.M., the Administrator said she would expect the facility to have a QAPI Plan in place and implement PIPs to address identified issues.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>46460</p> <p>Based on interview and record review, the facility failed to maintain quarterly Quality Assurance and Improvement Program (QAPI) committee meetings with the required members. The facility census was 49.</p> <p>The facility did not provide a policy or any documentation related to QAPI.</p> <p>Review showed no documentation the facility maintained the minimum required quarterly QAA meetings with the required members.</p> <p>During an interview on 04/17/24 at 4:30 P.M., the Regional Nurse said he/she was unable to find any documentation that the facility had any QAPI meetings. He/She did not believe the facility had been doing anything related to QAPI.</p> <p>During an interview on 04/19/24 at 3:45 P.M., the Administrator said she would expect the facility to have QAPI meetings at least quarterly with the required members present.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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**</b> 39360</p> <p>Based on observation, interview, and record review, the facility failed to maintain infection control practices when staff and a resident touched cups where residents put their mouth without performing hand hygiene. The facility failed to perform glove changes and hand hygiene and failed to clean the glucometer (a device to measure blood sugar) between resident use during blood sugar checks for two residents (Resident #30 and #252) outside the sample. The facility failed to perform glove changes and hand hygiene between residents when administering medications for one resident (Resident #18) out of 13 sampled residents and one resident (Resident #30) outside the sample. The facility failed to maintain proper infection control practices during wound care for one resident (Resident #1) out of one sampled resident. The facility failed in the prevention of communicable disease in regard to Tuberculosis (TB - a communicable disease that affects the lungs characterized by fever, cough and difficulty breathing) screening of two residents (Resident #26 and #102) out of five sampled residents. The facility failed to develop and implement a risk management process specific to Legionella disease (a serious type of pneumonia caused by Legionella bacteria) and maintain proper infection control practices while passing ice to residents, which had the potential to affect all residents, staff, and the public. The facility's census was 49.</p> <p>Review of the facility's undated policy, Standard Precaution, showed:</p> <ul style="list-style-type: none"> <li>- Use standard precautions for the care of all residents;</li> <li>- Wash hands before having direct contact, before putting on gloves, after removing gloves, after contact with body substances, articles or surfaces contaminated with body substances and after contact with resident's intact skin;</li> <li>- It may be necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites;</li> <li>- Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items;</li> <li>- Change gloves between tasks and procedures on the same resident after contact with material that may contain microorganisms;</li> <li>- Remove gloves promptly after use and before touching non-contaminated items and surfaces and wash hands as soon as possible after glove removal;</li> <li>- Gloves should not be worn away from bedside, to handle resident charts, clean linen, clean equipment, or resident care supplies or worn in hallways;</li> <li>- Make sure reusable equipment is not used for the care of another resident until it has been cleaned appropriately;</li> <li>- Clean and disinfect work surfaces after contamination with blood or other potentially infectious materials.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 facility's undated policy, Tuberculosis Testing showed:</p> <ul style="list-style-type: none"> <li>- All residents and employees will be tested for Mycobacterium Tuberculosis (an infectious bacterial disease affecting the lungs);</li> <li>- Review resident's chart to determine whether a Mantoux (a skin test to determine whether an individual is infected with tuberculosis) test was administered during the past year;</li> <li>- If test status can not be determined, administer the Mantoux test to resident according to standards of clinical practice, unless contraindicated;</li> <li>- Add information to the TB testing log.</li> </ul> <p>Review of the facility's undated policy, Blood Glucose Monitoring, showed:</p> <ul style="list-style-type: none"> <li>-Maintain a copy of each glucometer's manufacturer instructions on the unit;</li> <li>-Make arrangements to replace malfunctioning or missing equipment as soon as possible;</li> <li>-Test the unit's glucose monitors once per week and record the date, time, and results in a log;</li> <li>-Clean and disinfect blood glucose meter after use according to manufacturer specifications if it is used on more than one resident;</li> <li>-The unit nurse will order test strips in a timely manner to make sure they are always available;</li> <li>-For disinfection, wash hands for 15 seconds per policy and procedure or utilize alcohol based gel, apply gloves, utilizing a Clorox Healthcare Bleach Germicidal Wipe (white and blue container) cleanse glucometer thoroughly, place glucometer on clean paper towel, remove gloves and utilize hand hygiene for 15 seconds, allow glucometer to air dry for 3 minutes, apply gloves, remove glucometer from paper towel with one gloved hand while disposing the paper towel with the other gloved hand, complete hand hygiene, and now are ready to apply gloves and proceed to the next accucheck.</li> </ul> <p>Review of Super Sani-Cloth Germicidal Disposable Wipe (purple top) manufacturer recommendations showed:</p> <ul style="list-style-type: none"> <li>-Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for two minutes and let air dry;</li> <li>-For heavily soiled objects use the first wipe to remove soiled area. Use second wipe to thoroughly wet surface. Allow to remain wet for two minutes, let air dry.</li> </ul> <p>The facility did not have a policy in place for Legionella monitoring.</p> <p>1. Observation of wound care for Resident #1 on 4/03/24 at 11:55 A.M. showed:</p> <ul style="list-style-type: none"> <li>- Registered Nurse (RN) B obtained scissors from his/her pocket and removed a soiled dressing from the resident's right leg that was propped up by a pillow with no barrier;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>	<ul style="list-style-type: none"> <li>- With the same soiled gloves, RN B picked up the spray bottle of wound cleanser that had been placed on the bedside table (with no barrier and beside the resident's bowl of cereal and orange juice), and sprayed onto the dressing to loosen as the wound had dried drainage on the dressing;</li> <li>- RN B placed the soiled scissors on the bed with no barrier;</li> <li>- With the same soiled gloves, RN B removed gauze from a cup of dakins (wound cleanser) and cleaned the wound;</li> <li>- RN B placed the soiled dressing on the resident's bed, and with the same soiled gloves, touched multiple items on the bedside table in search of a pill crusher;</li> <li>- RN B, with the same soiled gloves, opened the door and left the room wearing gloves;</li> <li>- RN B returned wearing the same soiled gloves, removed saline soaked gauze from the wound and continued to wipe/clean the wound;</li> <li>- With the same soiled gloves, RN B removed Bactroban (antibiotic) ointment and cotton swab from a small package that had been placed on the bedside table;</li> <li>- With the same soiled gloves, RN B put ointment on the wound using a cotton swab, then placed the ointment back onto the bedside table and cotton swab back into package on the table;</li> <li>- With the same soiled gloves, RN B picked up a small package of powdered Flagyl (an antibiotic) from the bed side table and sprinkled onto the wound bed;</li> <li>- With the same soiled gloves, RN B picked up the soiled scissors from the resident's bed and cut Xeroform (non-adherent dressing clings to wound) gauze and placed onto the wound, then returned scissors to the bedside table;</li> <li>- With the same soiled gloves, RN B removed his/her personal cell phone from pocket and turned on the light to observe the wound;</li> <li>- RN B placed the phone onto the resident's soiled pillow and with the same soiled gloves, placed more Xeroform gauze (gauze with petroleum jelly) to the wound;</li> <li>- RN B removed gloves, did not wash hands, and left the room to obtain more supplies;</li> <li>- RN B returned to room, donned new gloves without washing hands, removed abdominal pad (ABD - pad for heavy drainage) from packaging and placed on wound;</li> <li>- With the same gloves, RN B opened the door and left the room again to obtain tape from cart in hall;</li> <li>- With the same soiled gloves, RN B ripped a couple pieces of tape and stuck to end of bed side table, wrapped kerlix gauze (a light weight gauze) around lower leg wound, and taped gauze;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>	<ul style="list-style-type: none"> <li>- With the same soiled gloves, RN B picked up cell phone and placed on the other side of the resident's bed, picked up scissors from the bedside table and removed dressing with yellow drainage (about 40 to 50% covered with yellow drainage) from left leg;</li> <li>- With the same soiled gloves, RN B picked up the wound cleanser spray bottle and moistened the dressing to loosen from wound bed, and touched the spray nozzle to the soiled side of the dressing;</li> <li>- With the same soiled gloves, RN B placed the soiled dressing onto the resident's bed, then placed saline gauze over wound and cleaned the wound bed;</li> <li>- With the same soiled gloves, RN B placed scissors onto the pillow under the resident's legs, and picked up cell phone again to use light;</li> <li>- With the same soiled gloves, RN B placed phone onto the resident's bedside table, removed gauze from package and dabbed wound dry;</li> <li>- With the same soiled gloves, RN B picked up phone again to use light while dabbing wound with gauze, and placed phone back on bedside table;</li> <li>- With the same soiled gloves, RN B picked up ointment and placed on wound using soiled gloved finger, picked up new ointment tube with the same soiled gloves, used cotton swab to apply more ointment to wound, touched dirty cotton swab to clean tube to obtain more ointment for wound;</li> <li>- With the same soiled gloves, RN B picked up Flagyl (antibiotic) powder package from bedside table and sprinkled onto wound;</li> <li>- With the same soiled gloves, RN B used scissors to cut Xeroform gauze and placed onto wound after placing scissors on the bed;</li> <li>- With the same soiled gloves, RN B placed ABD pads to wound, wrapped kerlix gauze around wound, taped gauze, reached into pocket to obtain a marker, dated and initialed dressings, and placed marker back into pocket;</li> <li>- With the same soiled gloves, RN B opened the resident's cabinet and touched the clothing looking for socks, closed door, and placed socks over dressings bilaterally (on both sides);</li> <li>- With the same soiled gloves, RN B removed all trash and soiled dressings from the resident's bed, and took out of the room;</li> <li>- RN B returned with no gloves and placed contaminated ointment tube back into package, picked up gauze package, wound cleanser, scissors, and cell phone and took back into hallway to cart;</li> <li>- RN B did not wash hands and placed contaminated scissors back into pocket.</li> </ul> <p>During an interview on 4/03/24 at 12:35 P.M., RN B said he/she should have changed gloves in between dirty and clean and washed hands after each glove change. There should have been a barrier under the resident's legs during dressing changes and he/she should have cleaned scissors in between dirty and clean or used two pair of scissors. RN B said he/she did a very bad job.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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>2. Observation on 04/03/24 at 1:17 P.M. showed:</p> <ul style="list-style-type: none"> <li>- RN B removed gloves, did not wash hands, and placed glucometer in medication cart after using it for Resident #252;</li> <li>- Removed glucometer back out of drawer, cleaned glucometer with purple top wipe for five seconds and put glucometer back in medication cart.</li> </ul> <p>During an interview on 04/04/24 at 4:54 P.M., RN C said the glucometer should be wiped down with the purple top wipes for 30 seconds to a minute and air dry for a couple minutes.</p> <p>During an interview on 04/05/24 at 11:54 A.M., RN E said the glucometer should be cleaned for 30 seconds and then let air dry for three to five minutes. Wash hands before and after checking blood sugar and changing gloves.</p> <p>3. Observation on 4/4/24 at 12:34 P.M. showed:</p> <ul style="list-style-type: none"> <li>- RN C donned gloves and swabbed Resident #18's mouth with mouthwash;</li> <li>- With the same soiled gloves, RN C opened new swab, dunked swab in Nystatin (an antifungal medication) and swabbed the resident's mouth;</li> <li>- With the same soiled gloves, RN C opened morphine (a pain medication) box containing morphine bottle and syringe;</li> <li>- With the same soiled gloves, RN C obtained 0.25 ml liquid morphine in syringe and administered medication into the resident's cheek;</li> <li>- With the same soiled gloves, RN C placed morphine bottle and syringe back in box, removed gloves, and washed hands.</li> </ul> <p>4. Observation on 4/05/24 at 11:28 A.M. showed:</p> <ul style="list-style-type: none"> <li>- Certified Nurse Aide (CNA) J and CNA K passed ice to residents;</li> <li>- CNA J told CNA K the ice scoop had dropped onto the floor in the hall and placed scoop on the lower shelf of cart;</li> <li>- CNA K took scoop from lower shelf and walked into room [ROOM NUMBER], then immediately back out;</li> <li>- CNA K placed the scoop back into the clean ice container.</li> </ul> <p>During an interview on 4/05/24 at 11:29 A.M., CNA K said the scoop was dropped onto the floor and that he/she had rinsed it off with water in room [ROOM NUMBER]. When asked if he/she thought the scoop had been cleaned properly with only water prior to placing back into container, CNA K said, No. I will take it back to the kitchen, clean the scoop, dump and clean the ice container.</p> <p>5. Observation on 4/5/24 at 12:17 P.M. showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>- RN B donned gloves, locked medication cart and checked Resident #30's blood sugar;</p> <p>- With the same soiled gloves, RN B placed the glucometer on the medication cart, disposed of lancet (a sharp device used to obtain blood for testing blood sugar) and blood sugar strip;</p> <p>- With the same soiled gloves, RN B opened the medication cart and obtained insulin pen, touched the computer mouse, looked up insulin orders, and locked the medication cart;</p> <p>- With the same soiled gloves, RN B primed the insulin pen, administered insulin, placed the insulin pen back in the medication cart, and removed gloves;</p> <p>- RN B cleaned the glucometer with purple top Sanicloth wipe for five seconds and left the glucometer on the cart.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the DON said the nurses do finger sticks. The RNs and Licensed Practical Nurse (LPNs) should calibrate the devices every night. All staff should follow proper infection control practices and hand hygiene for all tasks. Glucometer should be cleaned per policy.</p> <p>6. Record review provided from January 2024 through March 2024 showed the facility did not have a water management program in place to monitor for Legionella bacteria in water.</p> <p>During an interview on 04/05/24 at 11:15 A.M., the Director of Nursing (DON) said he/she was unable to find any Legionella testing.</p> <p>During an interview on 04/05/24 at 12:37 P.M., the Maintenance Supervisor said the water temps are checked on a weekly basis and empty rooms are flushed, but he/she but does not test for Legionella.</p> <p>7. Review of Resident #26's medical record showed:</p> <p>- admitted [DATE];</p> <p>- No documentation of TB testing or screening.</p> <p>8. Review of Resident #102's medical record showed:</p> <p>- admitted [DATE];</p> <p>- No documentation of TB testing or screening.</p> <p>During an interview on 04/05/24 at 11:10 A.M., the DON said we only have one small bottle of tuberculin (sterile protein used to diagnose tuberculosis) for the employees, but don't have enough to test the residents. We do not have a screening process for TB that I am aware of.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>During an interview on 04/19/24 at 3:44 P.M., the Administrator said she used to use rubbing alcohol and a cotton ball to clean glucometers, but she didn't know what they use now. The CNAs know. They don't do it, but they know because they watch. All medications and blood sugar checks should be done in a private area and proper infection control practices followed. If an ice scoop falls onto the floor, it should have been sent back to the kitchen and a new one obtained.</p> <p>49152</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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>39360</p> <p>Based on interview and record review, the facility failed to ensure at least one person had completed specialized training in infection prevention and control for the Infection Preventionist (IP - a professional who assures healthcare workers and residents are doing everything possible to prevent infection) position. This had the potential to affect all residents in the facility. The facility census was 49.</p> <p>Review of the facility's policy titled, Infection Control Nurse, undated, showed:</p> <ul style="list-style-type: none"> <li>- The Infection Control Nurse will stay informed of Centers for Disease Control (CDC - service organization that protects public health), Occupational Safety Health Administration (OSHA - ensures safe and healthful working conditions by providing training, outreach, education and assistance), Federal Drug Administration (FDA - protects the public health by ensuring safety of human and veterinary drugs) and state and federal health regulations on infection control to ensure the facility follows clinical guidelines and standards and remains in compliance with state and federal regulations;</li> <li>- Directs and maintains an infection control program designed to provided a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in the facility;</li> <li>- Contributes to inservices and staff meetings on subjects such as infection control practices, hand washing, infectious disease and isolation practices;</li> <li>- Monitors and facilitates the pneumococcal (infection caused by bacteria called pneumococcus) immunizations, orders the influenza (a highly contagious viral infection of the respiratory passages causing fever, severe aches and inflammation) vaccine and informs staff when the vaccine is available and immunization should begin;</li> <li>- Acts as the facility's IP.</li> </ul> <p>The facility did not provide documentation for any staff members who had completed the specialized training for the IP position.</p> <p>During an interview on 04/03/24 at 10:00 A.M., Registered Nurse (RN) B said he/she thought the certification had been completed. However, he/she did not have the certificate to prove it. RN B said he/she was performing the IP duties.</p> <p>During an interview on 04/19/24 at 3:45 P.M., the Administrator and Director of Nursing (DON) said they would expect to have an IP with the appropriate qualifications and certification. The Administrator and DON said RN B held the IP position.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on interview and record review, the facility failed to provide and document residents received or declined appropriate immunizations for five residents (Residents #1, #8, #26, #35 and #102) out of five sampled residents. The facility census was 49.</p> <p>Review of the facility's policy titled, Influenza (a highly contagious viral infection of the respiratory passages causing fever, severe aches and inflammation) Immunization, undated, showed:</p> <ul style="list-style-type: none"> <li>- Flu season is defined as October 1st through March 31st;</li> <li>- The Infection Control (IC) Nurse will inform charge nurse when influenza vaccine is available and when immunization process should begin;</li> <li>- Immunization log should contain the resident's name, room number, resident and/or family member given information about vaccine including benefits/side effects, date vaccine administered, refusal/contraindicated and reason, temperature for three consecutive days along with any side effects;</li> <li>- The IC Nurse will monitor the immunization log and unit practices to assure immunization process meets clinical standards of care.</li> </ul> <p>Review of the facility's policy titled, Pneumonia Vaccine, undated, showed:</p> <ul style="list-style-type: none"> <li>- Pneumococcal (infection caused by bacteria called pneumococcus) Pneumonia Vaccine (PPV) should be administered to all residents in the facility unless contraindicated or refused;</li> <li>- Log for residents should contain resident name, room number, information given including benefits/side effects, date given, refusal or contraindication, temperature for three consecutive days and side effects noted;</li> <li>- The IC Nurse will monitor the immunization log and unit practices to assure immunization process meets clinical standards of care.</li> </ul> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- No documentation of the education for the influenza and pneumococcal vaccinations were provided;</li> <li>- No documentation the influenza and pneumococcal vaccinations were provided or refused.</li> </ul> <p>2. Review of Resident #8's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- An undated, signed consent for the influenza vaccine located in admission packet;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- No documentation that the influenza vaccination had been administered;</li> <li>- No documentation of the education for the pneumococcal vaccination was provided;</li> <li>- No documentation the pneumococcal vaccination was provided or refused.</li> </ul> <p>3. Review of Resident #26's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- No documentation of the education for the influenza and pneumococcal vaccinations were provided;</li> <li>- No documentation the influenza and pneumococcal vaccinations were provided or refused.</li> </ul> <p>4. Review of Resident #35's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- No documentation of the education for the influenza and pneumococcal vaccinations were provided;</li> <li>- No documentation the influenza and pneumococcal vaccinations were provided or refused.</li> </ul> <p>5. Review of Resident #102's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- No documentation of the education for the influenza and pneumococcal vaccinations were provided;</li> <li>- No documentation the influenza and pneumococcal vaccinations were provided or refused.</li> </ul> <p>During an interview on 04/04/24 at 5:14 P.M., the Assistant Director of Nurses (ADON) said the pneumonia vaccine had not been given at the facility.</p> <p>During an interview on 04/05/24 at 11:10 A.M., the Director of Nursing (DON) said there was no documentation of vaccinations or refusals for influenza or pneumonia. They were waiting on the pneumonia vaccination to arrive. It had been ordered and would be given once received. The owner had to approve it due to the cost.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they would expect vaccinations for influenza and pneumonia to be given per the Center for Disease Control (CDC) guidelines and declinations signed if refused.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39360</p> <p>Based on interview and record review, the facility failed to ensure the Covid-19 (an infectious disease caused by a virus that could cause some people to become seriously ill and require medical attention) vaccination was offered, administered, or refused by the resident and/or resident's representative for three residents (Residents #1, #26 and #102) out of five sampled residents. The facility's census was 49.</p> <p>The facility did not provide a Covid-19 vaccination policy.</p> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- Diagnoses of diabetes mellitus (a disease which the body's ability produce or respond to insulin is impaired resulting in elevated levels of glucose in the blood), bradycardia (heart beats slower than normal) and high blood pressure;</li> <li>- No documentation of the education for the COVID-19 vaccination was provided;</li> <li>- No documentation the COVID-19 vaccine was provided or refused.</li> </ul> <p>2. Review of Resident #26's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- Diagnoses of anxiety, schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and heart failure (a chronic condition which the heart doesn't pump blood as well as it should);</li> <li>- No documentation of the education for the COVID-19 vaccination was provided;</li> <li>- No documentation the COVID-19 vaccine was provided or refused.</li> </ul> <p>3. Review of Resident #102's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> <li>- Diagnoses of kidney disease (a condition in which the kidneys are damaged and cannot filter blood as they should), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe) and history of Covid 19;</li> <li>- No documentation of the education for the COVID-19 vaccination was provided;</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- No documentation the COVID-19 vaccine was provided or refused.</p> <p>During an interview on 04/05/24 at 11:10 A.M., the Director of Nursing (DON) said there was no documentation of vaccination consents or refusals for Covid 19.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and DON said they would expect vaccinations for Covid 19 to be given per the Center for Disease Control (CDC) guidelines and declinations signed if refused.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>46555</p> <p>Based on observation and interview, the facility failed to provide a dining room large enough to accommodate the residents. This affected one resident (Resident #16) out of 13 sampled residents and two residents (Resident #27 and #252) outside the sample and had the potential to affect all residents. The facility census was 49.</p> <p>The facility did not provide a dining room policy.</p> <p>1. Observation on 04/03/24 at 1:22 P.M., showed:</p> <ul style="list-style-type: none"> <li>- Several of the residents finished their meal and left the dining area before staff brought additional residents to the dining room to eat;</li> <li>- Nine round tables and four rectangle tables with twenty-seven chairs were available for residents.</li> </ul> <p>2. Observation on 04/04/24 at 12:27 P.M., showed two residents (Resident #16 and #27) seated in the area where the vending machines were located due to no available seating for them in the dining room.</p> <p>3. Observation on 04/04/24 at 12:35 P.M., showed staff moved residents from where they were originally seated in an attempt to make enough room at a long rectangle table for residents in wheelchairs.</p> <p>During an interview on 04/09/24 at 4:04 P.M., the Dietary Manager (DM) said it got congested in the dining room at mealtimes. They used to have two dining rooms, but were instructed to have all the residents in one dining area. The types of tables they had did not work for the space or for the residents that were in wheelchairs. They needed rectangle-shaped tables. They had too many round tables that took up too much space and did not provide adequate seating.</p> <p>During an interview on 04/10/24 at 3:30 P.M., Certified Nurse Aide (CNA) I said there was not enough space in the dining room for the residents to eat.</p> <p>During an interview on 04/11/24 at 1:13 P.M., Certified Medication Technician (CMT) D said there was not enough space in the dining room for the residents to eat together at the same time.</p> <p>During an interview on 04/12/24 at 11:10 A.M., Housekeeping Staff L said the dining area was not large enough for all of the residents to comfortably eat their meals together at the same time. There were residents that were afraid to leave the dining area for fear they would not have a place to sit when meals were served.</p> <p>During an interview on 04/12/24 at 11:20 A.M., Resident #252 said he/she was afraid to leave the dining room for fear he/she would not have a seat at mealtime. It was too crowded and they needed more room for seating.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing said they thought the dining area was large enough for their residents to eat together.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46555</p> <p>Based on observation and interview, the facility failed to provide a safe and functional environment for the residents by allowing items to be stored on top of overbed light fixtures for residents in three rooms. Storing items on the overbed light creates a hazard of the items falling on the resident below, and does not utilize the light fixtures as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 49.</p> <p>The facility did not provide a policy for overbed lighting safety.</p> <p>1. Observation on 04/02/24 at 1:52 P.M. of room [ROOM NUMBER] showed:</p> <ul style="list-style-type: none"> <li>- A bottle containing artificial flowers lay sideways on top of the light fixture above the bed by the door;</li> <li>- A bottle of shampoo and a book sat on top of the light fixture above the bed by the window.</li> </ul> <p>2. Observation on 04/05/24 at 3:10 P.M. of room [ROOM NUMBER] showed six cards, one decorative gift bag, and one decorative plaque sat on top of the light fixture above the bed by the door.</p> <p>3. Observation on 04/09/24 at 11:51 P.M. of room [ROOM NUMBER] showed a foam cup on top of the light fixture above the bed by the door.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Director of Nursing (DON) and Administrator said items should not be placed on the light fixtures due to a possible hazard.</p> <p>49152</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46460</p> <p>Based on interview and record review, the facility failed to ensure that an effective training program for all new and existing staff was in place. The facility failed to implement a plan regarding the training needs listed in the facility assessment, and did not have a schedule of how or when required training would be completed. The facility census was 49.</p> <p>Review of the facility assessment, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Facility assessment not reviewed since 2022, when the facility opened and had a census of two residents;</li> <li>- Staff competencies and annual training requirements per regulatory authority and/or facility policy to include: Abuse, Neglect, Exploitation and Misappropriation, Advance Directives, Behavioral Health, Communication, Compliance and Ethics, Cardiopulmonary Resuscitation (CPR), Dementia Care Management, Equipment and assistive device training, Infection Control, Emergency Preparedness, Facility policies and procedures, Resident Rights, and Assessing Nutritional Needs and Meeting the needs of individuals with Mental Illness/Intellectual Disability/Developmental Delays;</li> <li>-The Facility Assessment did not address what training or frequency of training for before hire and/or ongoing, which individuals or departments conducting and tracking training, and how the process is monitored or audited.</li> </ul> <p>Review of the facility's policy titled, Abuse, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- This policy and procedure and the facility's abuse in service will be read to all newly hired employees during the facility orientation;</li> <li>- All employees are required to attend the yearly facility in-service on abuse.</li> </ul> <p>During an interview on [DATE] at 10:56 P.M., the Administrator said any education or in-services employees had received should be located in their employee file. She wasn't sure if there was a calendar or what training were required or had been completed, as she thought they just went by the checklist done during orientation.</p> <p>During an interview on [DATE] at 1:23 P.M., the Director of Nursing (DON) said she was unaware of an education calendar or schedule for the year, a list of required training, or a list of training identified in the facility assessment to complete as she has only been there two weeks. She was unaware of who was supposed to be keeping up with and tracking the education and in-service hours.</p> <p>During an interview on [DATE] at 3:44 P.M., the Administrator and DON said they would expect all facility staff to receive the regulatory required education, as well as any education to ensure adequate care for the facility's resident population. The DON said they were compiling a list of in-services and training that need to be done, as it was not done.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>46460</p> <p>Based on interview and record review, the facility failed to provide abuse/neglect training for five Certified Nursing Assistants (CNAs) and one Certified Medication Technician (CMT) of eight sampled staff hired in the last year. The facility census was 49.</p> <p>Review of the facility's policy titled, Abuse, dated 08/01/22, showed:</p> <ul style="list-style-type: none"> <li>- This policy and procedure and the facility's abuse in service will be read to all newly hired employees during the facility orientation;</li> <li>- All employees are required to attend the yearly facility in-service on abuse.</li> </ul> <p>1. Review of CMT F's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/20/23;</li> <li>- No documentation of abuse/neglect training.</li> </ul> <p>2. Review of CNA I's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/28/23;</li> <li>- No documentation of abuse/neglect training.</li> </ul> <p>3. Review of CNA S's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 10/04/23;</li> <li>- No documentation of abuse/neglect training.</li> </ul> <p>4. Review of CNA T's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/18/23;</li> <li>- No documentation of abuse/neglect training.</li> </ul> <p>5. Review of CNA U's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/22/23;</li> <li>- No documentation of abuse/neglect training.</li> </ul> <p>6. Review of CNA V's employee file showed:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A hire date of 08/29/23;</p> <p>- No documentation of abuse/neglect training.</p> <p>During an interview on 04/10/24 at 2:54 P.M., CMT F said he/she did not remember getting abuse/neglect training since being employed at the facility.</p> <p>During an interview on 4/10/24 at 3:13 P.M., CNA I said he/she did not receive any training on abuse/neglect while being employed at the facility.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing (DON) said they would expect all CNAs to have abuse/neglect training upon hire training. The DON said they were compiling a list of in-services and training that need to be done, as it was not done.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>42699</p> <p>Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year and failed to provide the required annual competencies of abuse prevention and dementia care for two out of two Certified Nursing Assistants (CNAs) sampled. The facility census was 49.</p> <p>Review of the facility's policy titled, Abuse, dated 08/01/22, showed:</p> <ul style="list-style-type: none"> <li>- This policy and procedure and the facility's abuse in-service will be read to all newly hired employees during the facility orientation;</li> <li>- All employees are required to attend the yearly facility in-service on abuse.</li> </ul> <p>The facility did not provide a policy regarding dementia care.</p> <p>1. Review of CNA K's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 03/17/23;</li> <li>- CNA K attended a total of 30 minutes of in-services, lacking an additional 11 hours and 30 minutes;</li> <li>- CNA K did not attend an annual competency in-service on abuse prevention;</li> <li>- CNA K did not attend an annual competency in-service on dementia care.</li> </ul> <p>2. Review of CNA R's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 02/28/23;</li> <li>- CNA R showed no documented time for in-services;</li> <li>- CNA R did not attend an annual competency in-service on abuse prevention;</li> <li>- CNA R did not attend an annual competency in-service on dementia care.</li> </ul> <p>During an interview on 04/10/24 at 3:30 P.M., CNA K said he/she had not received any annual training on abuse/neglect, Alzheimer's, dementia, or behavioral health. Employees sign a paper upon hire regarding abuse, but no orientation or training was done. In-services were done from time to time, but he/she did not remember an abuse/neglect in-service.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing (DON) said they would expect all CNAs to have 12 hours of continuing training each year and for the training to include abuse/neglect and dementia care training. The DON said they were compiling a list of in-services and training that need to be done, as it was not done.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>46460</p> <p>Based on interview and record review, the facility failed to provide behavioral health training for nine out of nine sampled staff hired in the last year. The facility census was 49.</p> <p>The facility failed to provide a policy regarding behavioral health training.</p> <p>Review of the medical diagnoses (dx) of the 49 residents present during the on-site survey showed:</p> <ul style="list-style-type: none"> <li>- Twenty-two residents had dx of schizophrenia (disorder that affects a person's ability to think, feel and behave clearly);</li> <li>- Eleven residents had a dx of bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs);</li> <li>- Seventeen residents had a dx of anxiety (intense, excessive and persistent worry and fear about every day situations);</li> <li>- Twenty-two residents had a dx of depression (loss of pleasure or interest in activities for long periods of time);</li> <li>- Seven residents had a dx of schizoaffective disorder (mental health condition including a combination of schizophrenia and a mood disorder like depression or bipolar);</li> <li>- Three residents had a dx of history of suicide attempt/suicidal ideations (thoughts);</li> <li>- One resident had a dx of agoraphobia (fear of places and situations that might cause panic, helplessness or embarrassment);</li> <li>- One resident had a dx of neurocognitive disorder with Lewy bodies (type of dementia which affects chemicals in the brain and can lead to problems with thinking, movement, behavior and mood);</li> <li>- One resident had a dx of personality disorder (condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems);</li> <li>- One resident had a dx of antisocial personality disorder (mental health condition characterized by disregard for other people);</li> <li>- One resident had a dx of borderline personality disorder (mental health disorder characterized by unstable moods behavior and relationships);</li> <li>- One resident had a dx of post traumatic stress disorder (PTSD - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event);</li> <li>- One resident had a dx of psychosis (mental disorder characterized by disconnection from reality);</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	
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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- One resident had a dx of disruptive mood dysregulation disorder (condition that causes chronic intense irritability and frequent temper outbursts that are out of proportion for the situation).</p> <p>1. Review of Certified Medication Technician (CMT) F's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/20/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>2. Review of Registered Nurse (RN) G's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 06/13/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>3. Review of Certified Nursing Assistant (CNA) I's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/28/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>4. Review of CNA K's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 03/17/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>5. Review of CNA R's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 02/28/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>6. Review of CNA S's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 10/04/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>7. Review of CNA T's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/18/23;</li> <li>- No documentation of behavioral health training.</li> </ul> <p>8. Review of CNA U's employee file showed:</p> <ul style="list-style-type: none"> <li>- A hire date of 08/22/23;</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265884	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Superior Manor of Festus, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  12827 State Rd Highway Tt Festus, MO 63028	

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- No documentation of behavioral health training.</p> <p>9. Review of CNA V's employee file showed:</p> <p>- A hire date of 08/29/23;</p> <p>- No documentation of behavioral health training.</p> <p>During an interview on 04/10/24 at 2:54 P.M., CMT F said he/she did not remember getting behavioral health training since being employed at the facility.</p> <p>During an interview on 4/10/24 at 3:13 P.M., CNA I said he/she did not receive any training on behavioral health while being employed at the facility.</p> <p>During an interview on 4/10/24 at 3:30 P.M., CNA I said he/she never received any behavioral health training, but it could be useful.</p> <p>During an interview on 04/19/24 at 3:44 P.M., the Administrator and Director of Nursing (DON) said they would expect all CNAs to have behavioral health training to best meet the needs of the residents. The DON said they were compiling a list of in-services and training that needed to be done, as it was not done.</p>