STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A469	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pemiscot County Memorial Hospital	946 E Reed Street Hayti, MO 63851

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to follow physician's orders for three residents (Residents #1, #2, and #3) out of three sampled residents. The facility census was 23. The facility did not provide a policy regarding following physician orders and medication administration. 1. Review of Resident #1's medical record showed: - admitted to the hospital on 10/20/24 - 10/24/24, with urinary tract infection (UTI) with sepsis (a life threatening condition of an infection); - An order for Bactrim (an antibiotic) 400-80 milligram (mg) every 12 hours for seven days, dated 10/24/24; - An order for amoxicillin 875 mg every 12 hours for seven days, dated 10/24/24; - An order for amoxicillin 500 mg) per tube three times a day for 10 days, for a UTI, dated 11/01/24. Review of the resident's October 2024 Medication Administration Record (MAR) showed: - For the Bactrim 400-80 mg every 12 hours for seven days, dated 10/24/24, six missed opportunities out of 14 opportunities; - For the amoxicillin 875 mg every 12 hours for seven days, dated 10/24/24, eight missed opportunities out of 14 opportunities. Review of the resident's November 2024 MAR showed: - For the amoxicillin 500 mg per tube three times a day for 10 days, for a UTI, dated 11/01/24, 12 missed opportunities of 30 opportunities. Review of the resident's Nurses Notes showed: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 11/21/24 at 8:30 A.M., a new order to send the resident to the emergency room for an evaluation of blood in the urine and pain; - On 11/21/24 at 10:05 P.M. a new order for Levaquin (an antibiotic) 500 milligram (mg) daily for 10 days; - On 11/22/24, the resident's Foley catheter was leaking and was changed. During an interview on 12/12/24 at 11:45 A.M., the Chief Nursing Officer (CNO) said Resident #1's Foley catheter had to be changed after his/her emergency room visit on 11/21/24. The urine sample provided from the new Foley catheter was sent to the lab for a urine analysis and the urine sample came back as negative for a UTI. She investigated why the resident's previous urine analyses showed positive for UTIs and found the urine provided in the emergency room visits for the urine testing was sampled from the resident's catheter bag instead of getting clean urine from the catheter. 2. Review of Resident #2's medical record showed: - admitted [DATE]; - admitted to the hospital on 10/08/24 - 10/11/24, for a UTI; - An order for Bactrim DS (an antibiotic) by mouth two times a day for seven days, dated 10/11/24. Review of the resident's October 2024 MAR showed: - For the Bactrim DS by mouth two times a day for seven days, dated 10/11/24, five missed opportunities out of 14 opportunities. 3. Review of Resident #3's medical record showed: - admitted [DATE]; - Diagnoses of seizures; - An order for Keppra (an anticonvulsant) 500 mg by mouth twice a day at 8:00 A.M. and 8:00 P.M., dated 09/26/24; - An order for a Keppra level in the A.M., dated 10/09/24; - No documentation of a completed Keppra level. Review of the resident's October MAR showed: - For the Keppra 500 mg by mouth twice a day at 8:00 A.M., and 8:00 P.M., dated 09/26/24, 10 missed opportunities out of 62 opportunities. Review of the resident's November MAR showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For the Keppra 500 mg by mouth twice a day at 8:00 A.M., and 8:00 P.M., dated 09/26/24, 10 missed opportunities out of 34 opportunities. During an interview on 11/25/24 at 11:50 A.M., the CNO said there was no Keppra order put in the system for the lab to obtain the Keppra level for Resident #3. She said she called the lab and was told there had not been a Keppra lab drawn, therefore there were no Keppra levels for the resident. During an interview on 11/20/24 at 11:05 A.M., Licensed Practical Nurse (LPN) C said the lack of documentation on the MARs by the hospital nurses and facility nurses had been reported to the DON, but it hadn't helped. He/She hoped that things were being done and just not documented. He/She was not aware of Resident #3 having any seizure activity. During an interview on 11/20/24 at 11:10 A.M., Certified Medication Technician (CMT) A said the lack of documentation on the MARs by the hospital nurses and the facility nurses had been noticed and the DON was made aware of them multiple times. There had not been any related in-services recently. During an interview on 11/19/24 at 3:28 P.M., the CNO said she was unaware of all the medications that weren't administered. She felt the medications had been administered, but just not documented. The Director of Nursing (DON) was responsible for completing audits on a regular basis. During an interview on 11/19/24 at 10:56 A.M., the DON said she did not consider it her responsibility to audit the resident charts to make sure orders were being completed and medications were administered as ordered. During an interview on 11/20/24 at 12:24 P.M., the Administrator said he would expect orders to be followed and accurate documentation be completed by all staff, including the hospital nurses when they provided care. He would also expect the DON to be auditing the charts and making sure things were being done correctly and if there was a questionable order, the physician should be notified for clarification. It was the DON's responsibility to audit the resident charts for the documentation of medications to be administered as ordered and that orders, such as labs, were completed as ordered. If there were things wrong in the facility, they needed to be addressed and fixed. During an interview on 11/21/24 at 2:44 P.M., the Physician said he/she would expect nursing to follow orders, administer medications, complete documentation, and notify him/her with any orders that had been delayed or unable to complete. During an interview on 11/25/24 at 11:50 A.M., the CNO said the facility did not have a system in place, other than the DON auditing the charts, to make sure orders were completed as ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide ongoing skin assessments, perform and document treatments, and monitor progression of a pressure ulcer (areas of localized damage to the skin and underlying tissue generally the result of pressure, shear, and/or friction) for one resident (Resident #1) out of one sampled resident. The facility census was 23. Review of the facility's policy titled, Wound Management, dated 05/2019, showed: - The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure ulcers; - The admitting nurse will initiate and complete the initial wound exam for each wound that has been identified. Review of Resident #1's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/01/24, showed: - admitted on [DATE]; - Admission weight of 122 pounds (lbs); - Diagnoses of congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension (high blood pressure), diabetes mellitus, cerebrovascular accident (stroke), and paraplegia (paralysis that affects all or part of the trunk, legs and pelvic organs); - Severe cognitive impairment; - Unclear speech; - Impairment to bilateral upper and lower extremities; - Dependent for all activities of daily living; - Indwelling catheter; - One unstageable (an ulcer that has full thickness tissue loss, covered by necrotic (dead) tissue or by eschar (a dry dark scab or falling away of dead skin) pressure ulcer; - Feeding tube for 51% or more of total calories and hydration received. Review of the resident's Physician Order Sheet (POS), dated April 2024, showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order to cleanse the coccyx wound with 1/4 Dakins solution (a solution used to prevent and treat skin and tissue infections), pat dry, apply santyl (ointment used to remove dead tissue), silver alginate (dressing used to treat wounds that are infected or have high risk of infection) and cover with foam dressing daily and as needed, dated 04/17/24. Review of the resident's Physician Order Sheet (POS), dated November 2024, showed: - An order, dated 04/15/24, for weekly skin assessments; - An order, dated 10/24/24, to cleanse and irrigate the wound to the coccyx (small triangular bone at the base of the spinal column) with Vashe (a wound solution used to cleanse, irrigate and moisten), apply silver impregnated foam dressing (a dressing that helps reduce inflammation, treats existing infection and prevents new infections) and ConvaFoam (foam dressing used for wound management) daily. Review of the resident's Admission Nursing Skin Assessments, dated 04/15/24 - 10/25/24, showed: - On 04/15/24, 4 centimeters (cm) by 8 cm coccyx wound with treatment completed; - On 04/25/24, 3.5 cm by 2.5 cm on the left side of coccyx and 6 cm by 4.5 cm on the right side of the coccyx with treatment completed. - On 10/24/24, the wounds on the left and right buttocks, from 04/25/24, merged into one wound of 5.5 cm by 6 cm open area to coccyx. - The assessments did not include a measurement of the depth of the wound. Review of the resident's Licensed Nurse Weekly Skin Assessments, dated 05/09/24 - 11/22/24, showed: - On 05/09/24, one stage four pressure ulcer (deep tissue injury, exposing muscle, tissue and potentially bone) to the coccyx with no measurements and no description; - On 06/18/24, one unstageable wound to the coccyx with necrotic and eschar tissue with no measurements and no description; - On 06/26/24, one unstageable wound to the coccyx with some necrotic tissue, some eschar tissue, some granulation (new connective tissue) tissue, improving slowly, and with no measurements; - No documentation of weekly skin assessments for 07/19/24 - 09/16/24; - On 11/25/24, one coccyx wound with granulation tissue and 7 cm by 6 cm with no stage documented. Review of the resident's Treatment Administration Record (TAR), dated October 2024, showed: - An order to cleanse the wound to the coccyx area with wound cleanser, pat dry, apply Santyl (a type of wound treatment) and silver to the top area of the wound, use calcium alginate (a type of wound treatment) to the bottom and mid area of the wound, and top with polymem (a type of wound dressing) every day, dated 07/19/24, with 21 missed opportunities out of 26 opportunities. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's TAR, dated November 2024, showed: - An order to cleanse and irrigate the wound to the coccyx with Vashe, apply silver impregnated foam dressing, then cover with ConvaFoam daily, dated 10/24/24, with four missed opportunities out of 22 opportunities. Observations of the resident's wound treatment on 11/22/24 at 2:00 P.M., showed: - Licensed Practical Nurse (LPN) D completed the wound care to the coccyx as ordered; - LPN D assessed the coccyx wound as a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed), 6 cm by 5 cm no odor, wound bed with red granulation tissue, and a small area of white exudate (fluid that leaks out of the blood vessels into nearby tissue). During an interview on 11/21/24 at 2:44 P.M., the Physician said he/she was aware of the pressure ulcer and the healing progress. During an interview on 11/22/24 at 1:45 P.M., LPN D said the charge nurse was usually responsible for dressing changes. The completion of the treatment should be documented and the description should be documented at least weekly. During an interview on 11/25/24 at 10:25 A.M., LPN C said he/she did the dressing change on Resident #1 often and should be making sure it was being documented at least weekly or with changes. The wound had improved, there was no necrotic tissue, the wound bed now has granulation tissue and is healing. The description of the wound, the location, the size, and the appearance should be documented. It is the responsibility of the charge nurse. During an interview on 11/25/24 at 10:45 A.M., the Chief Nursing Officer said she would expect skin assessments to be completed weekly, the charge nurse was responsible for doing them, and changes should be reported to the DON. She would also expect a complete wound assessment with documentation to be done weekly on all wounds until healed by the licensed nursing staff. The documentation should include the location, the stage, the size, the appearance of the wound bed, any undermining/tunneling, the surrounding skin, and drainage. It was the responsibility of the DON to do audits to ensure the treatments and documentation were being completed. Any care or treatment should be documented.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview and record review, the facility failed to ensure staff maintained proper positioning and placement of the indwelling urinary catheter (a tube inserted into the urinary bladder to drain urine) tubing and drainage bags and failed to ensure documentation of catheter care for one resident (Resident #1) out of two sampled residents. The facility census was 23. Review of the facility's policy titled, Indwelling Catheter Care, revised on 08/2023, showed: - The facility will ensure any residents receive care and services to prevent urinary tract infections in those residents with an indwelling catheter, in accordance with standards of practice; - Drainage bag and catheter tubing to be positioned below the bladder and not touching the floor. Review of Resident #1's medical record showed: - admitted [DATE]; - Diagnoses of congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension (high blood pressure), diabetes mellitus, cerebrovascular accident (stroke), and paraplegia (paralysis that affects all or part of the trunk, legs and pelvic organs). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/01/24, showed: - Impairment to bilateral upper and lower extremities; - Dependent for all activities of daily living; - Indwelling catheter. Review of the resident's Physician Order Sheet (POS), dated November 2024, showed: - An order to change the Foley (an indwelling catheter) catheter with 16 French (size of catheter) one time per month, dated 04/16/24; - An order to perform Foley catheter care every shift and as needed, dated 04/16/24. Review of the resident's Treatment Administration Records (TAR), dated October 2024, and November 2024, showed: - For October 2024, Foley catheter care every shift showed 54 missed opportunities out of 54 opportunities; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For November 2024, Foley catheter care every shift showed 28 missed opportunities out of 42 opportunities. Observations of Resident #1, showed: - On 11/19/24 at 8:26 A.M., the resident lay in bed with the catheter bag hanging from the bed frame in a privacy bag and four inches of the catheter tubing lay on the floor; - On 11/21/24 at 8:55 A.M., the resident sat in a wheelchair in the hall with the catheter bag and catheter tubing laying in his/her lap; - On 11/22/24 at 1:00 P.M., the resident sat in a wheelchair in his/her room with the catheter bag and the catheter tubing laying in his/her lap. Certified Nurse Assistant (CNA) E and CNA F transferred the resident from a wheelchair to the bed by a mechanical lift. CNA F picked up the catheter bag and held it up above the resident's bladder as he/she was transferred. During an interview on 11/22/24 at 1:10 P.M., CNA E and CNA F said the catheter should be below the level of the bladder, but was unsure what to do with it as they were transferring the resident. Review of the resident's Nurses Notes showed: - On 11/21/24 at 8:30 A.M., a new order to send the resident to the emergency room for an evaluation of blood in the urine and pain; - On 11/21/24 and untimed, a new order for Levaquin (an antibiotic) 500 milligram (mg) daily for 10 days. During an interview on 11/22/24 at 1:40 P.M., Licensed Practical Nurse (LPN) D said the catheter should be below the level of the bladder and it and the catheter tubing should not be on the floor. Catheter care should be completed and documented every shift. During an interview on 11/20/24 at 11:05 A.M., LPN C said the lack of documentation on the TARs by the hospital nurses and facility nurses had been reported to the Director of Nursing (DON), but it hadn't helped. He/She hoped that things were being done and just not documented. During an interview on 11/20/24 at 11:10 A.M., Certified Medication Technician (CMT) A said the lack of documentation on the TARs by the hospital nurses and the facility nurses had been noticed and the DON was made aware multiple times. There had not been any in-services about documentation recently. During an interview on 11/22/24 at 1:40 P.M., the Chief Nursing Officer said she would expect staff to provide catheter care as ordered and document it, she also felt that is was being completed a lot more than it was documented. The CNAs should do catheter care every shift and the charge nurse and the DON should be monitoring the charts to make sure things were done. It was everyone's responsibility to make observations of the catheter placement. If the catheter tubing and catheter bag were seen touching the floor or above the bladder, and staff were unable to take care of it, they should notify the nurse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to administer nutrition and water flushes for one resident (Resident #1), who was dependent upon a gastrostomy tube (g-tube - a tube inserted through the abdomen that brings nutrition directly to the stomach) for nutrition and hydration, which resulted in a severe weight loss (unplanned weight loss greater than 5% of the body weight in one month, greater than 7.5 % in three months or greater than 10% in six months) for the resident. The facility also failed to assess and notify the physician of the severe weight loss. The facility census was 23. The administrator was notified on 11/22/24 at 2:40 P.M., of an Immediate Jeopardy (IJ) which began on 11/01/24. The IJ was removed on 11/25/24, as confirmed by surveyor onsite verification. Review of the facility's policy titled, Weight Management, revised 05/2019, showed: - It is the policy of the facility to provide care and services related to weight management in accordance to State and Federal regulation; - All residents will be weighed day one on admission, day two, then weekly for 4 weeks; - All residents will be weighed monthly unless ordered otherwise; - A reweigh will be obtained for any weight change of plus or minus three pounds (lbs) from the previous weight unless other parameters have been ordered by the physician; - All reweighs will be obtained immediately, the reweigh process will be visualized by a nurse; - All weights will be documented in the resident's medical record; - The physician and the resident or resident representative will be notified by the resident's nurse of any significant unexpected and or unplanned weight changes. The nurse will document the notification in the resident's electronic medical record by completing the event report. Review of the facility's policy titled, Gastrostomy Tube Feeding, revised 12/2021, showed: -The purpose is to provide nutrients, calories and adequate hydration; - Any Registered Nurse (RN) or Licensed Practical Nurse (LPN) may administer and monitor tube feeding; - Tube feeding should be a cooperative effort between the attending physician, registered dietitian (RD), and nursing staff. Nursing services should consult with the RD on every patient that has tube feeding ordered; - Document type and amount of feeding, amount of water given, and resident tolerance of the procedure; (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Accurate documentation is important in management of the tube fed resident. The facility did not provide a policy on significant weight loss. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/07/24, showed: - admitted on [DATE]; - Admission weight was 122 lbs; - Diagnoses of congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension (high blood pressure), diabetes mellitus, cerebrovascular accident (stroke), paraplegia (paralysis that affects all or part of the trunk, legs and pelvic organs), and dysphagia (difficulty in swallowing); - Severe cognitive impairment; - Unclear speech; - Impairment to bilateral upper and lower extremities; - Dependent for all activities of daily living; - Feeding tube for 51% or more of total calories and hydration received. Review of the resident's Medication Administration Record (MAR), dated 10/04/24 - 10/31/24, showed: - An order, dated 04/15/24, for Glucerna (tube feeding formula) 1.5 cal 240 cubic centimeters (cc) at 6:00 A. M., 12:00 P.M., 6:00 P.M., per feeding tube; - Documentation for 10/04/24 - 10/19/24, showed 32 missed opportunities out of 76 opportunities; - An order, dated 04/15/24, for water flush 150 cc per tube every six hours after feeding; - Documentation for 10/04/24 - 10/19/24, showed 36 missed opportunities out of 76 opportunities. Review of the resident's medical record showed: - admitted to the hospital on 10/20/24 - 10/24/24, for a diagnoses of urinary tract infection (UTI). Continued review of the resident's Medication Administration Record (MAR), dated 10/04/24 - 10/31/24, showed: - Resident was hospitalized [DATE] - 10/24/24; (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- An order, dated 10/24/24, for Glucerna 1.5 cal 237 cc per tube five times a day at 2:00 A.M., 6:00 A.M., 12:00 P.M., 6:00 P.M.; - Documentation for 10/25/24 - 10/31/24, showed 20 missed opportunism out of 35 opportunities; - An order, dated 10/24/24, for water flush 60 cc per tube every six hours before and after feedings; - Documentation for 10/25/24 - 10/31/24, showed 20 missed opportunities out of 35 opportunities. Review of the resident's care plan, revised on 11/01/24, showed: - The resident received tube feedings and had a weight loss with no goals and interventions addressed. Review of the resident's MAR, dated 11/01/24 - 11/31/24, showed: - An order, dated 10/24/24, for Glucerna 1.5 cal 237 cc per tube five times a day at 2:00 A.M., 6:00 A.M., 12:00 P.M., 6:00 P.M.; - Documentation for 11/01/24 - 11/13/24, showed 27 missed opportunities out of 65 opportunities; - An order, dated 10/24/24, for water flush 60 cc per tube every six hours before and after feedings; - Documentation for 11/01/24 - 11/13/24, showed 22 missed opportunities out of 52 opportunities. Review of the resident's weights showed: - On 05/03/24, the resident weighed 126.2 lbs; - On 08/01/24, the resident weighed 120.4 lbs; - On 10/04/24, the resident weighed 120.4 lbs; - On 11/01/24, the resident weighed 109.4 lbs; - For 10/04/24 - 11/01/24, the resident had a 9.6% weight loss in 30 days; - For 08/01/24 - 11/01/24, the resident had a 9% weight loss in 90 days; - For 05/03/24 - 11/01/24, the resident had a 13.3% weight loss in 180 days. Review of the resident's medical record showed: - No documentation the physician was notified of the resident's missed tube feedings, water flushes, and severe weight loss until 11/14/24. (continued on next page)

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	26A469	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pemiscot County Memorial Hospital	946 E Reed Street Hayti, MO 63851

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/19/24 at 10:56 A.M., the Director of Nursing (DON) said on weekends, she only scheduled a certified medication technician (CMT) instead of a licensed nurse. If care was required for a licensed nurse, then one would come over from the hospital side. The DON denied staff reported to her the hospital staff were not documenting on treatments they provided. The DON said she had not provided inservice training to the hospital staff regarding documentation of treatments when they performed care on the skilled side. During an interview on 11/20/24 at 2:52 P.M., Registered Nurse (RN) B said the night of 10/15/24, was the first time he/she had been called over to administer Resident #1's tube feeding. After completing it, the CMT was told to contact him/her if additional help was required, but he/she never heard anything else from the CMT. He/She did not document the tube feeding and the water flush, because he/she did not realize it was on the resident's MAR. He/She had not been trained on the documentation of the facility residents. During an interview on 11/20/24 at 11:05 A.M., Licensed Practical Nurse (LPN) C said the lack of documentation on the MARs by the hospital and facility nursing staff had been reported to the DON, but it hadn't helped. He/She hoped things were being done and just not documented. During an interview on 11/20/24 at 11:10 A.M., CMT A said the lack of documentation on the MARs by the hospital and facility nursing staff had been noticed and the DON was made aware of them multiple times. There had not been any related in-services recently. During an interview on 11/21/24 at 3:28 P.M., the Chief Nursing Officer (CNO) said the facility did not schedule licensed staff on the weekend nights and on some weekend days. If licensed staff was needed, they just came over from the hospital. The incident was reported to her about a resident not getting a feeding, was investigated, and after completion of the investigation, it was decided the CMT failed to notify the nurse that additional feedings needed to be done that night. There was a sign up that stated to notify the hospital supervisor if there were orders that need completed and require licensed staff, and to notify the DON if that was unsuccessful. She thought it was a one-time occurrence and did not look at the MARs, so she was unaware of all the tube feedings that weren't administered. She felt the feedings had been completed, but just not documented. When she was made aware of the resident's weight loss, the physician was notified and a new order was obtained for a feeding pump (a device used to deliver continuous or intermittent feedings) on 11/14/24. She would expect significant weight loss to be addressed with the physician and the Registered Dietician (RD). She was unaware if residents' weights were discussed daily and if the RD had been notified and had addressed Resident #1's significant weight loss. She would expect the care plan to be updated as needed. During an interview on 11/20/24 at 12:24 P.M., the Administrator said he would expect orders to be followed and accurate documentation completed. He would also expect the DON to be auditing the charts and making sure things were being done correctly and if there was a questionable order, the physician should be notified for clarification. If there were things wrong in the facility, they needed to be addressed and fixed. During an interview on 11/21/24 at 2:44 P.M. the Physician said he/she would expect staff to follow orders, administer feedings as ordered, and for qualified staff to be available to perform the orders. He/She had not been made aware Resident #1 was having any issues with weight. It was expected of staff to keep the physician informed with concerns. The lack of tube feedings could result in weight loss for Resident #1. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Complaint #MO245032 and MO245090 NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Surveyor: [NAME], [NAME] Based on interview and record review, the facility failed to ensure sufficient nursing staff to provide nursing and related services to residents. The facility failed to have licensed nurse coverage 24 hours a day. The facility failed to ensure one resident (Residents #1) received tube feedings (a small tube placed through abdomen into the stomach to be used to give medicines, nutrition, and liquids through), medications as ordered, and wound treatments as ordered out of two sampled residents. The census was 23. The facility did not provide a policy for staffing of licensed nurses. Review of the Nursing Schedules for 10/01/24 - 11/19/24, showed: - No documentation licensed nursing staff scheduled and worked on the 7:00 A.M.-7:00 P.M., shift for 10/04/24, 11/10/24, and 11/17/24; - No documentation licensed nursing staff scheduled and worked on the 7:00 P.M. -7:00 A.M., shift for 10/27/24, 10/31/24, 11/01/24, 11/02/24, 11/03/24, 11/08/24, 11/09/24, 11/10/24, 11/15/24, 11/16/24, and 11/17/24. Review of the current Nursing Assignment Sheets, dated 10/01/24 - 11/19/24, showed: - No documentation licensed nursing staff scheduled and worked on the 7:00 A.M.-7:00 P.M., shift for 10/04/24, 11/10/24, and 11/17/24; - No documentation licensed nursing staff scheduled and worked on the 7:00 P.M. -7:00 A.M., shift for 10/27/24, 10/31/24, 11/01/24, 11/02/24, 11/03/24, 11/08/24, 11/09/24, 11/10/24, 11/15/24, 11/16/24, and 11/17/24. 1. Review of Resident #1's medical record showed: - admitted on [DATE]; - An order dated 04/15/24, for Glucerna 1.5 cal, 240 cubic centimeters (cc) at 06:00 AM, 12:00 PM, 6:00 PM, per feeding tube; - An order dated 04/15/24, for water flush, 150 cc per tube every six hours after feeding; - admitted to the hospital on 10/20/24 - 10/24/24, with urinary tract infection (UTI) with sepsis (a life threatening condition of an infection); - An order, dated 10/24/24, for Glucerna 1.5 cal, 237 cc per tube five times a day at 2:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An order dated 10/24/24, for water flush, 60 cc per tube every six hours before and after feeding; - An order for Bactrim (an antibiotic) 400-80 milligram (mg) every 12 hours for seven days, dated 10/24/24; - An order for amoxicillin (an antibiotic) 875 mg every 12 hours for seven days, dated 10/24/24; - An order for amoxicillin 500 mg per tube three times a day for 10 days, for a UTI, dated 11/01/24; - An order, dated 07/19/24, to cleanse the coccyx (small triangular bone at the base of the spinal column) wound with wound cleanser and pat dry, apply Santyl (a type of wound treatment to remove dead tissue) and silver to the top area of the wound. Apply calcium alginate (a highly absorbent wound dressing) and top with polymem (type of dressing to remove dead tissue and cleanse the wound(to the mid and bottom areas of the wound daily; - An order, dated 10/24/24, to cleanse and irrigate the wound to the coccyx with Vashe (a wound solution used to cleanse, irrigate and moisten), apply silver impregnated foam dressing (a dressing that helps reduce inflammation, treats existing infection and prevents new infections) and ConvaFoam (foam dressing used for wound management) daily. Review of the resident's October and November 2024 Treatment Administration Record, showed: - No documentation of administration of Glucerna for 6:00 and 12:00 dose on 10/27 and 10/31; - No documentation of administration of Glucerna for 6:00 A.M. dose on, 11/01, 11/02, 11/03 and 11/09; - No documentation of administration of Glucerna for 6:00 P.M. dose on, 11/10; - No documentation of administration of Glucerna for 12:00 A.M. dose on 11/01, 11/01, 11/03 and 11/10; - No documentation of administration of Glucerna for 2:00 A.M. dose on 11/01, 11/01, 11/03 and 11/09 - No documentation of administration of Bactrim for 6:00 A.M., dose on 10/27; - No documentation of administration of amoxicillin for 12:00 A.M. and 6:00 A.M., dose on 10/31; - No documentation of administration of amoxicillin for 6:00 A.M. dose on 11/1, 11/2, 11/3, and 11/9; - No documentation of administration of amoxicillin for 8:00 P.M., dose on 11/10; - No documentation of administration of wound treatment for 10/4; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No documentation of administration of wound treatment for 10/27. During an interview on 11/19/24 at 10:56 A.M., the Director of Nursing (DON) said on weekends, she only scheduled a certified medication technician (CMT) instead of a licensed nurse. If care was required for a licensed nurse, then one would come over from the hospital side. She did not consider it her responsibility to audit the resident charts to make sure orders were being completed and medications/treatments were administered as ordered. During interviews on 11/19/24 at 3:28 P.M. and 11/25/24 at 10:45 A.M., the Chief Nursing Officer (CNO) said the facility did not schedule licensed staff on the weekend nights and on some weekend days. If licensed staff was needed, they just came over from the hospital. This was a fairly new position for her and she had been told the hospital staff could be utilized instead of scheduling licensed staff for the facility. There was a sign up that stated to notify the hospital supervisor if there were orders that need completed and require licensed staff, and to notify the DON if that was unsuccessful. She was unaware of all the missed documentation on the MAR and felt some of it had been completed and not documented. It was the responsibility of the DON to do audits to ensure the treatments and documentation were being completed. Any care or treatment should be documented. During an interview on 11/20/24 at 12:24 P.M., the Administrator said he would expect orders to be followed, accurate documentation completed and qualified staff to be scheduled and available During an interview on 11/21/24 at 2:44 P.M. the Physician said he/she would expect staff to follow orders, administer feedings and medications as ordered, and for qualified staff to be scheduled and available to perform the orders.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37575 Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day, seven days a week. This deficiency had the potential to affect all residents residing in the facility. The facility census was 23. The facility did not provide a policy for RN scheduling. Review of the facility's Facility Assessment Tool, last reviewed 03/08/21, showed the facility required two RNs. Review of the Nursing Schedules for 10/01/24 - 11/19/24, showed no documentation a RN scheduled and worked eight consecutive hours on 10/01/24, 11/10/24, and 11/17/24. Review of the current Nursing Assignment Sheets, dated 10/01/24 - 11/19/24, showed no documentation a RN worked eight consecutive hours on 10/01/2024, 11/10/24, and 11/17/2024. During an interview on 11/22/24 at 1:40 P.M., the Chief Nursing Officer said she thought hospital staff were considered part of the long term care staff and RNs were not always scheduled. Staff could call and request assistance from the hospital supervisor as needed.