| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265142 | A. Building<br>B. Wing | 01/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Chateau Girardeau | 3120 Independence Street<br>Cape Girardeau, MO 63703 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152<br><br>Based on observation, interview, and record review, the facility failed to cover a resident's catheter (tube inserted into the bladder to drain urine) drainage bag with a dignity bag to ensure the dignity of one resident (Resident #2) out of two sampled residents. The facility census was 51.<br><br>Review of the facility policy titled, Dignity and Respect, undated, showed:<br><br>- All residents be treated with kindness, dignity, and respect;<br><br>- Privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident's safety;<br><br>- Residents shall be examined and treated in a manner that maintains the privacy of their bodies.<br><br>1. Review of Resident #2's medical record showed:<br><br>- admitted on [DATE];<br><br>- Diagnosis of acute cystitis (bladder infection) with hematuria (bloody urine);<br><br>- The resident with a urinary catheter present upon admission.<br><br>Observations on 01/21/25 at 11:48 A.M., 01/22/25 at 12:03 P.M., and 01/23/25 at 6:55 A.M., showed:<br><br>- The resident sat in a wheelchair in the dining room;<br><br>- A urinary catheter drainage bag, partially filled with yellow urine, hung from the bottom of the wheelchair and not covered with a dignity bag for privacy.<br><br>Observation on 01/22/25 at 9:10 A.M., 10:18 A.M., and 01/23/25 at 5:15 A.M., showed:<br><br>- The resident sat in a wheelchair in the common room;<br><br>- A urinary catheter drainage bag, partially filled with yellow urine, hung from the bottom of the wheelchair and not covered with a dignity bag for privacy.<br><br>(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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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 01/22/25 at 11:30 A.M., Certified Nurse Assistant (CNA) D said the resident's catheter drainage bag should have a dignity bag to protect the resident's privacy and dignity.<br><br>During an interview on 01/23/25 at 1:41 P.M., Licensed Practical Nurse (LPN) C said he/she would expect a resident with a catheter to have the catheter drainage bag in a dignity bag.<br><br>During an interview on 01/23/25 at 2:45 P.M., the Director of Nursing (DON) said she would expect a resident with a catheter to have their dignity maintained and for the catheter drainage bag to be covered when the resident was in a common area. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152<br><br>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 for two residents (Residents #2 and #35) out of three sampled residents. The facility's census was 51.<br><br>The facility did not provide a policy regarding a resident transfer/discharge.<br><br>1. Review of Resident #2's medical record showed:<br><br>- Transferred to the hospital on 12/14/24, and readmitted to the facility on [DATE];<br><br>- No documentation the resident and/or the resident representative was informed in writing of the transfer/discharge to the hospital at the time of the transfer.<br><br>2. Review of Resident #35's medical record showed:<br><br>- Transferred to the hospital on 10/18/24, and readmitted to the facility on [DATE];<br><br>- No documentation the resident and/or the resident representative was informed in writing of the transfer/discharge to the hospital at the time of the transfer.<br><br>During an interview on 01/23/25 at 2:25 P.M., Licensed Practical Nurse (LPN) B said nurses were responsible for filling out the transfer/bed hold paperwork. The nurse would make a copy and give one copy to the resident and the other copy would go in the resident's chart.<br><br>During an interview on 01/23/25 at 3:30 P.M., the Administrator said she would expect the appropriate forms be filled out and given to the resident or the resident representatives when a resident was transferred out to the hospital. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152<br><br>Based on interview and record review, the facility failed to inform the resident and/or the legal representative of their bed hold policy at the time of transfer to the hospital for two residents (Residents #2 and #35) out of three sampled residents. The facility's census was 51.<br><br>The facility did not provide a bed hold policy.<br><br>1. Review of Resident #2's medical record showed:<br><br>- Transferred to the hospital on 12/14/24, and readmitted to the facility on [DATE];<br><br>- No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer.<br><br>2. Review of Resident #35's medical record showed:<br><br>- Transferred to the hospital on 10/18/24, and readmitted to the facility on [DATE];<br><br>- No documentation the resident and/or the resident representative was informed in writing of the facility bed hold policy at the time of the transfer.<br><br>During an interview on 01/23/25 at 2:25 P.M., Licensed Practical Nurse (LPN) B said nurses were responsible for filling out the transfer/bed hold paperwork. The nurse would make a copy and give one copy to the resident and the other copy would go in the resident's chart.<br><br>During an interview on 01/23/25 at 3:30 P.M., the Administrator said she would expect the appropriate forms filled out and given to either the resident or the resident representative when a resident was transferred to the hospital. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>47447<br><br>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. The facility census was 51.<br><br>The facility did not provide a RN coverage policy.<br><br>Review of the facility's Facility Assessment, updated 08/01/24, showed:<br><br>- The facility required three licensed nurses providing direct care for day shift, which included at least one RN for the day shift;<br><br>- The facility required three licensed nurses providing direct care for the night shift, which included at least one RN for the night shift.<br><br>Review of the Center for Medicare & Medicaid Services (CMS) Payroll Based Journal (PBJ) staffing data Report from the Community Assessment for Public Health Emergency Response (CASPER) REPORT 1705D for the fiscal year quarter 4, 2024 (July 1, 2024 to September 30, 2024) showed:<br><br>- Triggered four or more days within the quarter with no RN hours;<br><br>- Seven days in July 2024 for 07/04/24- Thursday; 07/13/24- Saturday; 07/14/24- Sunday; 07/20/24- Saturday; 07/21/24- Sunday; 07/27/24- Saturday; and 07/28/24- Sunday;<br><br>- Three days in August 2024 for 08/10/24- Saturday; 08/11/24- Sunday; and 08/25/24- Sunday;<br><br>- Five days in September 2024 for 09/02/24- Monday; 09/14/24- Saturday; 09/15/24- Sunday; 09/21/24- Saturday; and 09/22/24- Sunday.<br><br>Review of the Nursing Schedules and the Daily Nursing Staffing Sheets for October 10/20/24 - 01/20/25, showed:<br><br>- No RN worked on 10/20/24, 11/03/24, 11/16/24, 11/17/24, 12/01/24; 12/14/24; 12/15/24, 01/11/25, 01/12/25, and 01/19/25;<br><br>- No RN worked for 10 days out of 93 days.<br><br>During an interview on 01/23/25 at 1:37 P.M., the Administrator said a RN had been scheduled on each day shift, but when one of the RN's quit, the RN position was replaced with a Licensed Practical Nurse (LPN). There was a RN on call every weekend, but the RN was not always in the building. The RN was available by phone instead. She was aware there should be a RN on duty at least eight hours a day, seven days a week. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>49152<br><br>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 36 opportunities with two errors made, resulting in an error rate of 5. 56% for two residents (Residents #2 and #26) out of seven sampled residents. The facility's census was 51.<br><br>Review of the facility's policy titled, Administering Medications, dated April 2019, showed:<br><br>- Medications are administered in a safe and timely manner, and as prescribed.<br><br>- Insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident;<br><br>- Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident;<br><br>- The policy did not address insulin pen administration technique.<br><br>Review of the insulin aspart (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) FlexPen (insulin in a pen-type device) instructions, revised, June 2023, showed:<br><br>- Prime the pen by turning the dose knob to two units;<br><br>- Hold the pen with the needle pointing up;<br><br>- Tap the cartridge holder gently to collect air bubbles at the top;<br><br>- Push the dose knob in until it stops, and zero is seen in the dose window, count to five slowly, the insulin will be visible at the tip of the needle;<br><br>- Select the dose;<br><br>- Give the injection after selecting the area and cleaning the site with an alcohol swab.<br><br>Review of the insulin Humalog (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) KwikPen (insulin in a pen-type device) manufacture guidelines for administration, revised 07/2023, showed:<br><br>- Prime the pen before each injection;<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Priming Directions of Insulin Pen: turn the dose knob to select two units; hold the pen with the needle pointing up; tap the cartridge holder gently to collect air bubbles at the top; push the dose knob in and continue holding the pen with the needle pointing up; push the dose knob in until it stops, and zero is seen in the dose window; hold the dose knob in and count to five slowly; check for insulin at the tip of the needle; if insulin wasn't present, repeat the priming steps one to three, no more than four times; if insulin still not present, change the needle, and repeat the priming steps;<br><br>- Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly;<br><br>- If the pen isn't primed before each injection, the patient may get too much or too little insulin.<br><br>1. Review of Resident #2's Physician Order Sheet (POS), dated January 2025, showed:<br><br>- An order for Humalog KwikPen 20 units per milliliter (ml) subcutaneous (an injection just below the skin) with meals, dated 03/20/24.<br><br>Observation of the resident's medication administration on 01/22/25 at 11:42 A.M., showed:<br><br>- Licensed Practical Nurse (LPN) B administered 20 units of of Humalog insulin subcutaneously with the resident's Humalog Kwikpen for a blood sugar of 183;<br><br>- LPN B failed to prime the Humalog Kwikpen per the manufacturer's instructions prior to the administration of the insulin to the resident.<br><br>2. Review of Resident #26's POS, dated January 2025, showed:<br><br>- An order for insulin aspart FlexPen 10 units per ml subcutaneous with meals, dated 01/02/25.<br><br>Observation of the resident's medication administration on 01/23/25 at 10:35 A.M., showed:<br><br>- LPN C administered 10 units of insulin aspart subcutaneously with the resident's insulin aspart FlexPen for a blood sugar of 210;<br><br>- LPN C failed to prime the insulin aspart FlexPen per the manufacturer's instructions prior to the administration of the insulin to the resident.<br><br>During an interview on 01/23/25 at 10:40 A.M., LPN C said when administering insulin, he/she would prime the insulin pen when it was brand new, and then after that, he/she did not prime the pen before each dose.<br><br>During an interview on 01/23/25 at 3:30 P.M., the Director of Nursing (DON) said all insulin pens should be primed before each individual dose and for the facility to have a less than five percent medication error rate. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>47447<br><br>Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during catheter (a tube that inserted into the bladder to drain urine) care for one resident (Resident #2) out of two sampled residents and during gastrostomy tube (device to deliver food or medicine into the resident's digestive system) care for one resident (Resident #44) out of two sampled residents, and while passing trays during meal times. The facility's census was 51.<br><br>Review of the facility's policy titled, Wearing Gloves for Food Safety, undated, showed:<br><br>- Wash hands before and after handling food, utensils, or equipment;<br><br>- Wash hands after touching hair or your body;<br><br>- Wash hands when you change tasks;<br><br>- Wash hands after touching anything that might result in contamination of hands.<br><br>Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), dated 10/03/24, showed:<br><br>- EBP employs gown, gloves, and face/eye protection;<br><br>- Foley catheters (a tube inserted into the bladder to drain urine) and feeding tubes or drains need EBP;<br><br>- The facility will conduct an annual infection control risk assessment;<br><br>- Residents with an indwelling device will be placed in EBP until the device is removed;<br><br>- Residents will be evaluated for the need of EBP upon admission, with a significant change, quarterly, with antibiotic use, placement of medical device, or with the development of a new skin condition;<br><br>- The resident and/or resident representative will be educated on the resident's need for EBP;<br><br>- Staff training regarding EBP will be conducted upon hire, annually, if changes occur, and as needed;<br><br>- Routine skill, competency, and/or compliance audits will be conducted by Infection Preventionist or designee;<br><br>- Staff must remove personal protective equipment (PPE) and perform hand hygiene after working with a resident in EBP before providing care to other residents;<br><br>- Post signage at the door or designated area and ensure a receptacle is placed at the room exit for removal.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Care of Indwelling Foley Catheters, dated January 2016, showed:<br><br>- Catheter care is provided every shift and more often as needed with the purpose to prevent possible urinary tract infections from bacteria;<br><br>- Wash hands and put on gloves, identify resident and yourself, explain what you are going to do, provide privacy, resident in supine (lay on back) position with legs apart, check catheter and drainage bag for leaks, kinks, level of bag, and ensure catheter bag is securely attached to the bed frame;<br><br>- Expose perineal area and gently wash around the opening of the urethra with soap and warm water, wash catheter tubing from opening of the urethra outward four inches or farther if needed without pulling on the catheter, using fresh washcloth, continue washing and rinsing the perineal area;<br><br>- Dry the perineal area;<br><br>- Remove gloves and dispose in appropriate container, then wash hands.<br><br>1. Observations on 01/21/25 of the lunch meal in the main dining room showed:<br><br>- At 11:36 A.M., Hostess A delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:40 A.M., Certified Nursing Assistant (CNA) G delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:42 A.M., Hostess A delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:45 A.M., CNA G delivered a meal tray to a resident, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:47 A.M., Hostess A delivered a meal tray to a resident, touched his/her hair, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray.<br><br>Observations on 01/22/25 of the lunch meal in the main dining room showed:<br><br>- At 11:40 A.M., Hostess A delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - At 11:43 A.M., Hostess A delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:44 A.M., CNA H delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:46 A.M., CNA H delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:48 A.M., CNA H delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:51 A.M., CNA G delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray;<br><br>- At 11:53 A.M., CNA G delivered a resident's meal tray, touched the trash can lid with his/her bare hands while discarding trash, did not perform hand hygiene, and delivered another resident's meal tray.<br><br>During an interview on 01/23/25 at 12:33 P.M., Hostess A said hand washing or sanitizing should be done before passing trays, after every few meal trays were passed, before assisting a resident to eat, and if hands were soiled.<br><br>During an interview on 01/23/25 at 3:45 P.M., the Director of Nursing (DON) said staff were expected to wash or sanitize their hands after touching soiled surfaces and between each tray when delivering meal trays.<br><br>2. Observation on 01/22/25 at 11:30 A.M., of Resident #2's catheter care showed:<br><br>- EBP signage posted outside the room;<br><br>- CNA D and CNA E put on gowns prior to entering the resident's room;<br><br>- CNA D put on two pair of gloves, got a wipe, wiped the area around the catheter, removed one pair of gloves, got a wipe, wiped the area around the catheter, and removed the gloves;<br><br>- CNA D did not perform hand hygiene, put on gloves, got a wipe, cleaned the area around the catheter, and removed the gloves;<br><br>- CNA D did not perform hand hygiene, put on gloves, got a wipe, wiped the resident's buttocks, and removed the gloves;<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - CNA D did not perform hand hygiene, put on gloves, got a wipe, wiped the resident's buttocks again, and removed the gloves;<br><br>- After completion of the catheter care, CNA D exited the resident's room with the gown on, went out into the hallway, removed the gown, and performed hand hygiene.<br><br>During an interview on 01/23/25 at 7:00 A.M., CNA D said staff received training on infection control, catheter care, incontinence care, and the new EBP precautions. Hand hygiene should be done between glove use, before and after care, and when visibly dirty.<br><br>During an interview on 01/23/25 at 2:33 P.M., CNA E said hand hygiene was done before doing a task, when going from clean to dirty care, when going from a dirty to clean task, and when the task was completed. Hand hygiene was done before passing food trays, between each food tray delivered to a resident, and after the last tray was delivered. Hand hygiene also was done if touching a contaminated surface between tasks. A EBP gown was taken off before exiting the room and placed in the appropriate disposal bins.<br><br>3. Observation on 01/23/25 at 5:25 A.M., of Resident #44's gastrostomy tube care showed:<br><br>- EBP signage posted outside the room;<br><br>- Licensed Practical Nurse (LPN) I did not put on a gown prior to beginning the gastrostomy tube care;<br><br>- LPN I provided gastrostomy tube care to the resident.<br><br>During an interview on 01/23/25 at 10:50 A.M., LPN C said residents with an indwelling device like a catheter or gastrostomy tube require staff to wear EBP when doing care. EBP, such as a gown and gloves, were put on before entering the resident's room and removed before exiting the resident's room.<br><br>During an interview on 01/23/25 at 3:30 P.M., the Director of Nursing (DON) and the Administrator said they expected hand hygiene and glove use to be done before and after incontinence care and catheter care. If someone double gloved and gloves were soiled, then both pairs of gloves should be taken off and hand hygiene performed before putting on new gloves. Staff were to use EBP precautions for close contact with residents with indwelling catheters, gastrostomy tubes, and wounds. EBP should be taken off prior to leaving a room and placed in an EBP trash can.<br><br>49152 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265142 | A. Building<br>B. Wing | 01/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Chateau Girardeau | 3120 Independence Street<br>Cape Girardeau, MO 63703 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>47447<br><br>Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year. This affected one Certified Nurse Assistant (CNA) (CNA F) out of two sampled CNAs. The facility's census was 51.<br><br>Review of the facility's policy titled, In-Service Training, Nurse Aide, revised 08/2022, showed:<br><br>- All personnel are required to participate in regular in-service education;<br><br>- Annual in-services are no less than 12 hours per employment year;<br><br>- Nurse aid participation in training is documented by the staff development coordinator, or his/her designee and includes: the date and time of the training; the topic of the training; the method used for the training; a summary of the competency assessment; and the hours of training completed.<br><br>1. Review of CNA F's in-service record showed:<br><br>- A hire date of 07/05/23;<br><br>- A total of seven hours of annual in-service training for July 2023 through July 2024;<br><br>- Less than twelve hours of in-service education for July 2023 through July 2024.<br><br>During an interview on 01/22/25 at 1:30 P.M., the Administrator said the Director of Nursing (DON) provided education more often than monthly, but apparently they had not documented all of the education the DON provided. She expected all CNAs to have at least 12 hours of in-service education per year. |