

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Nhc Healthcare, West Plains		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Davis Drive West Plains, MO 65775	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47445</p> <p>Based on observation, interview, and record review, the facility failed to ensure an environment free from accident hazards. Staff failed to secure access to soiled laundry and chemicals in an unlocked soiled linen laundry room. The room contained a sink basin of bleach water and an open container of multipurpose cleaner solution. The unlocked, unlatched soiled linen room presented a potential hazard to all residents who were able to move freely around the facility with 14 residents at increased risk due to their mental capacity from a diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning) or Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). The facility census was 61.</p> <p>Review of the facility policy titled, Chemical Storage, undated, showed:</p> <ul style="list-style-type: none"> - Keep chemicals locked up away from patients when not in use. <p>Review of the Product Specification Document titled, Rapid Multi-Surface Disinfectant Cleaner, dated 10/19/23, showed:</p> <ul style="list-style-type: none"> - Keep out of reach of children; - Precautions: Concentrate is corrosive. Causes irreversible eye damage and skin burns. Diluted solution causes moderate eye irritation; - Physical and Chemical Hazards: Do not mix with anything but water. <p>Observations of the soiled linen room in the laundry rooms showed:</p> <ul style="list-style-type: none"> - On 02/06/25 at 10:30 A.M. - 10:32 A.M., 10:38 A.M. - 10:42 A.M., 10:47 A.M. - 10:49 A.M., 11:00 A.M. - 11:02 A.M., the soiled linen room door in the laundry rooms was unlocked and unlatched with a sink basin filled with bleach water with one towel and an open container of multipurpose cleaner solution with a toilet brush sitting in the solution inside the right sink basin, a large bin of soiled items, and a large bin of trash items. No staff were present inside the laundry rooms. Multiple residents and staff walked by the unlocked and unlatched room door. Three residents sat in chairs in the common area approximately 20 feet from the soiled linen room; <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 02/07/25 at 7:50 A.M. - 7:54 A.M., 7:58 A.M. - 8:03 A.M., and 8:05 A.M. - 8:08 A.M., the soiled linen room door in the laundry rooms was unlocked and unlatched with a sink basin filled with bleach water and an open container of multipurpose cleaner solution with a toilet brush sitting in the solution inside the right sink basin, a large bin of soiled items, and a large bin of trash items. No staff were present inside the laundry rooms. Multiple residents and staff walked by the unlocked and unlatched room door. Two residents sat in chairs and one resident sat in a wheelchair in the common area approximately 20 feet from the soiled linen room.</p> <p>During an interview on 02/06/25 at 11:05 A.M., Laundry/Housekeeping E said the soiled linen door was left unlocked when staff were out rounding the halls to pick up soiled barrels. The door was locked when the task was complete.</p> <p>During an interview on 02/07/25 at 8:15 A.M., Housekeeper G said the soiled linen door in the laundry was not locked or latched when he/she pushed the door open to check the trash bin. The door was locked at times and a code must be entered to open the door.</p> <p>During an interview on 02/07/25 at 1:10 P.M., Laundry/Housekeeping Staff E and Laundry/Housekeeping F said the doors to the laundry, including the soiled linen, should be kept latched and always locked.</p> <p>During an interview on 02/07/25 at 1:30 P.M., the Director of Nursing (DON) said the laundry room doors should be latched and locked when unattended.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693</p> <p>Based on observation, interview, and record review, the facility failed to ensure a urinary indwelling catheter (a tube inserted into the bladder to drain urine) drainage bag was kept off the floor for one resident (Resident #61) out of three sampled residents. The facility census was 61.</p> <p>Review of the facility's policy titled, Catheter Care, undated, showed:</p> <ul style="list-style-type: none"> - The policy didn't address catheter tubing or drainage bags not touching the floor. <p>1. Review of Resident #61's medical record showed:</p> <ul style="list-style-type: none"> - admitted on [DATE]; - Diagnosis of urine retention. <p>Review of the resident's Physician Order Sheet (POS), dated February 2025, showed:</p> <ul style="list-style-type: none"> -An order to change the indwelling/suprapubic (catheter inserted through the abdomen into the bladder for urine drainage) catheter every 30 days. Insert the catheter size 16 French (Fr- the measurement used to measure sizes of urinary catheters) and bulb size 5-10 cubic centimeter (cc) on the 1st of the month, during day 6:00 AM - 06:00 PM. Diagnosis of urinary retention, dated, 01/23/25; - An order for an indwelling catheter/suprapubic catheter care every shift dated, 01/14/25. <p>Review of the resident's Care Plan, dated 01/21/25, showed:</p> <ul style="list-style-type: none"> - Resident had an indwelling catheter related to retention of urine, Size 16 Fr with 10 cc bulb. Maintain the drainage bag in privacy cover or fig leaf bag (a urinary drain bag that preserves the dignity of the patient by hiding the fluid from view with a built in cover). <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated process for clinical assessment of all residents in certified nursing homes), dated 01/08/25, showed:</p> <ul style="list-style-type: none"> - The resident had an indwelling catheter. <p>Observations on 02/04/25 at 11:45 A.M., and 12:09 P.M., showed the resident sat in a wheelchair and propelled him/herself down the hallway with six inches of the catheter tubing dragging the floor.</p> <p>Observation on 02/05/25 at 8:45 A.M., showed the resident transferred by two staff from the bed into the wheelchair. Certified Nursing Assistant (CNA) B sat the catheter drainage bag on the floor, opened the privacy bag under the wheelchair, and stuffed the catheter drainage bag inside.</p> <p>During an interview on 02/07/25 at 10:30 A.M., Licensed Practical Nurse (LPN) A said the catheter bag and tubing should never touch the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/07/25 at 10:45 A.M., LPN D said catheter bags and tubing should not touch the floor.</p> <p>During an interview on 02/07/25 at 1:50 P.M., the Director of Nursing (DON) said a catheter, including the drainage bag and tubing, should not touch the bag.</p> <p>During an interview on 02/07/25 at 1:55 P.M., the Administrator said catheters should not touch the floor.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47445</p> <p>Based on interview and record review, the facility failed to provide documentation of ongoing assessments, monitoring, and communication between the facility and the dialysis (a process for removing waste and excess water from the blood) center for one resident (Resident #264) out of one sampled resident. The facility census was 61.</p> <p>Review of the facility's policy titled, Care of a Hemodialysis Patient, undated, showed:</p> <ul style="list-style-type: none"> - Will communicate concerns with dialysis center of any pertinent information/changes with communication observation sent with resident; - The hemodialysis access site will be observed every shift to ensure the dialysis dressing is intact and if there are any signs and symptoms of infection. Should signs and symptoms of infection be noted, the physician will be contacted; - The hemodialysis access site will be palpated (to feel or exam the body with hands or fingers) for the presence of a thrill (a vibration caused by blood flow) or auscultated (use a stethoscope to listen to the sounds inside of your body) for a bruit (a whooshing sound as blood flows through a narrowed vessel) each shift if indicated. The physician will be contacted if there is no thrill or bruit at the access site; - Should the access site have major bleeding, pressure will be applied and emergency services will be contacted; - Pre and post dialysis weights may be obtained at the dialysis center or at the facility. This should be communicated between the dialysis clinic and the facility; - Nurse should assess/monitor and document: shunt (a connection between a vein and artery that helps your body create the flow of blood it needs for dialysis to work) site for bleeding and infection, weights as ordered. <p>1. Review of Resident #246's Physician Order Sheet (POS), dated February 2025, showed:</p> <ul style="list-style-type: none"> - admitted on [DATE]; - Diagnoses of end stage renal disease (the kidneys are no longer able to work at a level needed for day-to-day life) and dependence on renal dialysis; - An order for dialysis on Monday, Wednesday, and Friday, once a day, dated 12/04/24; - An order to complete the dialysis communication observation pre-dialysis with special instructions: do prior to dialysis, once a day on Monday, Wednesday, and Friday, dated 01/31/2025; - An order to remove pressure dressing the evening of dialysis, once a day on Monday, Wednesday, and Friday at 7:00 P.M., dated 12/04/24; <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - An order for monthly weights with special Instructions: change to correct day of the month resident to be weighed, once a day on the first of the month, dated 12/04/24; - An order for weekly weights, once a day on Wednesday, dated 12/18/24; - No order to assess/monitor and document the dialysis shunt location and status before and after dialysis treatments. <p>Review of the resident's Care Plan, last reviewed 11/07/24, showed:</p> <ul style="list-style-type: none"> - Hemodialysis addressed with interventions of observe the shunt site for the thrill/bruit present at the shunt site. Observe for emergency bleeding at the shunt site. If found, apply pressure to site and call the primary care provider. Observe skin around the dressing for signs/symptoms of infection. Make sure the dressing is intact. <p>Review of the facility's Dialysis Communication Worksheets, dated 01/01/25 - 02/04/25, showed:</p> <ul style="list-style-type: none"> - No Dialysis Communication Worksheets completed for 01/01/25, 01/20/25, and 01/27/25, with three out of 14 opportunities missed; - The pre-dialysis weights were not documented by the facility and the post-dialysis weights and other information/responses were not documented by the dialysis center for the completed Dialysis Communication Worksheets; - On 01/03/25, 01/17/25, and 01/29/25, the dialysis site assessment was not documented. <p>Review of the Dialysis Communication Reports provided by the dialysis center, dated 12/01/24 - 02/06/25, showed:</p> <ul style="list-style-type: none"> - No documentation of the Dialysis Communication Reports for 12/02/24, 12/04/24, 12/09/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, 12/20/24, 12/25/24, 12/27/24, and 12/30/24, with 11 out of 13 opportunities missed; - No documentation of the Dialysis Communication Reports for 01/01/25, 01/03/25, 01/06/25, 01/08/25, 01/13/25, 01/17/25, 01/22/25, 01/24/25, 01/29/25, and 01/31/25, with 10 out 14 opportunities missed; - No documentation of the Dialysis Communication Reports for 02/03/25, and 02/05/25, with two out of two opportunities missed. <p>Review of the resident's Progress Notes, dated 12/01/24 - 02/05/25, showed:</p> <ul style="list-style-type: none"> - No documentation of the resident assessments completed after dialysis treatments; - No documentation of the resident assessments of the dialysis site. <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/04/25 at 2:14 P.M., the resident said he/she went to dialysis on Monday, Wednesday, and Friday. He/She had a fistula (a surgical connection made between an artery and a vein for dialysis access) in the left upper arm. Staff did not look at it, feel of it, or check the bandage when he/she returned from dialysis. He/She removed the dressing him/herself after he/she returned from dialysis.</p> <p>Observations and interviews of the resident showed:</p> <ul style="list-style-type: none"> - On 02/05/25 at 12:35 P.M., the resident with an undated gauze bandage taped on his/her left upper extremity (LUE) that covered the dialysis site. The resident said no one looked at the dressing when he/she returned from dialysis; - On 02/06/25 at 9:15 A.M., the resident sat in a recliner in his/her room with an undated gauze bandage taped on his/her LUE that covered the dialysis site. The resident said it was the same dressing that was on 02/05/25, and no one had looked at it or done anything to it. <p>During an interview on 02/07/25 at 10:44 A.M., Registered Nurse (RN) K said night shift completed the dialysis communication form and printed it to be sent with the resident when he/she left the facility for dialysis. When the resident returned, the resident had the dialysis communication paper if the dialysis center sent it. The form was sent from the dialysis center to the facility was not the same form that was sent with the resident from the facility. The communication form usually showed pre and post dialysis weights, and the amount of fluid pulled off during dialysis. Staff had to ask the resident for the paperwork, but he/she usually didn't have it. If the resident didn't have it, the RN would call over to the dialysis center and they faxed the paperwork over to the Assistant Director of Nursing (ADON), the Director of Nursing (DON), or the dialysis center might send it back with the resident on the next dialysis appointment. The weights on the paperwork were entered into the resident's electronic medical record (EMR) at the facility. RN K didn't do anything with the resident when he/she returned from dialysis and he/she was unsure where the resident's dialysis access site was located. The resident had a port (a medical device placed under the skin in the chest, arm or abdomen that allows for easy access to a vein for receiving treatments) and RN K believed it was in the resident's left arm. RN K did not do anything with the access site when the resident returned from dialysis and did not assess the site daily.</p> <p>During an interview on 02/07/25 at 10:55 A.M., the DON said there was a communication sheet in the resident's EMR. The nurses filled it out and sent it with the resident when he/she went to the dialysis center. All questions on the communication sheet should be answered. She expected the resident to be weighed per the physician's orders. If the resident returned from the dialysis center without the communication paper from the dialysis center, it should be followed up on by calling the dialysis center and having it faxed/sent to the facility. Resident #245 was transported to and from the dialysis center by an outside transport company so the resident should have the paperwork if it was sent. The nurse should check the access site bandage upon return, and check it daily for signs of infection. If there was a fistula , the nurse should check for the bruit every shift and before dialysis.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>45693</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication cart was locked while unattended and failed to ensure a safe medication system when leaving medications unattended and unsupervised for one resident (Resident #16) out of ? sampled residents during a medication pass. This had the potential to affect all residents. The facility census was 61.</p> <p>Review of the facility policy titled, Specific Medication Administration Procedures, dated 01/01/19, showed:</p> <ul style="list-style-type: none"> - All medication storage areas (carts) are locked at all times unless in use and under direct observation of the medication nurse/technician. <p>Review of the facility policy titled, Medication Storage in the Facility, dated 01/01/19, showed:</p> <ul style="list-style-type: none"> - Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access; - Schedule II medications are stored in an affixed, double locked compartment separate from all other non-controlled medications; - Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team; - All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage. <p>Review of the facility's policy titled, Specific Medication Administration, Oral Medications, dated 01/01/19, showed:</p> <ul style="list-style-type: none"> - Do not leave medication at bedside unless specifically ordered by the prescriber. <p>1. Review of Resident #16's Physician Order Sheet (POS), dated February 2025, showed:</p> <ul style="list-style-type: none"> - An order for Benefiber Sugar Free powder (a prebiotic fiber supplement) 3 gram (gm)/4 gm 15 gm by mouth once a day and mix in at least 8 ounces (oz) of water, dated 01/06/25; - An order for Celexa (an antidepressant medication) 20 milligrams (mg) by mouth daily for major depressive disorder, dated 10/13/21; - An order for cholecalciferol (Vitamin D3 - a supplement) over the counter (OTC) 1,000 unit three tablets by mouth every day for vitamin D3 deficiency, dated 01/09/19; <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - An order for cranberry (supplement) OTC 450 mg administer 2 tab by mouth every day, dated 06/21/2017; - An order for Daily-Vite with folic acid (a multivitamin) 400 microgram (mcg) by mouth for Vitamin B deficiency, dated 10/30/24; - An order for lisinopril (a blood pressure medication) 20 mg by mouth twice a day for hypertension (HTN - high blood pressure), dated 11/13/21; - An order for Metformin (an antihyperglycemic medication) tablet extended release 24 hour 500 mg once a day for diabetes, dated 01/17/24; - An order for methenamine (an antibiotic) 1 gm by mouth daily for retention of urine. Special instructions: take with Vitamin C, this will be a long-term medication for urinary tract infection (UTI) suppression due to urinary retention, dated 11/13/21; - An order for metoprolol succinate (a blood pressure medication) tablet extended release 24 hour 50 mg by mouth once a day for HTN, dated 03/24/22; - An order for Vitamin C OTC 500 mg by mouth twice a day, for retention of urine. Special instructions: take with methenamine), dated 01/09/19; - An order for Wellbutrin XL (an antidepressant medication) extended release 24 hour 150 mg by mouth once a day for major depressive disorder, dated 10/14/21; - No order to keep medications at bedside; - No order for the resident to self administer medications. <p>Review of the resident's medical record showed:</p> <ul style="list-style-type: none"> - No assessment for the resident to have medications at the bedside; - No assessment for the resident to self-administer medications. <p>Review of the resident's comprehensive care plan, last reviewed 01/21/25, showed:</p> <ul style="list-style-type: none"> - Did not address self-administration of medications; - Did not address medications to be left in the room for resident to take at his/her discretion. <p>Observations of the resident showed:</p> <ul style="list-style-type: none"> - On 02/04/25 at 10:45 A.M., 11 pills in a medication cup on the resident's bedside table and one plastic cup of Benefiber mixed in water. The resident took the pills and the Benefiber himself/herself at 10:55 A.M.; <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 02/05/25 at 8:34 A.M., 11 pills in a medication cup on the resident's bedside table and one plastic cup of Benefiber mixed in water. The resident took the pills and the Benefiber himself/herself at 8:52 A.M.;</p> <p>- On 02/06/25 at 8:14 A.M., 11 pills in a medication cup on the resident's bedside table and one plastic cup of Benefiber mixed in water. The resident took the pills and the Benefiber himself/herself at 8:52 A.M.</p> <p>During an interview on 02/04/25 at 10:45 A.M., Resident #16 said his/her medications were left on the bedside table every morning because the staff trust him/her to take the medications. He/She wanted to eat breakfast and drink coffee first. The pills were his/her morning medication.</p> <p>2. Observation on 02/06/25 at 3:20 P.M. - 3:29 P.M., of the medication cart on the locked memory care unit showed:</p> <p>- At 3:20 P.M., the medication cart was unlocked in the dining room beside the nurse station and faced the dining room;</p> <p>- Four residents sat in the dining room, two residents sat in the TV room within view of the medication cart;</p> <p>- Certified Nursing Assistant (CNA) in resident rooms and Licensed Practical Nurse (LPN) A exited the unit;</p> <p>- At 3:29 P.M., LPN A entered the unit, walked to the unlocked cart, opened it, and put in supplies.</p> <p>3. Observation on 02/07/25 at 7:40 A.M. - 7:48 A.M., of Hall A medication cart showed:</p> <p>- At 7:40 A.M., the unlocked medication cart sat against the wall beside the central supply closet facing the hall. A resident sat in a wheelchair in the hall and Certified Medication Technician (CMT) C stood in the hall with another resident. CMT C was not in direct view of the unlocked medication cart;</p> <p>- At 7:42 A.M., CMT C walked down the hall to a different resident and pushed the resident into a room;</p> <p>- At 7:44 A.M., staff walked past the unlocked cart;</p> <p>- At 7:46 A.M., CMT C walked past the unlocked medication cart to the kitchen;</p> <p>- At 7:48 A.M., LPN D walked up to the unlocked medication cart, opened it, took out a medication, and locked the cart.</p> <p>During an interview on 02/07/25 at 10:30 A.M., LPN A said medication carts should be locked at all times when not in use, especially if the responsible staff members were not with them. Medication should not be left unattended in resident rooms and residents shouldn't be allowed to self-administer them without an order to do so.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/07/25 at 10:45 A.M., LPN D said medication carts should always be locked when not in use. Medication shouldn't be left unattended in resident rooms and self-administered.</p> <p>During an interview on 02/07/25 at 1:00 P.M., Registered Nurse (RN) A said medications should not be left unattended in a resident's room and self-administered. Resident #16 took the medications later, not when given. He/She believed it was care planned.</p> <p>During an interview on 02/07/25 at 1:30 P.M., the Director of Nursing (DON) said medication carts should be locked when unattended. Medication shouldn't be left unattended in resident rooms and self-administered without an order to do so, assessment, and care planned.</p> <p>During an interview on 02/07/25 at 1:35 P.M., the Administrator said medication carts should always be locked when left unattended. The policy for medications being left unattended in resident rooms and self-administered should be followed. In general, medications shouldn't be left unattended.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693</p> <p>Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during incontinent care for two residents (Residents #5 and #16) out of four sampled residents, catheter (a tube inserted into the bladder to drain urine) care for one resident (Resident #21) out of one sampled resident, and wound care for two residents (Residents #5 and #58) out of two sampled residents. The facility failed to ensure proper infection control measures during administration of insulin for one resident (Resident #37) out of one sampled resident and touched medications with bare hands for one resident (Resident #118) out of five sampled residents. The facility also failed to ensure proper infection control measures during laundry services. The facility census was 61.</p> <p>Review of the facility's policy titled, Safety and Sanitation Best Practice Guidelines, dated 11/2017, showed:</p> <ul style="list-style-type: none"> - Glove use should never take the place of the first and primary barrier against germs, proper handwashing; - Gloves should be changed often, before moving from one task to another, or if contaminated; - Always wash hands using correct hand washing procedures before putting on gloves, putting on gloves with contaminated hands will contaminate the outside of the glove; - Change gloves after any action that might contaminate foods; - Remove gloves, then wash hands; - Dry hands and arms with disposable paper towel or other sanitary means, such as an air-drying device. Do not use a cloth towel for a continuous towel system that has been used by others. <p>Review of the facility's policy titled, Peri Care Check List Female/Male, undated, showed:</p> <ul style="list-style-type: none"> - Gather supplies, perform hand hygiene, put on gloves, clean the peri area using a clean portion of the washcloth each time, assist the resident to turn, hand hygiene and change gloves, cleanse the buttocks, remove gloves, hand hygiene, dispose of soiled linen. <p>Review of the facility's policy titled, Specific Medication Administration, Injectable Medication, dated 01/01/19, showed:</p> <ul style="list-style-type: none"> - Wash hands with soap and water; - Prepare medication; - Sanitize hands, put on gloves; - Expose area to be injected, clean with alcohol wipe; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - For subcutaneous (injection under the skin) pinch the skin up between the thumb and forefinger; - Inject the medication, remove the needle, apply adhesive bandage or apply gentle pressure to the site; - Dispose of the syringe in a sharps container; - Remove and discard gloves, clean hands by washing or sanitizing. <p>Review of the facility's policy titled, Specific Medication Administration, Oral Medication Administration, dated 01/01/19, showed:</p> <ul style="list-style-type: none"> - Wash hands when beginning medication pass or when contact with resident is expected or has occurred; - Pour correct number of tablets or capsules into the medication cup, taking care to avoid touching the tablet or capsule, unless wearing gloves. <p>Review of the facility's policy titled, Linen and Laundry Management, undated, showed:</p> <ul style="list-style-type: none"> - Always wear gloves before handling soiled linen; - Never carry soiled linen against the body; - Have handwashing facilities; - If there is risk of splashing, staff should always wear gowns or aprons and face protection; - Transport laundry from patient rooms to laundry chute or area. Avoid leaning into cart when gathering laundry to prevent direct contact of skin and clothes with dirty linens. <p>The facility referenced Centers of Medicare and Medicaid Services (CMS) Memo QSO-24-08-NH as their policy for Enhanced Barrier Precautions (EBP) in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs), dated 03/20/24, showed:</p> <ul style="list-style-type: none"> - EBP recommendations now include the use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their MDRO status; - EBP refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high contact resident care activities; - EBP is for residents with chronic wounds and indwelling medical devices (examples include urinary catheters); - High contact resident care activities include (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care. <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Observation of incontinent and catheter care on 02/04/25 at 11:02 A.M., for Resident #16 showed:</p> <ul style="list-style-type: none"> - EBP signage for the resident; - Registered Nurse (RN) A did not perform hand hygiene, put on gloves and a gown, removed the split gauze dressing soiled with a brown substance from the suprapubic catheter (a thin tube that drains urine from the bladder through a small incision in the lower abdomen) site; - Certified Nurse Assistant (CNA)/Certified Medication Technician (CMT) H did not perform hand hygiene, put on gloves and a gown, opened a zip lock bag with gauze and DermaKlenz (a wound cleanser); - RN A did not change gloves, did not perform hand hygiene, removed the clean gauze from the zip lock bag, touched the DermaKlenz bottle, sprayed the DermaKlenz to the skin around the suprapubic catheter site, used the gauze to wipe the skin around the catheter site multiple times, and wiped the catheter with a twisting motion down the tube with the same gauze, and placed the soiled gauze into the zip lock bag; - RN A did not change gloves, did not perform hand hygiene, placed a clean split gauze to the catheter site, secured with tape, placed the DermaKlenz bottle into the zip lock bag with the soiled gauze, removed the DermaKlenz bottle, closed the zip lock bag, changed gloves, did not perform hand hygiene, and touched the resident's pillow; - CNA/CMT H retrieved the resident's clean clothes from the dresser and closet. RN A and CNA/CMT H assisted the resident with putting on his/her socks and pants; - RN A removed a previously used catheter leg bag stored in a trash bag, did not perform hand hygiene, did not change gloves, unattached the catheter from the large drainage bag, attached the leg strap to the resident's right thigh area, did not perform hand hygiene, did not change gloves, attached the leg catheter drainage bag to the catheter, and secured to the right thigh leg strap; - RN A exited the room, removed the gloves, did not perform hand hygiene, did not remove the gown, walked down the hall to the closet, touched the door knob, retrieved a zip lock bag and wash cloths, pumped soap into the zip lock bag with the washcloths, entered the resident's room with the same gown, put on gloves, went to the bathroom and added water to the zip lock bag with the wash cloths and soap; - RN A did not change gloves, did not perform hand hygiene, removed two wash cloths from the zip lock bag, cleaned the resident's buttocks soiled with fecal material, and placed the wash cloths soiled with fecal material back into the zip lock bag; - RN A did not change gloves, did not perform hand hygiene, touched the wipe package, removed the wipes, cleaned the resident's buttocks, did not remove all of the fecal material from between the anus to the perineal area, picked up the Nystatin (a medication used to treat fungal or yeast infections of the skin) tube, applied the Nystatin to the resident's buttocks, removed the gloves, did not perform hand hygiene, exited the room, retrieved more gloves, entered the room, did not perform hand hygiene, and put on gloves; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - RN A put slippers on the resident's feet and transferred the resident to an electric wheelchair via a Hoyer lift (a mechanical device used to move or transfer a person); - RN A and CNA/CMT H removed the gowns and gloves, and did not perform hand hygiene; - CNA/CMT H took the zip lock bags of soiled items and trash to the soiled utility closet, went to another resident's room, and did not perform hand hygiene; - RN A did not perform hand hygiene, exited the room with the DermaKlenz bottle in his/her bare hand, did not perform hand hygiene, entered into another resident's room with the bottle in his/her bare hand, did not perform hand hygiene, exited the resident's room, did not perform hand hygiene, entered the central supply closet on A hall, touched the doorknob, opened the drawer of of the treatment cart, placed the DermaKlenz bottle in the drawer, exited the room, went into the medication room, and performed hand hygiene. <p>2. Observation on 02/04/25 at 1:48 P.M., of Resident #58's wound care showed:</p> <ul style="list-style-type: none"> - EBP signage for the resident; - Licensed Practical Nurse (LPN) J gathered supplies on a paper plate, performed hand hygiene, put on a gown, entered the resident's room, and sat the plate on the resident's bedside table; - LPN J opened the gauze roll package with the scissors from the plate, put on gloves, removed the dressing soiled with a brown substance and the packing strip from the left elbow wound; - LPN J did not perform hand hygiene, did not change gloves, used a cotton swab to apply lidocaine solution (a local anesthetic used to ease pain) to the skin around the elbow wound, removed the gloves, performed hand hygiene, put on gloves, removed the sock and Tubi grip (an elastic tubular support bandage used for light/moderate compression) from the resident's left lower extremity, did not sanitize the scissors and cut the gauze dressing from the left heel wound, and removed the dressings; - LPN J did not perform hand hygiene; did not change gloves; opened a container of Aquaphor (an ointment which protects the skin to enhance the natural healing process and help prevent external irritants from reaching the wound) ointment; sat the Aquaphor container on the floor; did not perform hand hygiene; did not change gloves; dipped his/her fingers into the Aquaphor container; applied the Aquaphor ointment to the resident's left lower leg, foot and toes; did not perform hand hygiene; did not change gloves; dipped his/her fingers into the Aquaphor container; and applied the Aquaphor ointment to the left lower leg, foot, and toes; - LPN J did not perform hand hygiene, did not change gloves, removed the bordered foam dressing from the package, placed it on the left heel, wrapped with a gauze roll, did not sanitize the scissors and cut the gauze wrap, removed the gloves, and performed hand hygiene; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- LPN J removed the sock from the right foot, performed hand hygiene, put on gloves, removed the ace wrap from right lower leg and foot, removed the dressings from the right heel, did not perform hand hygiene, did not change gloves, retrieved a gauze pad and normal saline from the plate, cleaned the right heel, did not perform hand hygiene, did not change gloves, did not sanitize scissors and cut a piece of Polymem max silver (a wound care treatment made for wounds with heavier drainage), placed the Polymem max silver on the right heel wound, secured with a bordered foam dressing, did not perform hand hygiene, did not change gloves, dipped his/her fingers into the Aquaphor ointment container, and applied to the right foot;</p> <p>- LPN J did not perform hand hygiene, did not change gloves, wrapped the right heel with a gauze roll, did not sanitize the scissors and cut the gauze wrap, secured the dressing with tape, wrapped the right foot and lower leg with an ace wrap, removed the gloves, performed hand hygiene, and put on gloves;</p> <p>- LPN J cleaned the left elbow wound with a gauze pad and normal saline, did not perform hand hygiene, did not change gloves, packed the wound with dry packing tape with a cotton swab, did not sanitize the scissors and cut the packing tape, opened and applied the bordered foam, did not perform hand hygiene, did not change gloves, wrapped the elbow with gauze wrap, did not sanitize the scissors and cut the gauze wrap, removed the gloves, did not perform hand hygiene, exited the room with the gown on, retrieved gloves, entered the room, performed hand hygiene, did not change gowns, put on gloves, cleaned the right elbow wound with normal saline and gauze, did not perform hand hygiene, did not change gloves, did not sanitize the scissors and cut a small piece of Polyman max silver to cover the wound on the right elbow, did not perform hand hygiene, did not change gloves, secured with a gauze roll, secured with tape, removed the gloves, did not perform hand hygiene, picked up trash from the area, placed the Tubi grip to the left lower leg, placed non-slip socks to both feet, removed the gown, and performed hand hygiene;</p> <p>- LPN J did not sanitize the Aquaphor ointment container, the lidocaine solution, and the bottle of hand sanitizer, and placed them back into treatment cart;</p> <p>- LPN J entered the resident's room, did not perform hand hygiene, put on gloves, retrieved a trash bag, did not perform hand hygiene, did not remove gloves, exited the resident's room, took the trash to the soiled closet, removed gloves, and sanitized hands.</p> <p>During a phone interview on 02/17/25 at 11:45 A.M., LPN J said the scissors should be cleaned before and after each wound. Before using on a new wound area, the scissors should be cleaned with alcohol. Gloves should be changed and hand hygiene should be performed between dirty and clean tasks. Staff should perform hand hygiene, take off a gown and gloves when leaving a room and put on new gown and gloves and perform hand hygiene when re-entering. If a treatment item was reusable, the container should be cleaned with a disinfecting cloth before putting it back into the treatment cart.</p> <p>3. Observation on 02/04/25 at 2:21 P.M., of Resident #5's incontinent and wound care showed:</p> <p>- EBP signage for the resident;</p> <p>- CNA /CMT H did not perform hand hygiene, put on gloves, grabbed a bag of wash cloths and squirted soap in it from the hall closet;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - CNA/CMT H did not perform hand hygiene, did not put on a gown, did not change gloves, entered the resident's room and added water to the bag of washcloths from the resident's bathroom; - CNA/CMT H did not perform hand hygiene, did not change gloves, cleaned the resident's peri area with the same side/area of the wash cloth multiple times; - CNA/CMT H put the dirty wash cloths in a bag, did not remove gloves, did not perform hand hygiene, and exited the resident's room with the bag of dirty wash cloths; - CNA/CMT H put the bag of dirty wash cloths in the closet, removed the gloves, touched the door to the closet twice, and did not perform hand hygiene; - Registered Nurse (RN) A entered the resident's room, performed hand hygiene, put on gloves, did not put on a gown, and removed strips of the wick silver (a dressing that [NAME] sweat and has microbial factors) from the resident's right groin area and the right abdominal fold; - RN A did not perform hand hygiene, did not change gloves, cleaned and dried the groin area and the abdominal fold to the resident's right side; - RN A did not perform hand hygiene, did not change gloves, applied a new wick silver to the resident's right groin area and the right abdominal fold; - RN A did not perform hand hygiene, did not change gloves, removed the old wick silver and the soiled with blood calcium alginate (dressings absorb wound exudate, forming a gel that keeps the wound moist and promotes healing) from the left groin area and the left abdominal fold; - RN A did not perform hand hygiene, did not change gloves, cleaned the left groin area and the left abdominal fold; - RN A did not perform hand hygiene, did not change gloves, applied a new calcium alginate over the open bleeding area and new wick silver into the left abdominal fold; - CNA/CMT H entered the resident's room, did not perform hand hygiene, put on gloves, and assisted with a Hoyer lift transfer, and touched the resident, the hoyer lift sling, the resident's shirt, and the Hoyer lift; - RN A changed gloves, did not perform hand hygiene, and CNA/CMT H assisted with the Hoyer lift transfer. <p>During an interview on 02/04/25 at 2:30 P.M., CNA/CMT H said hands should be washed and gloves changed before providing incontinent care, when going from dirty to clean care, and when leaving a resident's room.</p> <p>During an interview on 02/04/25 at 2:45 P.M., RN A said hands and gloves should be changed at the start of wound care, when going from dirty to clean care, a new wound site, and at the end of the wound care.</p> <p>4. Observation on 02/06/25 at 10:20 A.M., of Resident #21's catheter care showed:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/07/25 at 1:00 P.M., RN A said hand hygiene should be performed between the residents, and gown and gloves should be worn during care of a resident on EBP. Perform hand hygiene and put on gloves before providing care to a resident, performing incontinent care, or catheter care. Perform hand hygiene and change gloves when moving from dirty to clean tasks during care, and when performing catheter care. Catheter care should start at the entry point, and move down the catheter away from the body, and should use a new area of the cloth with each wipe, do not clean up and down the catheter or in a twisting motion.</p> <p>5. Observation on 02/06/25 at 10:42 A.M., the laundry showed:</p> <ul style="list-style-type: none"> - Laundry Staff (LS) E entered the soiled linen room of the laundry area with barrels of dirty laundry. With a glove on his/her right hand, LS E opened the soiled linen room door with his/her bare left hand, rolled the soiled linen barrels inside the room, did not perform hand hygiene, put on a glove on the left hand, did not put on a gown, opened the lid of the barrel, and leaned into the barrel to retrieve the linen and bags with his/her jacket and shirt touching the inside lip of the barrel; - LS E did not perform hand hygiene, did change gloves, removed the lid from the second barrel, removed the unbagged linens soiled with urine in the barrel, leaned into the barrel to retrieve the items from the bottom of the barrel with his/her jacket and shirt touching the outside and the inside of the barrel; - LS E removed the gloves, washed his/her hands in the second sink basin with a container of cleaning solution and a toilet brush inside of it, dried his/her hands on a large white towel that hung on the wall of the clean linen side of the laundry, and put on gloves; - LS E retrieved the toilet brush from the container of cleaning solution from the second sink basin, brushed the cleaning solution around the inside walls and the bottom of the barrel, and dipped the toilet brush back into the cleaning solution three times; - LS E removed the gloves, did not perform hand hygiene, put on a glove onto the right hand, placed the lids on barrels with the right gloved hand, opened the laundry room door to the hall with the ungloved left hand, placed the empty barrels outside the door into the hall, did not remove the glove from the right hand, and did not perform hand hygiene; - LS E entered the spa/shower room near the C hall, touched the door handle with the ungloved left hand, retrieved the barrel, and pushed it to the soiled utility room; - LS E did not put on a gown, removed the lid of the barrel with the gloved right hand, placed the lid upside down on the soiled linen bin, leaned into the barrel to retrieve the dirty items from the barrel; - LS E did not change the glove to the right hand, did not perform hand hygiene, replaced the lid on the linen barrel with the gloved right hand, put on a glove to the left hand, rolled the barrel with the soiled items to the clean side of the laundry area, placed the soiled linen into the washer, including one green dining napkin to the same washer, placed the unsprayed wash cloths soiled with fecal material into the same washer; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Nhc Healthcare, West Plains		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Davis Drive West Plains, MO 65775	
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 - Some</p>	<p>- LS E rolled the barrel back to the soiled linen room of the laundry area, removed the gloves, washed hands, dried hands on the same white towel that hung on the wall in the clean linen side of the laundry;</p> <p>- LS E put on gloves, rolled the lined barrel of residents' personal linens and clothing to the clean side of the laundry, placed the items into a second washer, retrieved trash from the clean side of the laundry, placed the trash in an empty barrel, rolled the barrel to the soiled side of the laundry, removed the liner from the barrel and placed it in a large trash bin, removed the gloves, washed hands, dried on the same white towel that hung on the wall in the clean linen side of the laundry;</p> <p>- LS E put on a glove to the right hand, cleaned the inside of the barrel with the toilet brush from toilet brush from the container of cleaning solution from the second sink basin, sprayed Lysol into the lined barrel, removed the right glove, did not perform hand hygiene, put on a glove to the right hand, transferred the empty barrels to the hall outside the door, transferred the empty lined barrel back to the spa/shower room, removed the right glove, and sanitized hands.</p> <p>During an interview on 02/06/25 at 11:05 A.M., LS E said the process for the laundry was to take a cleaned laundry barrel to the hall with one gloved hand to retrieve the dirty barrel from the hall soiled utility closet, transfer it to the soiled linen side of the laundry, sort the items with the same gloved hand to the appropriate bin, remove the glove, wash hands, wear a glove on one hand and transfer the barrels to and from the other halls with the same process. When taking items to the clean side of the laundry, staff kept on the same one glove used to sort the laundry, open the cut through door with their foot, use the non-gloved (clean) hand to open the washer, transfer the items into the washer with the gloved hand, shut the washer door with the non-gloved hand, transfer the barrel back to the soiled side of the laundry room, remove the glove, wash hands, dry on the hanging towel on the clean side, and fold clothes if needed. The door to the soiled linen side of the laundry was left unlocked and unlatched during the process of picking up barrels from the halls and sorting laundry, then the room was locked when the task was completed. When the barrels were cleaned or sprayed, they were placed into the hall outside the laundry room with no more than three empty barrels were to be left in the hall outside the laundry room at a time. This allowed other staff to grab a barrel if an empty one was needed. When sorting and washing laundry, the residents' personal items were washed separate from the facility linens, and dining room linens were washed separate from all other linens. The white towel hanging on the clean side of the laundry room was used throughout the day by staff. It was changed at least every shift, or if it was used a lot and was damp.</p> <p>6. Observation on 02/07/25 at 7:53 A.M., of Resident #37's insulin administration showed:</p> <p>- RN A primed two insulin pens, performed hand hygiene, did not put on gloves, cleaned the resident's abdomen with an alcohol pad, did not perform hand hygiene, did not put on gloves, administered one insulin, did not perform hand hygiene, did not put on gloves, administered the second insulin, and performed hand hygiene.</p> <p>During an interview on 02/07/25 at 11:00 A.M., RN A said gloves should be worn during administration of insulins.</p> <p>7. Observation on 02/07/25 at 8:40 A.M., of Resident #118's medication administration showed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Nhc Healthcare, West Plains		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Davis Drive West Plains, MO 65775	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - RN A performed hand hygiene, did not put on gloves, removed two medications from the medication bubble packs, and the two medications fell on the plate under the medication cup; - RN A picked up the two medications from the plate with his/her bare hands and placed them into the medication cup; - RN A administered the medications in the medication cup to the resident. <p>During an interview on 02/07/25 at 11:00 A.M., RN A said medications shouldn't ever be touched with his/her bare hands.</p> <p>8. Observation of the laundry on 02/07/25 at 7:54 A.M., showed:</p> <ul style="list-style-type: none"> - LS F entered the soiled linen room of the laundry area with a barrel of soiled linen and with one large dishwashing glove on the right hand; - LS F put another large dishwashing glove on the left hand, did not put on gown, and sorted the items from the barrel; - LS F did not change gloves, did not perform hand hygiene, touched the inside door knob of the soiled linen room, opened the door, and exited the room; - LS F did not change gloves, did not perform hand hygiene, took one barrel from the hall outside the door, removed one glove, sat the glove on the lid of the barrel, did not perform hand hygiene, and touched the door knob of the A Hall soiled closet; - LS F swapped the barrels with the gloved hand, pushed open the soiled linen side door of the laundry room with the his/her bare hand, did not put on a gown, emptied the items from the barrel with the gloved hand, leaned into the barrel, and the front of LS F's clothing touched the side and lip of the soiled linen barrel; - LS F did not change gloves, did not perform hand hygiene, exited the room with the same barrel to transport soiled linen down B Hall, touched the door knob and the latch chain of the soiled utility closet with his/her bare hand, and pulled the latch chain with his/her bare hand, touched the outside of the door with his/her gloved hand to close the door; - LS F did not change gloves, did not perform hand hygiene, went to the B Hall shower room, opened the shower room door with his/her bare hand, checked the laundry, exited the shower room, removed the glove from the one hand, did not perform hand hygiene, did not put on gloves, and lay his/her bare hand on top of the transport barrel; - LS F did not perform hand hygiene, retrieved keys from his/her pocket, unlocked the salon door, entered and checked the linen, and the exited room; - LS F did not perform hand hygiene, put on one glove, entered the other shower room near C Hall with the transport barrel, opened the door with his/her bare hand, transferred the soiled linen from the shower room barrel to the transport barrel with the one gloved hand, and took the transport barrel to the soiled linen room; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- LS F did not perform hand hygiene, put on one glove to his/her bare hand, did not put on a gown, transferred the soiled linen from the barrel to the bins, leaned into the barrel, and the front of LS F's clothing touched the side and inside of the soiled linen barrel;</p> <p>- LS F did not perform hand hygiene, did not change gloves, exited the soiled laundry room with the same gloves, touched the door, retrieved another full barrel from the hall, did not put on a gown, leaned into the barrel, and the front of LS F's clothing touched the soiled linen barrel;</p> <p>- LS F removed one glove, did not perform hand hygiene, went down D Hall with a barrel, touched the soiled utility closet with his/her bare hand, swapped barrels, returned to the soiled linen room of the laundry with another full soiled linen barrel;</p> <p>- LS F did not perform hand hygiene, did not change gloves, did not put on gown, put on a glove to his/her bare hand, leaned into barrel, and the front of LS F's clothing touched the soiled barrel;</p> <p>- LS F did not perform hand hygiene, did not change gloves, rolled the soiled empty barrel to the clean side of the laundry, loaded the washer with the soiled linens, did not perform hand hygiene, did not change gloves, pushed the barrel back to the soiled side of the laundry. LS F removed the gloves, washed hands, dried hands on the same white towel that hung on the wall in clean linen side of the laundry;</p> <p>- LS F did not put on a gown, folded the clean linens with the clean linens touching the front of LS F's contaminated clothing, and placed the clean linens on the clean linen carts.</p> <p>During an interview on 02/07/25 at 1:35 P.M., the Director of Nursing (DON) said hands should be sanitized and gloves changed before any care was started, when going from dirty to clean care, a new site or task, and at the end. Catheters should be cleaned from the insertion point down with a new side of a wash cloth for each wipe. Gloves should be worn during insulin administration and medications should not be touched with bare hands. Laundry was expected to not cross contaminate themselves or other items.</p> <p>During an interview on 02/07/25 at 1:40 P.M., the Administrator said she would expect staff to follow infection control guidelines when providing care to residents.</p> <p>47445</p>		