| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265156 | A. Building<br>B. Wing | 10/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Delmar Gardens on the Green | 15197 Clayton Road<br>Chesterfield, MO 63017 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 37681<br><br>Based on observation, interview and record review, the facility failed to ensure all residents were treated in a manner to maintain dignity when staff left a resident exposed and visible from the hallway (Resident #10) and another resident in a hospital gown in the main dining room (Resident #21). In addition, staff failed to ensure two residents' (Resident #8 and #285) catheter bags (urine drainage bag) were not visible in the hallway from the residents' rooms. Staff also entered resident rooms without knocking (Resident #30 and #46). The sample size was 18. The census was 96 with 83 in certified beds.<br><br>Review of the facility's undated Resident's Rights policy, showed:<br><br>-Dignity and Respect: Your right to be treated with dignity and respect is the foundation on which all other resident rights and responsibilities are based. You have a right to expect that we will:<br><br>-Treat you as an individual and assist you in getting the most out of the programs and services we offer;<br><br>-Make sure your surroundings are safe, clean and comfortable;<br><br>-Privacy and Confidentiality: Your right to privacy and confidentiality is as important to you as it is to any other person. You have the right to have other people respect your personal privacy as you receive care.<br><br>1. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/9/24, showed:<br><br>-Mild cognitive impairment;<br><br>-Rejection of care occurred one to three out of seven days;<br><br>-Dependent on staff for all personal care;<br><br>-Diagnoses included stroke, diabetes, seizures, depression and respiratory failure.<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 - Some | Review of the resident's care plan, revised 8/12/24, in use during the time of the investigation, showed:<br><br>-Problem: Activities of Daily Living (ADL, self-care) functional status/rehabilitation potential;<br><br>-Goal: The resident will participate in ADL activities promoting maximum independence through next review;<br><br>-Approach: Assist with repositioning in bed and in wheelchair frequently.<br><br>During an interview on 9/30/24 at approximately 11:29 A.M., the resident said he/she preferred his/her door shut.<br><br>Observation on 10/4/24 at 8:26 A.M., showed the resident's door was open. The resident lay on his/her back in bed with his/her eyes closed. The resident was undressed and a towel covered his/her genitals. One resident passed the resident's room as the resident lay exposed.<br><br>During an interview on 10/4/24 at 8:31 A.M., Certified Nursing Assistant (CNA) H said he/she was assigned to the resident. When shown the resident lay in bed with the door opened and exposed, CNA H said he/she provided care earlier that day and closed the door. CNA H did not leave the resident laying exposed. The resident's door should have been closed to maintain his/her dignity. The nurse was probably providing care to the resident. CNA H closed the resident's door.<br><br>During an interview on 10/4/24 at 8:33 A.M., Licensed Practical Nurse (LPN) D, who was in the hallway during the time resident was exposed, said he/she did not leave the resident exposed. However, the resident's door should have been closed while he/she lay in bed exposed to maintain his/her dignity.<br><br>2. Review of the resident's quarterly MDS, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-Clear speech;<br><br>-Able to make self understood;<br><br>-Able to understand others;<br><br>-Moderate cognitive impairment;<br><br>-Diagnosis included memory deficit, kidney disease, diabetes, and heart failure.<br><br>Review of Resident's #21 care plan, revised 9/18/24, in use during the time of the investigation, showed the resident has a deficit in ADLs functioning and requires assistance related to weakness and cognitive deficit at times. Assist resident with ADLs as needed and requested.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation in the main dining room on 9/30/24 at 12:36 P.M., showed the resident sat at the table wearing a hospital gown opened in the back, exposing his/her skin, pants, and shoes. During an interview, the resident said he/she preferred to wear a shirt to meals.<br><br>Observation on 9/30/24 at 12:38 P.M., showed CNA P approached the resident while he/she was eating and said he/she would take the resident down the room to put a shirt on the resident. The CNA removed the resident from the dining room and returned at 12:47 P.M. The resident resumed eating his/her meal.<br><br>During an interview on 10/2/24 at 9:51 A.M., LPN D said the resident should be dressed appropriately when eating in the dining room and the resident should not be removed while eating to be dressed.<br><br>During an interview on 10/02/24 at 10:12 A.M., CNA F said residents should be dressed in clothes and not hospital gowns when eating in the dining room. A resident should not be removed from the dining room while they are eating so the hospital gown could be removed. When the resident returned their food could be cold and the resident may not continue to eat their meal.<br><br>3. Review of Resident #8's care plan, revised 8/30/24, in use during the time of the investigation, showed:<br><br>-Problem: Indwelling catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time). The resident has a catheter related to diagnosis of dysfunction of bladder;<br><br>-Goal: The resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection through next review date;<br><br>-Approach: Keep catheter system closed. Store collection bag inside a protective dignity pouch.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-No behaviors;<br><br>-Required substantial assistance with staff for personal hygiene;<br><br>-Diagnoses included renal disease, neurogenic bladder, multiple sclerosis, depression and anxiety.<br><br>Observations on 9/30/24 at approximately 11:45 A.M. and 10/1/24 at 9:03 A.M., showed the resident lay in bed on his/her back. The resident's door was open and a catheter bag hung on the side of the bed, outside of a dignity bag and exposed to the hallway.<br><br>Observation on 10/4/24 at 8:38 A.M., showed the resident sat in bed eating breakfast. The door was open and the catheter bag hung on the side of the bed, exposed and visible from the hallway. The resident said he/she could not cover the bag him/herself and wanted it covered and not visible from the hallway.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/4/24 at 8:40 A.M., CNA I said he/she was not assigned to the resident and did not leave the catheter bag exposed. However, the bag should be covered to maintain the resident's dignity.<br><br>During an interview on 10/4/24 at 8:33 A.M., LPN D said catheter bags should be covered or the door should be shut to maintain a resident's dignity.<br><br>4. Review of the Resident #285 care plan, created 10/1/24, in use during the time of the investigation, showed the resident needed assistance with all ADLs.<br><br>Review of the resident's face sheet, dated 10/1/24, showed diagnoses included kidney cancer, heart failure, and liver transplant.<br><br>Observation on 10/2/24 at 7:45 A.M., showed the resident lay in bed, and the urinary catheter gravity bag attached to the bed frame, visible to persons passing by the room.<br><br>During an interview on 10/2/24 9:51 A.M., LPN D said that the urinary catheter gravity bag should not be visible and should be placed in dignity bag or covered.<br><br>During an interview on 10/2/24 at 10:12 A.M., CNA F said that a urinary catheter bag should be in a dignity bag, as to not embarrass the resident.<br><br>5. Review of Resident #30's annual MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-Adequate hearing and vision;<br><br>-Makes self understood and understands others;<br><br>-No impairment to upper extremities;<br><br>-No impairment to both lower extremities;<br><br>-Dependent to lower body dressing and personal hygiene;<br><br>-Diagnoses included anemia, heart diseases, high blood pressure, kidney disease, arthritis.<br><br>Review of the resident's care plan, in use during the time of the investigation, showed:<br><br>-Problem: The resident requires monitoring for continued bowel and bladder incontinence related to<br><br>current incontinence, history of urinary tract infections (UTIs), and need for assistance with all toileting transfers and mobility;<br><br>-Goal: The resident will remain clean, dry, and fee from odors;<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Approach: Observe for signs and symptoms of infection, such as fever, hematuria (blood in urine), sedimentation (solid components in urine), mood or behavior changes.<br><br>6. Review of Resident #46's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-Adequate hearing and vision;<br><br>-Makes self understood and understands others;<br><br>-No impairment to both upper and lower extremities.<br><br>Review of the resident's care plan, in use during the time of the investigation, showed:<br><br>-Problem: The resident is at risk for skin breakdown related to incontinent of bowel and bladder, history of pressure areas, diuretic use;<br><br>-Goal: The resident's skin will remain intact;<br><br>-Approach: Assist or encourage turning and repositioning frequently, keep clean and dry as possible, minimize skin exposure to moisture.<br><br>Observation on 9/30/24 at 1:56 P.M., showed Resident #30's call light was on. He/She said he/she had pushed the call light at approximately ten minutes ago. At 2:00 P.M., CNA C entered the resident's room without knocking the door, turned off the call light and did not speak or ask the resident what he/she needed. The CNA then left the room. Resident #46 said CNA C was always in a hurry and enters the room without saying anything to both residents. He/She said the CNA slams the door at times. Resident #30 asked Resident #46 to turn on the call light again. At 2:26 P.M., CNA C and CNA F entered the room without knocking the door. Both CNAs assisted Resident #30.<br><br>During an interview on 10/4/24 at 8:31 A.M., CNA H said staff were supposed to knock and announce themselves before entering a resident room.<br><br>7. During an interview on 10/4/24 at 1:52 P.M., the Administrator and Regional Nurse said they would expect all residents to be treated with dignity. Residents should not be exposed, catheter bags should be covered and staff should knock before entering a resident's room.<br><br>45083<br><br>Surveyor: [NAME], [NAME] |

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151<br><br>Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected three of three sampled residents who expired and had money in their accounts longer than 30 days (Residents #301, #302 and #300). The census was 96 with 83 in certified beds.<br><br>The deficiency was changed to past non-compliance after an Informal Dispute Resolution conference where both parties agreed the deficient practice was corrected prior to the survey. Facility staff realized in mid-April, 2024 that some discharged residents still had funds in the resident trust account. The facility completed the proper documentation for those discharged residents and the remaining trust fund balances were refunded to the proper authority. The past-noncompliance was corrected on [DATE].<br><br>1. Review of Resident #301's financial records, showed:<br><br>-Expired on [DATE];<br><br>-Ending balance of $150.13;<br><br>-TPL form sent on [DATE].<br><br>2. Review of Resident #302's financial records, showed:<br><br>-Expired on [DATE];<br><br>-Ending balance of $50.00;<br><br>-TPL form sent on [DATE].<br><br>3. Review of Resident #300's financial records, showed:<br><br>-Expired on [DATE];<br><br>-Ending balance of $0.13;<br><br>-TPL form sent on [DATE].<br><br>4. During an interview on [DATE] at 11:16 A.M., the Business Office Manager (BOM) said the facility was supposed to send the TPL form within 30 days. The BOM said she started working at the facility in April and did not see many records where the funds were concurrent, some were lapsing. She said it was not acceptable to send the funds later than 30 days. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 36151<br><br>37681<br><br>42247<br><br>45083<br><br>Based on interview and record review, the facility failed to provide residents with a transfer notice when transferred to the hospital, for seven of seven residents investigated for hospital transfers (Residents #12, #45, #20, #43, #32, #81, and #8). The Census was 96 with 83 residents in certified beds.<br><br>Review of the facility's undated Residents' Rights Policy, showed:<br><br>-Admission, Transfer, Discharge: The residents have the right to due notice of the reasons for transfer or discharge if such occurrence takes place.<br><br>1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 9/13/24, showed:<br><br>-Should a brief interview for mental status be conducted? No;<br><br>-Both long-term and short-term memory loss;<br><br>-Diagnoses included: heart failure, high blood pressure, obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow), stroke, hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body), or hemiparesis (slight weakness in a leg, arm, or face);<br><br>-Indwelling catheter (a thin, hollow tube that's inserted into the bladder to drain urine).<br><br>Review of the resident's medical record, showed:<br><br>-discharged to the hospital on 1/18/24;<br><br>-Returned to the facility from the hospital on 1/25/24;<br><br>-discharged to the hospital on 2/21/24;<br><br>-No documentation transfer notices were given when the resident was sent to the hospital.<br><br>2. Review of Resident #45's quarterly MDS, dated [DATE], showed:<br><br>-Moderately impaired cognition;<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Diagnoses included: urinary tract infection (UTI) in the past 30 days, high blood pressure and Parkinson's disease (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns).<br><br>Review of the resident's medical record showed:<br><br>-discharged to the hospital on 8/11/24;<br><br>-Returned to the facility from the hospital on 8/14/24;<br><br>-discharged to the hospital on 8/27/24;<br><br>-Returned to the facility from the hospital on 9/1/24;<br><br>-discharged to the hospital on 9/20/24;<br><br>-Returned to the facility from the hospital on 9/23/24;<br><br>-No documentation transfer notices were given when the resident was sent to the hospital.<br><br>3. Review of Resident #20's quarterly MDS, dated [DATE], showed:<br><br>-Severe cognitive impairment;<br><br>-Diagnoses included: heart failure, high blood pressure, anxiety, depression, acquired absence of the right leg above the knee.<br><br>Review of the resident's medical record, showed:<br><br>-discharged to the hospital on 3/24/24;<br><br>-Returned to the facility from the hospital on 4/1/24;<br><br>-No documentation transfer notice was given when the resident was sent to the hospital.<br><br>4. Review of Resident #43's quarterly MDS, dated [DATE], showed;<br><br>-Moderately impaired cognition;<br><br>-Diagnoses included heart failure, kidney failure, high blood pressure, and diabetes.<br><br>Review of the resident's medical record, showed;<br><br>-discharged to the hospital on 1/17/24;<br><br>-Returned to the facility from the hospital on 1/26/24;<br><br>-discharged to the hospital on 4/5/24;<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Returned to the facility from the hospital on 4/8/24;<br><br>-discharged to the hospital on 7/2/24;<br><br>-Returned to the facility from the hospital on 7/19/24;<br><br>-No documentation transfer notices were given when the resident was sent to the hospital.<br><br>5. Review of Resident #32's admission MDS, dated [DATE], showed;<br><br>-Moderately impaired cognition;<br><br>-Diagnoses included heart disease, kidney failure, high blood pressure, and dementia.<br><br>Review of the resident's medical record, showed;<br><br>-discharged to the hospital on 7/18/24;<br><br>-Returned to the facility from the hospital on 7/20/24;<br><br>-discharged to the hospital on 7/23/24;<br><br>-Returned to the facility from the hospital on 7/30/24;<br><br>-No documentation transfer notices were given when the resident was sent to the hospital.<br><br>6. Review of Resident #81's admission MDS, dated [DATE], showed:<br><br>-Severe cognitive impairment;<br><br>-Diagnoses included stroke, heart disease, high blood pressure, high cholesterol, and dementia.<br><br>Review of the resident's medical record, showed:<br><br>-discharged to the hospital on 7/3/24;<br><br>-Returned to the facility from the hospital on 7/12/224;<br><br>-Transferred to the hospital on 7/13/24;<br><br>-Returned to the facility from the hospital on 7/14/224;<br><br>-Transferred to the hospital on 7/15/24;<br><br>-Returned to the facility from the hospital on 7/16/224;<br><br>-Transferred to the hospital on 7/16/24;<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -No documentation transfer notices were given when the resident was sent to the hospital.<br><br>7. Review of Resident #8's medical record, showed:<br><br>-Diagnoses included renal disease, multiple sclerosis (a chronic disease that affects the central nervous system), depression and anxiety;<br><br>-discharged to the hospital on 6/23/24;<br><br>-Returned to the facility from the hospital on 6/29/24;<br><br>-discharged to the hospital on 8/15/24;<br><br>-Returned to the facility from the hospital on 8/29/24;<br><br>-No documentation transfer notices were given when the resident was sent to the hospital.<br><br>8. During an interview on 10/2/24 at 5:43 A.M., the Administrator said they had not issued any notices of transfer to residents upon their discharges to the hospital. They had identified this issue in Quality Assurance (QA) and would start issuing notices of transfers upon discharge with an anticipated return. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 36151<br><br>37681<br><br>42247<br><br>45083<br><br>Based on interview and record review, the facility failed to provide written notice to the resident, or their legal representative of the facility bed hold policy at the time of transfer to the hospital, for seven of seven investigated residents for hospital transfers (Residents #12, #45, #20, #43, #32, #81 and #8). The Census was 96 with 83 residents in certified beds.<br><br>Review of the facility's undated Bed Hold Policy, showed:<br><br>-Purpose: to notify the resident or representative of the Bed-Hold Policy in writing at the time of admission, upon discharge or revision and when transferred to a hospital or during therapeutic leave, as well as the intent of readmission according to state and federal regulations;<br><br>-Procedure: The facility will inform and give a written copy of this policy to the resident and/or representative upon admission. The facility will also give a copy of this policy to the resident and representative if transferred to a hospital or during therapeutic leave. In addition, the facility will call the representative, if applicable, within 24 hours of the transfer or leave;<br><br>-It is the policy of the facility to permit residents to return to the facility after they are hospitalized or placed on therapeutic leave.<br><br>1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 9/13/24, showed:<br><br>-Both long-term and short-term memory loss;<br><br>-Diagnoses included: heart failure, high blood pressure, obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow), stroke, hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body), or hemiparesis (slight weakness in a leg, arm, or face);<br><br>-Indwelling catheter (a thin, hollow tube that's inserted into the bladder to drain urine).<br><br>Review of the resident's medical record showed:<br><br>-discharged to the hospital on 1/18/24;<br><br>-Returned to the facility from the hospital on 1/25/24;<br><br>-discharged to the hospital on 2/21/24;<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265156 | A. Building<br>B. Wing | 10/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Delmar Gardens on the Green | 15197 Clayton Road<br>Chesterfield, MO 63017 |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>2. Review of Resident #45's quarterly MDS, dated [DATE], showed:<br><br>-Moderately impaired cognition;<br><br>-Diagnoses included: urinary tract infection (UTI) in the past 30 days, high blood pressure and Parkinson's Disease.<br><br>Review of the resident's medical record showed:<br><br>-discharged to the hospital on 8/11/24;<br><br>-Returned to the facility from the hospital on 8/14/24;<br><br>-discharged to the hospital on 8/27/24;<br><br>-Returned to the facility from the hospital on 9/1/24;<br><br>-discharged to the hospital on 9/20/24;<br><br>-Returned to the facility from the hospital on 9/23/24;<br><br>-No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>3. Review of Resident #20's quarterly MDS, dated [DATE], showed:<br><br>-Severe cognitive impairment;<br><br>-Diagnoses included: heart failure, high blood pressure, anxiety, depression, acquired absence of the right leg above the knee.<br><br>Review of the resident's medical record showed:<br><br>-discharged to the hospital on 3/24/24;<br><br>-Returned to the facility from the hospital on 4/1/24;<br><br>-No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>4. Review of Resident #43's quarterly MDS, dated [DATE], showed;<br><br>-Moderately impaired cognition;<br><br>-Diagnoses included heart failure, kidney failure, high blood pressure, and diabetes.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's medical record, showed;<br><br>-discharged to the hospital on 1/17/24;<br><br>-Returned to the facility from the hospital on 1/26/24;<br><br>-discharged to the hospital on 4/5/24;<br><br>-Returned to the facility from the hospital on 4/8/24;<br><br>-discharged to the hospital on 7/2/24;<br><br>-Returned to the facility from the hospital on 7/19/24;<br><br>-No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>5. Review of Resident #32's admission MDS, dated [DATE], showed;<br><br>-Moderately impaired cognition;<br><br>-Diagnoses included heart disease, kidney failure, high blood pressure, and dementia.<br><br>Review of the resident's medical record, showed;<br><br>-discharged to the hospital on 7/18/24;<br><br>-Returned to the facility from the hospital on 7/20/24;<br><br>-discharged to the hospital on 7/23/24;<br><br>-Returned to the facility from the hospital on 7/30/24;<br><br>-No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>6. Review of Resident #81's admission MDS, dated [DATE], showed:<br><br>-Severe cognitive impairment;<br><br>-Diagnoses included stroke, heart disease, high blood pressure, high cholesterol, and dementia.<br><br>Review of the resident's medical record showed:<br><br>-discharged to the hospital on 7/3/24;<br><br>-Returned to the facility from the hospital on 7/12/224;<br><br>(continued on next page) |

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| | 265156 | A. Building<br>B. Wing | 10/04/2024 |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Transferred to the hospital on 7/13/24;<br><br>-Returned to the facility from the hospital on 7/14/224;<br><br>-Transferred to the hospital on 7/15/24;<br><br>-Returned to the facility from the hospital on 7/16/224;<br><br>-Transferred to the hospital on 7/16/24;<br><br>-No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>7. Review of Resident #8's medical record, showed:<br><br>-Diagnoses included renal disease, neurogenic bladder, multiple sclerosis, depression and anxiety;<br><br>-Transferred to the hospital on 6/23/24;<br><br>-Returned to the facility from the hospital on 6/29/24;<br><br>-Transferred to the hospital on 8/15/24;<br><br>-Returned to the facility from the hospital on 8/29/24;<br><br>-No documentation the resident or the resident's representative received written notice of the facility's bed hold policy at the time of transfer.<br><br>8. During an interview on 10/3/24 at 12:00 P.M., Registered Nurse (RN) A said when a resident was sent to the hospital, he/she sent a copy of the Continuity of Care Document (CCD) and the bed hold policy with the resident.<br><br>9. During an interview on 10/2/24 at 5:43 A.M., the Administrator said they had not issued a copy of the facility's bed hold policy to residents upon their discharges to the hospital. They had identified this issue in Quality Assurance (QA) and would start issuing the bed hold policy upon discharge with an anticipated return. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>42247<br><br>Based on interview and record review, the facility failed to ensure professional standards of practice where met, when staff failed to transcribe one resident's new treatment order onto the electronic treatment administration record (eTAR), resulting in the new treatment order not being administered from 7/24/24 to 8/2/24 as ordered by the physician for one resident (Resident #8) resulting in the wound showing signs and symptoms of infection. The sample was 18. The census was 96 with 83 residents in certified beds.<br><br>Review of the facility's Following Physician Orders Policy, dated June 29, 2021, showed:<br><br>-Purpose: It is the policy of the community to ensure that all Licensed Professional Nurses (Registered Nurse (RN)/Licensed Practical Nurse (LPN)/ Licensed Vocational Nurse (LVN)) and other healthcare professionals, follow physician orders in accordance with state, federal regulations, and their respective practice acts;<br><br>-Procedure:<br><br>-All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record;<br><br>-All physician or other health care professional's verbal, telephone or written orders will be immediately entered in the electronic health record (EHR) by the nurse obtaining the order.<br><br>Review of the facility's Wound Care Protocol Policy, dated reviewed 7/23, showed:<br><br>-How to assess/document: Initially assess the ulcer(s) for location, measurement, exudate (fluid that leaks out of blood vessels into nearby tissue), and tissue type;<br><br>-Treatment should be determined based on the assessment;<br><br>-Documentation of the initial and weekly assessment finding should be noted in the wound management section of the EHR.<br><br>Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 9/5/24, showed:<br><br>-Cognitively intact;<br><br>-No behaviors or refusal of care;<br><br>-Diagnoses included: anemia (decrease in number of red blood cells), high blood pressure, diabetes, and muscular dystrophy (a genetic disease that cause progressive weakness and loss of muscle mass).<br><br>Review of the care plan in use at the time of survey, showed:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Problem: currently has an alteration in skin integrity and required wound monitoring;<br><br>-Goal: wound will not increase in size or exhibit signs of infection through next review;<br><br>-Approach: Staff monitor the condition of skin during activities of daily living (ADL, self care) care. Nursing to complete weekly skin audits and document as required. All abnormal/new findings are reported to physician for treatment;<br><br>-Wound treatment(s) to be completed per eTAR/physician order.<br><br>Review of the resident's weekly skin audits, provided by the facility for June, July, and August 2024, showed:<br><br>-On 6/1/24, open area noted on right ankle;<br><br>-On 7/13/24, wounds to scrotum/ right ankle and right shin;<br><br>-No other skin assessments were provided.<br><br>Review of the progress notes dated 7/10/24 through 7/14/24, showed:<br><br>-On 7/10/24 at 2:11 P.M., new wound noted to resident's scrotum (a pouch of skin containing the testicles) area, buttocks noted to be red. Wound on scrotum measures 0.6 centimeters (cm) X 1.0 cm. Peri area (area between legs and buttocks) was painful to touch due to wound being sore and buttocks being red and inflamed. Orders for Santyl (sterile enzymatic debriding ointment) and zinc (skin barrier) have been entered. Physician has been notified;<br><br>-On 7/14/24 at 3:41 P.M., seen by the wound management team related to multiple wounds. Will continue to monitor wounds weekly for progress;<br><br>-The note did not show the wound on the scrotum;<br><br>-Staff did not document the treatment had changed or the resident refused the treatment;<br><br>-Staff did not document why the treatment was not completed.<br><br>Review of the wound management team notes, dated 7/18/24, showed:<br><br>-Location: scrotum/posterior (back);<br><br>-Type: Pressure ulcer/injury (any lesion caused by unrelieved pressure that results in damage to the underlying tissue): unstageable (depth obscured);<br><br>-Wound bed description: no description was documented;<br><br>-Measurements: no measurements were documented;<br><br>-Exudate: moderate;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Peri-wound: erythema (redness of the skin), macerated (a softening and breaking down of the skin resulting from prolonged exposure to moisture) and scarring;<br><br>-Color: sero-sanguineous (containing blood and serum);<br><br>-Wound status: initial evaluation;<br><br>-Treatment: cleanse with Normal Saline (NS) then apply Santyl and apply dry dressing, change daily and as needed.<br><br>Review of the eTAR, dated 7/1/24 through 7/25/24, showed:<br><br>-An order for Santyl apply to wound on scrotum, start date was 7/14/24 and discontinue date was 8/2/24;<br><br>-Documentation showed: treatment was not completed on 7/15, 7/16, 7/17, 7/22, 7/23 and on 7/25;<br><br>-There was no order for gentamicin and there was no order for weekly skin audits.<br><br>Review of the progress notes, dated 7/24/24 through 7/30/24, showed:<br><br>-On 7/24/24 at 12:47 P.M., resident was seen by the wound management team on 7/17/24 related to multiple wounds. New treatment order for gentamicin (antibiotic) and Santyl to the scrotum;<br><br>-On 7/26/24 at 1:04 P.M., resident was seen by wound management team on 7/25/24 related to multiple wounds. Will continue the current treatments in place for all wounds. Will continue to monitor wounds weekly for progress;<br><br>-There was no documentation showing the treatment was changed, or the resident refused the treatment and no documentation showing why the treatment was not completed.<br><br>Review of the wound management team's notes, dated 7/25/24, showed:<br><br>-Location: scrotum/posterior;<br><br>-Type: Pressure ulcer/injury: unstageable (depth obscured);<br><br>-Wound bed description: 25% granulation tissue (new connective tissue that forms in a wound during the healing process) and 75% necrotic tissue (dead or dying tissue);<br><br>-Measurements: 3.1 cm length, X 6.3 cm width X 0.2 cm depth;<br><br>-Peri-wound: erythema, macerated and scarring;<br><br>-Exudate: moderate;<br><br>-Color: sero-sanguineous;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Wound status: unchanged/stable;<br><br>-Treatment: cleanse with NS then apply Santyl and apply dry dressing, change daily;<br><br>-Wounds: scrotum/posterior-new on 7/18/24, stable, continue santyl and gentamicin.<br><br>Review of the eTAR, dated 7/26/24 through 7/31/24, showed:<br><br>-An order for Santyl apply to wound on scrotum, start date was 7/14/24 and discontinue date was 8/2/24;<br><br>-There was no order for gentamicin.<br><br>Review of the progress notes, dated 8/1/24 through 8/4/24, showed:<br><br>-On 8/4/24 at 1:42 P.M., provider summary received for routine visit on 8/2/24. No new recommendations at this time, staff to continue to monitor and treat wound on left toe and continue monitoring and treatment of pressure ulcer to left medical side of left knee with tubi grip (elastic tubular support bandage) for added protection. No other concerns at this time;<br><br>-The note did not show wound on scrotum.<br><br>Review of the wound management team's notes, dated 8/1/24, showed,<br><br>-Location scrotum/posterior;<br><br>-Wound Bed Description: 0 % Granulation Tissue and 100 % Necrotic Tissue;<br><br>-Measurements: 4.8 cm x 3.7 cm x unable to determine (UTD) depth;<br><br>-Peri-wound: Erythema, Macerated and Scarring;<br><br>-Exudate: Moderate;<br><br>-Color: Sero-sanguineous;<br><br>-Treatment: Cleanse with NS then apply Santyl and apply dry dressing; change daily and as needed;<br><br>-Wound Status Improved - continue current treatment plan;<br><br>-Wound: scrotum/posterior-new on 7/18/24, stable, continue santyl and gentamicin.<br><br>Review of the eTAR dated 8/1/24 through 8/3/24, showed:<br><br>-An order for: Santyl apply daily to wound on scrotum, start date was 7/14/2024 and discontinued on 8/02/2024;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -An order for: Santyl, cleanse posterior scrotum with NS, mix Santyl and gentamicin, apply nickel thick and cover with a foam dressing, start date was 8/3/24;<br><br>-An order for: gentamicin ointment 0.1 %; mix with Santyl and apply nickel thick to right ankle, right shin, and posterior scrotum, change daily, start date 8/3/24.<br><br>Review of the progress notes, dated 8/4/24 through 8/15/24, showed:<br><br>-On 8/15/24 at 5:10 P.M., resident was seen by wound doctor and was recommended to send to hospital for treatment. Contacted emergency medical service (EMS) for transport to the hospital.<br><br>Review of the wound management team notes, dated 8/15/24, showed:<br><br>-Location scrotum/ posterior;<br><br>-Type: Pressure Ulcer/Injury: Unstageable (Depth Obscured);<br><br>-Wound Bed Description: 100 % Granulation Tissue and UTD/ % Necrotic Tissue;<br><br>-Measurements: 6.0 cm x 2.8 cm x UTD depth;<br><br>-Exudate: Moderate;<br><br>-Peri-wound: erythema, macerated and scarring;<br><br>-Color: Sero-sanguineous;<br><br>- Wound Status Deteriorated - See plan of care (POC);<br><br>-Additional Notes: send out to hospital due to deteriorated wound with odor. Altered mental status (AMS).<br><br>-Treatment: Cleanse with NS then apply Santyl; gentamicin; cover with foam dressing daily and as needed;<br><br>-Wound: scrotum/posterior (new on 7/18/24): deteriorated, send out due to signs of infection.<br><br>Review of the eTAR, dated 8/3/24 through 8/16/24, showed:<br><br>-An order for: Santyl, cleanse posterior scrotum with NS, mix Santyl and gentamicin, apply nickel thick and cover with a foam dressing, start date was 8/3/24;<br><br>-Documentation showed: On 8/7/24, not administered: day shift; on 8/10/24, not administered, resident unavailable, up in wheelchair doesn't want treatment completed at this time; on 8/13/24, not administered: previous shift;<br><br>-An order for: gentamicin ointment 0.1 %; mix with Santyl and apply nickel thick to right ankle, right shin, and posterior scrotum, change daily ,start date 8/3/24;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Documentation showed: On 8/10/24, not administered, resident unavailable, up in wheelchair doesn't want treatment completed at this time; on 8/13/24, not administered: previous shift;<br><br>During an interview on 10/2/24 at 9:00 A.M., the Wound Nurse said the floor nurse was responsible for completing the weekly skin audits and providing the treatments. She provided wound care for resident who required a wound vacuum (wound treatment that uses suction to help wounds heal). When the wound management team visited the facility, she rounded with the Nurse Practitioner (NP), then she would document some type of note in the EHR regarding the wounds.<br><br>During an interview on 10/4/24 at 12:00 P.M., the Nurse Manager said skin audits were completed weekly on the resident's shower day, by the floor nurse. If the resident had a wound, it should be documented on the skin assessment and documented with treatment in place. If the wound was new, staff should assess the wound and document it, notify the physician and note any orders that were obtained or whatever the physician said to do and notify the resident/resident representative. If the nurse documented a new order in the progress notes she would expect for the order to also be noted on the physician order sheet and the eTAR. The Nurse Manager checked the eTAR for July 2024 and said she did not see an order for the gentamicin. She would expect for an order to be placed on the physician order sheet and on the eTAR.<br><br>During an interview on 10/4/24 at 12:08 P.M., the NP said when she visited the facility, she assessed the wounds that were being treated unless the staff notified her the resident had a new wound or area of concern. If a resident needed new orders, the NP either wrote them down on a piece of paper or gave the nurse a verbal order. The nurse at the facility was responsible for entering the orders into the EHR. The NP said she likely gave an order for gentamicin and santyl because she preferred to use an antimicrobial agent (kills microorganisms or inhibits their growth) sometimes with the santyl.<br><br>During an interview on 10/4/24 at 1:53 P.M., the Administrator said she would expect for staff to follow physician orders and for skin audits to be completed weekly. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>42247<br><br>Based on interview and record review, the facility failed to position one resident safely (Resident #20) when staff turned the resident on the shower bed resulting in a fall, in which the resident was sent to the hospital and received 14 sutures. The sample was 18. The census was 96 with 83 residents in certified beds.<br><br>The Administrator was notified on 10/4/24 at 3:00 P.M., of the past non-compliance, which occurred on 3/4/24. The facility provided training and in-servicing that began on 3/6/24 and ended on 3/18/24, for all staff regarding their policies on proper transfers and body mechanics. The past non-compliance was corrected on 3/18/24.<br><br>Review of the facility's Transfer and Lift Policy (butterfly), dated reviewed 5/21, showed:<br><br>-Purpose: To provide communication to staff about resident transfer abilities and to assure we take all precautions necessary to maintain the safe of our residents including acknowledgment that this facility has adopted a no lift policy for residents requiring a mechanical means of transfer;<br><br>-Policy: Upon admission each resident will be assessed by the inter-disciplinary team on the capabilities of how the resident transfers; this will be re-assessed with changes in condition and at the quarterly care plan;<br><br>-A butterfly magnet will be placed inside of the resident's room on the overhead light or door frame of resident's room indicating how the resident transfers. The butterfly will be coded to inform the staff of transfer ability. An additional red dot sticker will be placed on the magnets to indicate two people for all means of transfer and bed mobility;<br><br>-The resident's transfer ability will be indicated in the resident's orders and included on the resident profile and care plan, as well as the butterfly;<br><br>-All staff involved in the transfer of residents will be responsible for knowing how to identify transfer status of each resident.<br><br>Review of Resident #20's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/14/24, showed:<br><br>-Severe cognitive impairment;<br><br>-Functional limitation in range of motion (ROM) in lower extremities (hip, knee, ankle, foot), impairment on both sides;<br><br>-Shower/bathe self: dependent (helper does all the effort. Resident does none of the effort to complete the activity);<br><br>-Roll left to right: dependent;<br><br>(continued on next page) |

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|---|---|---|---|
| | 265156 | A. Building<br>B. Wing | 10/04/2024 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Tub/shower transfer: dependent;<br><br>-Diagnoses included heart failure, high blood pressure, anxiety, depression, acquired absence of the right leg above the knee.<br><br>Review of the care plan, in use at the time of survey, showed:<br><br>-Problem: is at risk for falls related to his need for assistance with transfers, increased weakness, acquired absence (amputation) of right leg above knee, and psychotropic medication (drugs that affect the brain and nervous system to treat mental illnesses) use and bowel and bladder (B&B) incontinence, pacemaker, start date was 4/8/22;<br><br>-Goal: Minimize the risk for falls and related injury thru next review;<br><br>-Approach: On 3/04/24, Resident fell attempting to assist aide with transfer. Sent to hospital for evaluation. Sutures noted to forehead. Inservice and education completed on proper transfers. Will continue with plan of care (POC).<br><br>-Problem: has a deficit in activities of daily living (ADL) functioning and impaired mobility related to increased weakness, history of repeated falls, decreased cognition, and acquired absence of right leg above knee;<br><br>-Goal: will participate in ADL activities promoting maximum independence through next review;<br><br>-Approach: Provide assistance with ADL's as needed or requested. Is dependent with ADLs; Transfer status: Hoyer (mechanical lift) assist x 2.<br><br>Review of the progress notes, dated 3/4/24, showed:<br><br>-At 4:25 P.M., the nurse went to resident's shower room to assist with fall from this resident. Upon entering the shower room, resident found lying face first on the floor, blood noted on the floor. The nurse asked the Certified Nurse Aide (CNA) what happened, CNA stated he/she had just finished giving the resident a shower. CNA attempted to place mechanical lift sling under the resident. CNA turned the resident onto his/her left side. The resident tried to hold onto the wall but fell out of the shower bed. The nurse called out to the resident. Resident was able to respond yes. The nurse asked the resident if he/she was hurting anywhere besides his/her head, resident responded no. Upon assessment resident noted to have laceration on left eyebrow, and skin tear to left wrist. Towel placed on the floor by resident's eyebrow to help with bleeding. Another nurse called 911 and printed all paperwork. Resident noted to be wheezing but still communicated with staff. Oxygen saturation was 83% (normal is 95% through 100%) no oxygen was applied because Emergency Medical Technicians (EMT) were at the facility to transport resident.;<br><br>-At 10:44 P.M., resident returned to the facility by ambulance at 10:33 P.M., 14 stitches noted to left forehead above eyebrow, left hand bruised with skin tear, left leg has scabbing noted and left second toe bruised.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/3/24 at 11:31 A.M., Licensed Practical Nurse (LPN) N said the CNA was calling out for help. When he/she got to the shower room, the CNA and nurse were in the room. The resident was on the floor. There was so much blood on the floor, they were just trying to get him/her sent out (to the hospital). The CNA went to turn the resident and the resident fell out of the shower bed. Normally he/she would hold onto something when staff assisted him/her with turning.<br><br>During an interview on 10/4/24 at 10:57 P.M., CNA C said two staff used the mechanical lift with a regular sling to transfer the resident onto the shower bed. After the resident was transferred, the other staff member left out of the shower room. CNA C provided the shower. Then, CNA C assisted the resident to roll over by giving the resident a little push and the resident rolled off the shower bed. CNA C called for the nurse.<br><br>During an interview on 10/4/24 at approximately 12:00 P.M., the Nurse Manager said there should be two staff present when a resident was on a shower bed. The only bar in the shower room to grab onto is in the shower. It is not appropriate for staff to ask a resident to hold on to the wall.<br><br>During an interview on 10/4/24 at 10:02 A.M., the Administrator said the resident did not fall during the transfer. The failure was the procedure was not followed. The CNA used the regular lift sling to transfer the resident in place of the shower sling which was mesh. The CNA was turning the resident when the resident fell . All nursing staff were educated on using the correct sling for showers and using two people for the shower bed and mechanical lift transfers. The agency binder has also been updated.<br><br>MO00240083 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>49992<br><br>Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in a sufficient detail to enable accurate reconciliation. The facility failed to ensure accuracy and monitoring for controlled substances for one of four electronic narcotic counts reviewed. The census was 96 with 83 in certified beds.<br><br>Review of the facility's Medication Administration policy, effective date January 2021, showed:<br><br>-All inventoried drugs are to be counted by licensed/certified personnel at each shift change. Any discrepancy must be called to the attention of the Director of Nursing (DON).<br><br>Review of the facility's electronic narcotic count system reviewed on 9/30/24 at 1:39 P.M., showed the electronic screen showed a count 120 tablets of tramadol (opioid) 50 milligrams (mg) and the card in the cart showed 114 tablets.<br><br>During an interview on 9/30/24 at 1:39 P.M., the Certified Medication Technician (CMT) G said he/she mentioned to the DON that the count was not correct, and the count had been off since last Friday, 9/27/24. A count should be done at the beginning and end of each shift.<br><br>During an interview on 10/2/24 at 10:12 A.M., Licensed Practical Nurse (LPN) D said narcotics should be counted at the beginning and end of each shift. If the count was not correct, staff should notify the supervisor on call.<br><br>During an interview on 10/2/24 at 11:34 A.M., the interim DON said that she would expect the narcotic count to be correct during the exchange of keys at shift change. If the count was not correct, staff should notify nursing administration. The count should be corrected as soon as possible and not be allowed to be incorrect for days. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>49992<br><br>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 30 opportunities observed, five errors occurred resulting in a 16.67% error rate (Residents #50, #74, #19 and #26). The census was 96 with 83 residents in certified beds.<br><br>Review of the facility's Insulin Administration via Pen Devices policy, effective date 5/21, showed:<br><br>-Purpose: To safely administer insulin via pen devices according to physician orders and the facility's Policy and Procedure recommendations;<br><br>-Procedure: Prime the pen immediately before injection. Priming is dialing up two units of insulin and pressing the bottom on the pen to shoot some insulin into the air. You should see a drop of insulin at the end of the needle. More than one prime may be required for a new pen.<br><br>Review of the facility's Following Physicians Orders, dated June 29, 2021, showed:<br><br>-Purpose: It is the policy of the community to ensure that all Licensed Professional Nurses and other Healthcare Professionals, follow physician's orders in accordance to State, Federal regulations and their respective practice acts;<br><br>-Procedure: All physicians orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record.<br><br>Review of the Humalog KwikPen, lispro solution, (a pre-filled, disposable pen that contains insulin lispro, a fast-acting insulin used to treat high blood sugar in people with diabetes) manufacture's instructions showed:<br><br>-Prime before each injection;<br><br>-Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensure that the pen is working correctly;<br><br>-If you do not prime before each injection, you may give too much or too little insulin.<br><br>Review of the Advair Diskus (prescription medicine used long term to treat chronic obstructive pulmonary disease (COPD)) manufacturer's highlights of prescribing information showed after inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis (fungal infection in the mouth).<br><br>1. Review of Resident #50's medical record, showed:<br><br>-Diagnoses included diabetes, heart failure, kidney disease, and venous insufficiency (blood flow back to the heart is slowed);<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 - Some | -An order, dated 3/2/24, showed Humalog KwikPen Insulin (insulin lispro) 100 units/milliliter (mL), 15 units subcutaneous (under the layers of the skin) three times a day before meals;<br><br>-An order, dated 2/14/24, Humalog KwikPen Insulin (insulin lispro) 100 units/mL per sliding scale, before meals and at bedtime:<br><br>-If blood sugar is less than 50, call physician;<br><br>-If blood sugar is 50-150, give 0 units;<br><br>-If blood sugar is 151-200, give 2 units;<br><br>-If blood sugar is 201-250, give 4 units;<br><br>-If blood sugar is 251-300, give 6 units;<br><br>-If blood sugar is 301-350, give 8 units;<br><br>-If blood sugar is 351-400, give 10 units;<br><br>-If blood sugar is greater than 400, call physician.<br><br>During a medication administration observation, on 10/1/24 at 7:10 A.M., the resident's blood sugar was 179. Registered Nurse (RN) A dialed the pen to 17 units/mL. He/she did not prime the pen.<br><br>During an interview on 10/1/24 at 7:19 A.M., RN A said that he/she did not need to prime the pen because the pen was primed automatically when the pen was first accessed.<br><br>During an interview on 10/2/24 at 9:51 A.M., Licensed Practical Nurse (LPN) D said insulin pens had to be primed to make sure the pen was working properly.<br><br>During an interview on 10/2/24 at 11:35 A.M., the interim Director of Nursing (DON) said that insulin pens had to be primed before dialing up the dosage to be administered so the resident would get the right amount of insulin.<br><br>2. Review of Resident #74's medical record, showed:<br><br>- Diagnosis included chronic obstructive pulmonary disease (permanent damage to the lung that makes it difficult to breath), lung cancer, anxiety, high blood pressure, and high cholesterol;<br><br>- An order, dated 2/6/24, showed Advair Diskus 250-50 microgram (mcg)/dose, inhale twice a day. Rinse mouth after use;<br><br>- An order, dated 4/14/24, showed insulin lispro 100 unit/mL, 5 units subcutaneous three times a day.<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 - Some | During a medication administration observation, on 10/1/24 at 7:35 A.M. Certified Medication Technician (CMT) J, prepped the diskus and handed to the resident. After the resident inhaled the medication, he/she handed the diskus to CMT J. CMT J insluin lispro pen did not offer the resident a cup of water to rinse his/her mouth after inhaling the medication.<br><br>During a medication administration on 10/2/24 at 7:35 A.M., LPN E dialed the pen to 5 units/mL. He/she did not prime the pen prior to administration.<br><br>During an interview on 10/2/24 at 9:51 A.M., LPN D said staff should follow physician's orders as written. The resident was to swish with a liquid and spit into a cup. The rinsing with liquid removed leftover medication off the tongue.<br><br>During an interview on 10/2/24 at 10:01 A.M., CMT G said a resident who used an Advair Diskus must rinse their mouth out.<br><br>During an interview on 10/2/24 at 11:35 A.M., the interim DON said if a resident was ordered an Advair Diskus, staff should provide liquid to rinse out their mouth.<br><br>3. Review of Resident #19's medical record, showed:<br><br>-Diagnosis included diabetes, anxiety, high blood pressure, and high cholesterol;<br><br>-An order, dated 7/23/24, showed insulin lispro 100 units/mL, 10 units subcutaneous three times a day before meals;<br><br>-An order, dated 7/23/24, insulin lispro 100 units/mL per sliding scale, before meals and at bedtime:<br><br>-If blood sugar is less than 70, call physician;<br><br>-If blood sugar is 151-200, give 2 units;<br><br>-If blood sugar is 201-250, give 4 units;<br><br>-If blood sugar is 251-300, give 6 units;<br><br>-If blood sugar is 301-350, give 8 units;<br><br>-If blood sugar is 351-400, give 10 units;<br><br>-If blood sugar is greater than 400, give 12 units;<br><br>-If blood sugar is greater than 401, call physician.<br><br>During a medication administration observation, on 10/1/24 at 7:19 A.M., the resident's blood sugar was 307. RN A dialed the pen to 18 units/mL. He/she did not prime the pen prior to administration.<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 - Some | During an interview on 10/1/24 at 7:19 A.M., RN A said he/she did not need to prime the pen because the pen was primed automatically when the pen was first accessed.<br><br>4. Review of Resident #26's medical record, showed:<br><br>-Diagnosis included diabetes, high blood pressure, high cholesterol, and heart failure;<br><br>-An order, dated 9/8/24, insulin lispro pen 100 units/mL, 22 units subcutaneous three times a day before meals;<br><br>During a medication administration observation, on 10/2/24 at 7:14 A.M., LPN E dialed the pen to 22 units/mL. He/She did not prime the pen prior to administration.<br><br>During an interview on 10/2/24 at 7:35 A.M., LPN E said that he/she did not need to prime the pen because the pen was primed automatically when the dial was turned.<br><br>During an interview on 10/2/24 at 11:35 A.M., the interim Director of Nursing said insulin pens had to be primed before drawing up the dosage to be administered so the resident would receive the right amount of insulin. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>49992<br><br>Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored per acceptable standards of practice. Problems were noted in one of three identified facility medication rooms and in one of four medication administration carts. The facility census was 96 with 83 residents in certified beds.<br><br>Review of the facility's Storage of Drugs policy, updated 12/21, showed:<br><br>-Drugs and medications are to be stored in the original container in which they were received. Refrigerator, freezer, and control room will be available in the pharmacy for medications requiring specific storage;<br><br>-No discontinued, outdated, or deteriorated drugs or medications are stored in the facility over thirty (30) days.<br><br>Review of the facility's Pharmacy Responsibility, dated 12/20, showed: Date opened stickers will be attached to all multi-dose vials and other medications with time-limited use.<br><br>1. Observation on 9/30/24 at 11:08 A.M. of the facility's 300 Division medication room, showed:<br><br>-One 3 milliliter (mL) bottle of True Metrix Control Solution (a control solution used to check the accuracy of the glucometer machines that check resident's blood sugar) expired as of 12/31/23;<br><br>-One 3 mL bottle of True Metrix Control Solution expired as of 1/31/24;<br><br>-One 100 mL opened bottle of Levetiracetam (used to treat seizures associated with epilepsy, episodes of abnormal electrical activity in the brain) expires on 8/15/25, not dated;<br><br>-One 16-ounce (oz) opened bottle of Robitussin (used to treat cough) with the expiration date blacked out and no date opened;<br><br>-In the cabinet where medication was stored, there were opened bag of potato chips, a half empty bottle of soda, and a tied bag of food items.<br><br>During an interview on 9/30/24 at 10:55 A.M., Registered Nurse (RN) A said it was the nurses' responsibility to remove expired medications from the medication rooms. Staff personal items should not be in the medication rooms.<br><br>2. Observation on 9/30/24 at 1:30 P.M., of the Division 100 Certified Medication Technician (CMT) cart, showed one bottle of Geri Tussin (used to treat cough) opened, with dry residue built up under the cap, with no date opened.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/30/24 at 1:30 P.M., CMT K said that the pharmacy came into the facility every week to check the carts. He/She was not aware when items were opened, they were to be dated.<br><br>During an interview on 10/2/24 at 9:51 A.M. the Licensed Practical Nurse (LPN) D said medications were to be dated when opened and an expired medication to be removed from the medication cart or medication room.<br><br>During an interview on 10/2/24 at 11:35 A.M., the interim Director of Nursing (DON) said the term time-limited use referred to the expiration date printed on a bottle or package. Medication should be dated when opened. If a bottle of medication had a build-up of residue near the cap it should be removed. It was the expectation that staff remove expired items from the medication carts. Staff and resident personal items should not be stored in the medication rooms. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681<br><br>Based on observation and interview, the facility failed to ensure the main kitchen floors, appliances and food storage areas were clean and free from debris. In addition, the facility failed to ensure outdated food was discarded. This affected all residents who ate at the facility. The census was 96 with 83 residents in certified beds.<br><br>Review of the facility's undated Dining Services Clean-Sanitize-Disinfect policy, showed:<br><br>-Policy: This facility will store, prepare, distribute and serve food under sanitary conditions to ensure proper cleanliness and food handling practices to prevent the outbreak of food-born illnesses is attained continuously;<br><br>-Cleaning: The process of removing visible debris, dirt and dust and organize a space.<br><br>Observation of the kitchen on [DATE] at 11:08 A.M., showed:<br><br>-The floors throughout the entire kitchen contained white specs, dust, grease and water stains;<br><br>-Two refrigerators in the preparation area were stained with debris on the doors of both refrigerators;<br><br>-The prep table had several dirty dish rags on top. Several containers of various spices and sauces with debris and food spilled on the outside of the containers were on a shelf were under the prep table;<br><br>-Visible rust, dirt and debris on the surface areas of the stove, oven, fryer and tilt skillet;<br><br>-The dry storage area had several balled up napkins/paper towels on the floor;<br><br>-Five boxes of cake mix sat on the shelf with a use by date of [DATE].<br><br>Observation of the kitchen on [DATE] at 8:16 A.M., showed:<br><br>-The floors throughout the kitchen contained several white specs, balled up napkins/paper towels, grease and water;<br><br>-The walk in freezer contained a bag of chicken on the floor;<br><br>-The dry storage area contained four balled up napkins/paper towels on the floor, two bug traps under the shelving and five boxes of cake mix with a use by date of [DATE];<br><br>-The preparation area floor was wet with water and grease;<br><br>-The two refrigerators contained white substances and dust on the doors of both refrigerators;<br><br>(continued on next page) |

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|---|---|---|---|
| | 265156 | A. Building<br>B. Wing | 10/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Delmar Gardens on the Green | 15197 Clayton Road<br>Chesterfield, MO 63017 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The shelf under the preparation table contained several bottles of sauces and seasoning with dust and spillage on the outside of the bottles and containers;<br><br>-The stove, oven, fryer and tilt skillet contained rust, dirt, debris and grease on the surfaces.<br><br>Observation of the kitchen on [DATE] at 6:03 A.M., showed:<br><br>-The floors throughout the kitchen contained white specs, grease and dust;<br><br>-The dry storage area contained five boxes of cake mix with a use by date of [DATE], two cups under the shelf on the floor and two bug traps on the floor;<br><br>-The walk in freezer contained a smoked cigar on the floor;<br><br>-The preparation area's table had several dish towels, papers, gloves and various other items on the table;<br><br>-The two refrigerators contained white substances and dust on the doors of both refrigerators;<br><br>-The shelf under the preparation table contained several bottles of sauces and seasoning with dust and spillage on the outside of the bottles and containers;<br><br>-The stove, oven, fryer and tilt skillet contained rust, dirt, debris and grease on the surfaces.<br><br>Observation of the kitchen on [DATE] at 10:42 A.M., showed:<br><br>-The floors throughout the kitchen contained white specs, grease and dust;<br><br>-The dry storage area contained two cups under the shelf on the floor and two bug traps on the floor;<br><br>-The walk in freezer contained a smoked cigar on the floor;<br><br>-The preparation area's table had several dish towels, papers, gloves and various other items on the table;<br><br>-The two refrigerators contained white substances and dust on the doors of both refrigerators;<br><br>-The shelf under the preparation table contained several bottles of sauces and seasoning with dust and spillage on the outside of the bottles and containers;<br><br>-The stove, oven, fryer and tilt skillet contained rust, dirt, debris and grease on the surfaces.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 11:00 A.M., Dietary Aide (DA) O said all dietary staff were responsible for ensuring the kitchen was clean. They deep cleaned the kitchen daily. DA O said the floor contained dirt, grease and was not considered clean. The tilt skillet had a build up of food and the fryer contained years of build-up. He/she said the oven, stove and fryer were deep cleaned a month ago and now contained build up of grease, rust and debris. The stove and splatter guard were recently cleaned but now contained dirt, debris, grease and rust. The refrigerators were cleaned a couple of days ago but had dirt and debris on the doors. The kitchen was not considered clean.<br><br>During an interview on [DATE] at 11:09 A.M., the Dietary Manager said the appliances were cleaned on Monday and the oven and stove was cleaned daily. The sauces and seasonings would be thrown away and not used. The cake mixes were discovered yesterday and thrown away. Staff were expected to clean after each meal service. They cleaned daily and deep cleaned monthly. The kitchen was short-staffed and the concern was ensuring the residents received hot food on time. She would expect the kitchen to be clean.<br><br>During an interview on [DATE] at 1:52 P.M., the Administrator said she would expect the kitchen to be clean and expired foods to be discarded. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681<br><br>42247<br><br>Based on observation, interview and record review, the facility failed to follow acceptable infection control standards when staff failed to perform hand hygiene between glove changes and/or between residents for four residents observed. (Resident #50, #19, #26 and #74). In addition, staff left the catheter bag for one resident (Resident #12) on the floor without a protective barrier, and failed to wear appropriate personnel protective equipment (PPE) for residents who required Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs, bacteria or fungi resistant to multiple antimicrobials (an agent that kills microorganisms or stops their growth)); that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for one resident (Resident #61). The sample was 18. The census was 96 with 83 residents in certified beds.<br><br>Review of the facility's Medication Administration Policy, dated January 2021, showed:<br><br>-Procedure: Wash your hands before and after each different resident contact. An alcohol-based commercial wash may be substituted.<br><br>Review of the facility's Catheter Care policy, revised 3/2021, showed:<br><br>-Purpose: To keep indwelling catheter (a hollow tube that is inserted into the bladder to drain urine) free of discharge and/or crusting which can cause infections;<br><br>-Procedure:<br><br>-Catheter care should be given every shift and as needed;<br><br>-Observation and Reporting:<br><br>-Check tubing for positioning. Coil on bed;<br><br>-Attach bag to bed frame only.<br><br>Review of the facility's EBP policy, dated reviewed 8/24, showed:<br><br>-Purpose: to reduce the spread of MDRO;<br><br>- Types of MDROs include but not limited to:<br><br>- Carbapenems-producing carbapenem-resistant Acinetobacter baumannii (CRAB, causes colonization and infection predominantly in hospitalized patients);<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 - Some | -Residents with colonization of MDRO and/or with indwelling medical devices (urinary catheter) will be placed on Enhanced Barrier Precautions (EBP);<br><br>-Signage will be placed outside of their rooms to alert staff that PPE is needed such as gowns and gloves;<br><br>-PPE including gowns and gloves, will be available in an area accessible to use when high contact resident care activities are anticipated;<br><br>-PPE should be worn with during high-contact resident care activities:<br><br>-Bathing/showering;<br><br>-Providing hygiene;<br><br>-Changing linens;<br><br>-Changing briefs or assisting with toileting;<br><br>-Device care or use: urinary catheter.<br><br>Review of the magnet used for signage, showed:<br><br>-EBP Steps:<br><br>-Perform hand hygiene;<br><br>-Wear gown;<br><br>-Use gloves;<br><br>-Dispose of gown and gloves in the room;<br><br>-Repeat hand hygiene.<br><br>1. Review of Resident #50's medical record, showed diagnoses included diabetes, heart failure, kidney disease, and venous insufficiency (blood flow back to the heart is slowed).<br><br>Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by the facility staff, dated 2/14/24, showed:<br><br>-admitted [DATE];<br><br>-Clear speech;<br><br>-Able to make self-understood;<br><br>-Able to understand others;<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 - Some | -Cognitively intact.<br><br>During an observation on 10/1/24 at 7:10 A.M., showed Registered Nurse (RN) A prepared to check resident the resident's blood sugar and provide insulin. He/She entered the room, washed his/her hands in the resident's sink and put on gloves. He/She performed the blood sugar test, removed his/her gloves and documented in the computer. Without washing his/her hands, RN A put on another pair of gloves, and gathered insulins. Once the dosage was selected on the insulin pen, RN A removed his/her gloves and put on another pair of gloves. RN A administered the insulin, removed the gloves, and washed his/her hands.<br><br>2. Review of Resident #19's medical record, showed diagnoses included diabetes, high blood pressure, heart failure, kidney disease, and anxiety.<br><br>Review of the resident's admission MDS, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-Clear speech;<br><br>-Able to make self-understood;<br><br>-Able to understand others;<br><br>-Cognitively intact.<br><br>During an observation on 10/1/24 at 7:19 A.M., showed RN A prepared to check the resident's blood sugar and provide insulin. He/She put on gloves and gathered supplies from the cart. RN A removed gloves, washed his/her hands in the resident sink, and put on another pair of gloves. RN A performed the blood sugar test, removed his/her gloves and documented in the computer. Without washing his/her hands, RN A put on another pair of gloves. He/She administered insulin to the resident, removed the gloves, washed his/her hands.<br><br>3. Review of Resident #26's medical record, showed diagnoses included Parkinson's (disorder of the nervous system, causing triggers), diabetes, high blood pressure, high cholesterol, and anxiety.<br><br>Review of the resident's admission MDS, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-Clear speech;<br><br>-Able to make self-understood;<br><br>-Able to understand others;<br><br>-Cognitively intact.<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 - Some | Observation on 10/2/24 at 7:14 A.M., showed Licensed Practical Nurse (LPN) E set up the cart to perform blood sugar tests at the nurse's station. LPN E pushed the cart down the hall to resident the resident's room. LPN E removed the insulin pens from the drawer and put on a pair of gloves. He/She entered the resident's room and administered insulins. LPN E returned to the cart and removed the gloves. LPN E did not wash his/her hands and then documented in the computer.<br><br>4. Review of Resident #74's medical record, showed diagnosis included chronic obstructive pulmonary disease (permanent damage to the lung that makes it difficult to breath), lung cancer, anxiety, high blood pressure, and high cholesterol.<br><br>Review of the resident's admission MDS, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-Clear speech;<br><br>-Able to make self-understood;<br><br>-Able to understand others;<br><br>-Mild cognitive impairment.<br><br>Observation on 10/2/24 at 7:25 A.M., showed LPN E gathered supplies to perform a blood sugar test and put on gloves. He/She performed the blood sugar test for the resident. LPN E removed the gloves, and documented in the computer. LPN E then put on a pair of gloves and administered insulin to the resident and then removed the gloves. LPN E did not wash his/her hands prior to checking the resident's blood sugar or after insulin administration.<br><br>During an interview on 10/2/24 at 9:51 A.M., LPN D said that hands should be washed prior to any resident interaction and when gloves are changed. A hand sanitizer can be used in place of handwashing.<br><br>During an interview on 10/2/24 at 10:12 A.M., Certified Nursing Assistant (CNA) F said staff should wash their hands when they put on and take off gloves.<br><br>5. Review of Resident #61's care plan, revised 8/28/24, in use during the time of the investigation, showed no information regarding the use of a catheter or urine drainage bag (a container that collects urine that drains from a catheter).<br><br>Review the resident's annual MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-No behaviors;<br><br>-Substantial/maximal assistance for toileting hygiene;<br><br>-Indwelling catheter;<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 - Some | -Diagnoses included heart failure, diabetes, and respiratory failure.<br><br>Review of the resident's active physician's orders, viewed 10/1/24, showed:<br><br>-An order dated 8/29/24, for Catheter Care, per shift;<br><br>-An order dated 9/15/24, for Catheter output, every shift.<br><br>Observation on 10/2/24 at 5:56 A.M. and 8:09 A.M., showed the resident lay in bed on his/her back. The resident's catheter bag lay on the floor on the right side of the bed. The tubing was also on the floor. At 8:10 A.M., the resident opened his/her eyes. He/She said staff provided catheter care and ensured the catheter bag was off the floor.<br><br>During an interview on 10/4/24 at 8:31 A.M., CNA H said catheter bags should be in a privacy bag, off the floor.<br><br>During an interview on 10/4/24 at 8:33 A.M., Nurse D said catheter bags should not be on the floor, due to infection control.<br><br>6. Review of Resident #12's quarterly MDS, dated [DATE], showed:<br><br>-Should a brief interview for mental status be conducted? No;<br><br>-Both long-term and short-term memory loss;<br><br>-Diagnoses included: obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow);<br><br>-Indwelling catheter.<br><br>Review of the care plan, in use at the time of survey, showed:<br><br>-Problem: Resident had a MDRO, CRAB that required the use of personal protective equipment during high contact activities;<br><br>-Goal: will not exhibit complications to MDRO by the next review date;<br><br>-Approach: is on EBP, staff must perform hand hygiene before and after providing care;<br><br>-Problem: resident required an indwelling urinary catheter related to his history of malignant neoplasm of prostate (a cancerous tumor that forms in the prostate gland);<br><br>-Goal: will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma through next review;<br><br>-Approach: Monitor drainage. Record the amount, type, color, odor. Observe for leakage.<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 - Some | Observation and interview on 10/2/24 at 6:25 A.M. showed PPE hanging on the resident's door and there an EBP magnet on the door frame. CNA L was in the resident's room wearing a face mask and gloves. He/She emptied 150 milliliters of urine from the resident's catheter. CNA L said nobody told him/her why there was PPE on the resident's door, maybe the resident had covid and the facility forgot to take the PPE off the door. CNA L did not wear a gown while providing care to the resident.<br><br>Observation and interview on 10/2/24 at 10:25 A.M., showed the PPE remained hanging on the resident's door. The EBP magnet remained on the door frame. The resident lay flat in bed with no sheet covering the him/her. CNA M was in the resident's room wearing a mask and gloves. He/She did not wear a gown. CNA M said he/she had just finished cleaning the resident up. CNA M rolled the resident over and placed a pillow under the resident's knees and adjusted his/her catheter tubing. CNA M placed a new pillowcase on the pillow and placed it under the resident's head, then put the resident's protective boots on and covered the resident up. CNA M said he/she did not have to wear PPE while working with the resident. He/She wore the mask and gloves just because he/she had kids at home. When asked about the PPE on the door, CNA M said maybe he/she should have worn a gown because the resident had a catheter.<br><br>During an interview on 10/3/24 at 12:00 P.M., RN A said, residents with indwelling catheters require EBP (gowns, gloves, and mask) while providing personal care for the residents. Staff knew which residents required EBP because there was PPE outside the door and a magnet on the door frame.<br><br>During an interview on 10/4/24 at 12:28 P.M., the Nurse Manager said residents who had tested positive for CRABS and/or had an indwelling medical device required EBP. Staff knew which residents required EBP because there was PPE and a magnet on the door frame and through report. Agency and hospice staff were made aware when they came on board, or any staff could go to the nurse's station and ask the nurse. Staff should wear gown and gloves when they came in contact with a resident. They may need a mask if they could come in contact with splashes. PPE should be worn when staff empted a catheter, provided bed linen changes and when providing personal care.<br><br>7. During an interview on 10/4/24 at 1:53 P.M., the Administrator said she would expect for staff to follow the facility's policies and procedures for infection control.<br><br>49992 |