STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265158	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Desloge	801 Brim Street, Desloge, MO 63601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and in a respectful manner by leaving one resident (Resident #45) out of nine sampled residents exposed during care. The facility census was 62. Review of the facility's policy titled, Dignity, dated August 2009, showed: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality; - Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1. Review of Resident #45's medical record showed: - admitted [DATE]; - Diagnoses of Parkinson's disease (a disorder of the nervous system that affects movement, often including tremors), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and dementia (loss of memory, language, problem solving and other thinking abilities). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/16/24, showed: - Cognition severely impaired; - Always incontinent of bladder and bowel; - Dependent for toileting hygiene, and mobility. Observation of the resident on 03/28/24 at 2:26 P.M., showed: - The resident lay in bed; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Certified Nursing Assistant (CNA) A and CNA B entered the room to perform incontinent care; - The CNAs did not close the blind to the window; - The yard could be seen through the window with a person mowing; - CNA A left the room to obtain more wipes and the resident lay on his/her back with the genitalia area exposed. During an interview on 03/28/24 at 4:36 P.M., CNA A said prior to providing resident care, the door and window blinds/curtains should be closed and the privacy curtains should be drawn if needed. During an interview on 03/28/24 at 4:48 P.M., CNA B said the door, curtains and/or blinds should be closed. During an interview on 03/28/24 at 4:50 P.M., the Assistant Director of Nursing (ADON) said she would expect staff to be sure to close the door, pull the privacy curtain, and close the blinds if they were open.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 46521 Based on interview and record review, the facility failed to ensure residents and/or responsible parties were notified in a timely manner when a resident's account was within the $200.00 Social Security (SSI) limit ($5, 726.00) or when the resident's account was over the SSI limit. This affected two residents (Resident #2 and #8) reviewed who received Medicaid benefits. The census was 62. Review of the facility's policy titled, Bookkeeping Manual, dated, August 2007, showed: - Patient trust files and related information must be maintained and properly stored by the bookkeeping office for legal compliance and operational efficiency; - Patient trust file must include quarterly statement documentation that residents have been notified of their balance. 1. Review of the Resident Trust Statement for the period 01/31/24 through 03/31/24, showed Resident #2 had the following balances: Date Amount 01/31/24 $5,795.05 02/29/24 $7,217.68 03/31/24 $5,488.34 Review of the resident's fund documentation showed no resident fund notifications were provided to the resident and/or the representative. 2. Review of the Resident Trust Statement for the period 01/31/24 through 03/31/24, showed Resident #8 had the following balances: Date Amount 01/31/24 $5,053.21 02/29/24 $6,336.49 03/31/24 $5,643.45 Review of the resident's fund documentation showed no resident fund notifications were provided to the resident and/or the representative. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/29/24 at 1:30 P.M., the Business Office Manager (BOM) said he/she was responsible for identifying when the residents got close to the need of a spend down. A notification letter should be sent to the resident/resident's representative. He/She did not send a letter to Resident #2 or Resident #8. Some of the resident accounts had built up over the limit for a while and they were working to make corrections. During an interview on 03/31/24 at 5:00 P.M., the Administrator said she expects the residents' accounts to be kept below the limit and notification to be sent when they were close to their limit. During an interview on 04/02/24 at 3:30 P.M., the Regional Accountant said notice letters should have been sent out by the facility when residents were over the limit but were not. Just the quarterly statements were sent. There had been issues with this concern and the last office manager quit suddenly in December 2023. There were balances due for policy premiums that would have corrected the fund balances.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45693 Based on observation, interview, and record review, facility staff failed to administer medications in a safe and effective manner for one resident (Resident #23) out of six sampled residents. The facility census was 62. The facility did not provide a policy regarding medication administration. 1. Review of Resident #23's medical record showed: - Date of admission 09/14/22; - Diagnosis of kidney failure and required dialysis (process of purifying the blood of a person whose kidneys aren't working normally); - An order for sevelamer carbonate (medication to treat too much phosphate in the blood) 800 milligram (mg) five tablets by mouth with meals at 7:00 A.M., 11:00 A.M., 4:00 P.M., when food is in front of resident, dated 02/05/24; - No documentation of an order for the resident to administer his/her own medication; - No documentation of assessments for the resident's competency to administer his/her own medication. Review of the resident's care plan, last revised 03/27/24, showed: - Administer sevelamer carbonate when food is in front of resident; - The care plan did not address self-administration of the medication. Observations on 03/27/24 of the resident showed: - At 3:35 P.M., the resident sat at a dining room table with a medication cup which contained five pills; - From 3:35 P.M., through 4:43 P.M., the resident sat unsupervised with a cup of five pills in front of him/her; - At 4:43 P.M., the resident received his/her food and self-administered the five pills in the medication cup. During an interview on 03/27/24 at 3:37 P.M., Resident #23 said he/she took the pills when he/she received his/her meal. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/29/24 at 1:30 P.M., Certified Medication Technician (CMT) N said he/she always gave Resident #23 his/her medications at the dining room table and left them. He/She had been told that it was care planned to leave the medication with the resident to self-administer. During an interview on 03/29/24 at 2:40 P.M., the Assistant Director of Nursing (ADON) said there should be an order and/or care plan for the resident to receive and self-administer medication at the dining room table. During an interview on 03/29/24 at 3:30 P.M., the Administrator said she knew Resident #23 received the medication at the table and sat with it in the dining room. The resident can't take it until his/her food arrives.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to ensure proper placement of a Foley catheter (a tube inserted into the bladder to drain urine) tubing and drainage bags for two residents (Residents #10 and #307) out of five sampled residents. The facility census was 62. Review of the facility's policy titled, Urinary Cath Care, undated, showed: - Catheter care is performed appropriately; - Wash hands or hand sanitize before any manipulation of the catheter site and/or apparatus; - The only place in the closed system intended to be open is the empty spout at the bottom of the drainage bag; - The drainage bag should be kept below the level of the bladder. The facility did not provide a policy regarding Foley catheter placement, keeping the catheter tubing off of the floor for infection control issues or keeping the catheter bag covered for privacy/dignity. 1. Review of Resident #10's medical record showed: - admitted [DATE]; - Diagnoses of unspecified dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), anxiety disorder (persistent worry and fear about everyday situations), acquired absence of kidney (missing one or both kidneys due to an injury or operation), major depressive disorder (long-term loss of pleasure or interest in life), and retention of urine (an inability to empty the bladder of urine); - The Physician Order Sheet (POS), dated March 2024, showed an order to change the catheter twice a month and as needed, dated 03/13/24. Review of the resident's care plan, reviewed on 03/13/24, showed to maintain the catheter drainage bag in a privacy cover. Observations of Resident #10 showed: - On 03/26/24 at 10:37 A.M., the resident lay in bed and the uncovered catheter drainage bag hung from the bed frame. The bottom of the drainage bag and tubing touched the floor; - On 03/26/24 at 12:12 P.M., the resident sat in a wheelchair in the dining room, the catheter tubing touched the floor, and no privacy bag covered the drainage bag; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/27/24 at 9:18 A.M., and on 03/28/24 at 8:47 A.M., and 1:35 P.M., the resident lay in bed while the bottom of the uncovered catheter drainage bag touched the floor. The catheter tubing lay on the floor; - On 03/28/24 at 2:50 P.M., and on 03/29/24 at 11:30 A.M., the resident lay in bed while the bottom of the uncovered catheter drainage bag touched the floor. 2. Review of Resident #307's medical record showed: - Date of admission 03/13/24; - Diagnoses of unspecified dementia with agitation, depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), anxiety disorder, pyoderma gangrenosum (a rare skin condition that causes painful ulcers), neuromuscular dysfunction of the bladder (condition that results in lack of bladder control due to a brain, spinal cord or nerve problem), and overactive bladder (when the muscles of the bladder start to tighten on their own even when the amount of urine in the bladder is low); - Nurse's Note, dated 03/13/24, showed the resident with an indwelling Foley catheter, patent and draining amber urine; - The POS, dated March 2024, with orders to change the indwelling catheter every 30 days and to perform catheter care every shift, dated 03/26/24. Observation on 03/26/24 at 12:01 P.M., showed Resident #307 sat in a high back wheelchair in the dining room and fed by staff. The catheter tubing lay in the floor under the wheelchair. Observation on 03/26/24 at 3:40 P.M., showed Certified Nursing Assistant (CNA) A and CNA H transferred the resident from the wheelchair to the bed by a mechanical lift. The catheter drainage bag was placed on the foot of the bed by CNA H. CNA A rolled the resident and the catheter drainage bag fell off the bed onto the floor. CNA H picked up the bag and placed it back onto the foot of the bed. During an interview on 03/28/24 at 4:30 P.M., Registered Nurse (RN) I said catheter tubing and bags should be lower than the bladder and secured. Staff should wipe from the catheter insertion point and down the tube. The drainage bag and tubing should never touch the ground, the urine should flow by gravity away from the bladder, and the catheter drainage bag should be covered in a privacy bag, especially when leaving the resident's room. During an interview on 03/28/24 at 4:32 P.M., CNA J said catheter drainage bags and tubing should never touch the ground. The catheter should be cleaned from the insertion point down the tube. The catheter drainage bags should be kept covered in a privacy bag. During an interview on 03/28/24 at 4:36 P.M., RN C said catheters shouldn't touch the floor and should be kept in a privacy bag. During an interview on 03/29/24 at 11:30 A.M., the Assistant Director of Nursing (ADON) said catheters shouldn't touch the floor and should be kept covered in a privacy bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47445

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to ensure proper care of the enteral feeding (the intake of food through a gastrostomy tube (G-tube) (a tube placed directly through the abdomen into the stomach for feeding and/or medication administration) for two residents (Residents #46 and #308) out of a sample of two residents. The facility census was 62. The facility did not provide a tube feeding policy. 1. Review of Resident #46's medical record showed: - admitted [DATE]; - Diagnoses of nontraumatic subdural hemorrhage (a kind of intracranial hemorrhage (bleed) which is the bleeding in the area between the brain and the skull), acute embolism (a blood clot, air bubble, or piece of fatty deposit inside the bloodstream) and thrombosis (a blood clot that forms inside one of the veins or arteries) of an unspecified vein, dysphagia (difficulty swallowing), G-tube status, and the presence of cerebrospinal fluid (a clear, colorless body fluid found within the tissue that surrounds the brain and spinal cord) drainage device; - An order for Jevity 1.5 calories (CAL) (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for tube feeding) 320 milliliters (ml) four times a day with 200 ml free water flush four times a day at 5:00 A.M., 10:00 A.M., 5:00 P.M., and 10:00 P.M., dated 11/01/23. Observation on 03/27/24 at 9:30 A.M., showed: - The resident lay in bed with the head of the bed elevated; - Licensed Practical Nurse (LPN) K performed hand hygiene, put on gloves, and placed the tube feeding supplies on the resident's table; - LPN K checked the resident's residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding that are pulled through the tube by a syringe) and the placement of the G-tube by auscultation (instilling air into the feeding tube with a syringe while using a stethoscope placed over the stomach to listen for rushing air); - LPN K added 15 ml of water to the medication cup and mixed it with the crushed medication in it; - LPN K administered 30 ml of water into the tube; - LPN K administered the crushed medication mix into the tube; - LPN K administered 30 ml of water into the tube; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN K administered 120 ml of Jevity by gravity (letting the formula drain through the tube with no assistance); - LPN K administered another 60 ml of Jevity; - The LPN thinned out the remaining Jevity by adding 120 ml of water in increments of 20 ml, 40 ml, 10 ml, 40 ml, and 10 ml and administered it through the tube; - LPN K flushed the tube with 60 ml of water; - LPN K administered a total of 255 ml of water, 55 ml over the ordered 200 ml. During an interview on 03/27/24 at 9:33 A.M., LPN K said he/she added the extra water to the Jevity 1.5 CAL to thin out the product a little to aid in administration. 2. Review of Resident #308's medical record showed: - admitted [DATE]; - Diagnosis of sinus cancer; - An order for tube feeding formula Jevity 1.5 CAL 240 ml every eight hours, dated 03/18/24; - An order for 60 ml water before and after the feeding every eight hours at 6:00 A.M., 2:00 P.M., and 10:00 P.M., dated 03/18/24 Observation on 03/27/24 at 2:10 P.M., showed: - Resident #308 sat in a recliner in his/her room; - Registered nurse (RN) C performed hand hygiene, put on gloves, and sat the tube feeding supplies on the resident's cleansed table; - RN C checked the resident's residual; - RN C checked the resident's placement of the tube by auscultation; - RN C administered 60 ml of water into the tube and then 60 ml of Jevity 1.5 CAL by gravity; - RN C administered another 60 ml of Jevity and used the plunger (the moving part of a syringe which forced the formula through the tubing) to push the last 50 ml; - RN C administered another 60 ml of Jevity and used the plunger to push the last 40 ml; - RN C administered the last 30 ml of Jevity by gravity; - RN C flushed the tube with another 60 ml of water; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The RN failed to allow the feeding to flow by gravity and used the plunger to push it. During an interview on 03/28/24 at 4:36 P.M., RN C said he/she should not have used the plunger during the tube feeding for Resident #308. All physicians' orders should be followed. During an interview on 03/29/24 at 11:30 A.M., the Assistant Director of Nursing (ADON) said nurses should not use a plunger during tube feedings. It was the expectation for staff to follow orders as written.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to follow a physician's order for oxygen for one resident (Resident #33) and failed to obtain a physician's order for oxygen for one resident (Resident #307) out of two sampled residents. The facility census was 62. Review of the facility's policy titled, Respiratory Therapy, undated, showed: - Oxygen therapy will be initiated only by a Respiratory Therapist, a Registered Nurse (RN) or Licensed Practical Nurse (LPN) on the order of a physician or physician extender, except in case of emergency. When oxygen therapy is initiated without an order in an emergency situation, the physician will be contacted as soon thereafter as possible; - Respiratory therapy will be given only upon the order of a physician. 1. Review of Resident #33's medical record showed: - An admitted [DATE]; - Diagnoses of chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), dependence on supplemental oxygen, and essential primary hypertension (high blood pressure); - An order for oxygen at four liters per minute (L/min) via nasal cannula (NC) nasal cannula (a tube inserted into the nostrils to deliver supplemental oxygen), dated 01/22/24; - An order to change the oxygen tubing weekly on Sunday evening, dated 01/22/24. Review of the resident's care plan, last reviewed on 03/14/24, showed: - Administer oxygen at five L/min per NC; - Oxygen change per protocol. Observation of Resident #33 showed: - On 03/26/24 at 1:10 P.M., 03/28/24 at 2:25 P.M., and 03/29/24 at 1:56 P.M., the resident lay in bed with oxygen on at three L/min per NC and the tubing undated; - The facility failed to ensure the resident received the oxygen as ordered. During an interview on 03/29/24 at 1:56 P.M., Resident #33 said he/she couldn't breathe without wearing the oxygen. 2. Review of Resident #307's medical record showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An admitted [DATE]; - Diagnoses of unspecified dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) with agitation, atherosclerotic heart disease (the buildup of cholesterol, fats and other substances in and on the artery walls), peripheral vascular disease (PVD) (a condition that causes partial or complete obstruction of blood flow), and dysphagia (difficulty swallowing); - Nurse's note, dated 03/20/24, 03/21/24, 03/23/24, and 03/24/24, showed the resident with oxygen on at two L/min per NC. Review of the resident's Physician's Order Sheet (POS), dated March 2024, showed: - No documentation of an order for oxygen use; - No documentation of an order for oxygen tubing or humidifier changes. Review of the resident's care plan, last revised 03/27/24, showed oxygen not addressed. Review of the resident's admission Minimum Data Set (MDS) (a federally mandated assessment instrument completed by the facility staff), dated 03/18/24, showed the resident did not receive oxygen therapy. Observations of Resident #307 showed on 03/26/24 at 12:01 P.M., and 3:30 P.M., 03/27/24 at 8:30 A.M., and 2:25 P.M., and 03/28/24 at 10:00 A.M., 3:45 P.M., the resident sat in a wheelchair with oxygen on at three L/min per NC. During an interview on 03/29/24 at 3:30 P.M., the Assistant Director of Nursing (ADON) said there should be orders for oxygen and the orders should be followed. 46521

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	265158	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Desloge	801 Brim Street, Desloge, MO 63601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50260 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #26) out of two sampled residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. The facility's census was 62. Review of the facility's policy titled, Pain Management, undated, showed: - Every patient is assessed for pain on admission, daily, as needed, and with all quarterly Minimum Data Set (MDS) (a federally mandated assessment completed by the facility) assessments; - Interventions for pain consist of pharmacological and non-pharmacological; - Medications will be given per physician orders, as needed orders will be assessed for effectiveness. Physicians will be notified if current medications or non-pharmacological interventions are not effective. 1. Review of Resident #26's medical record showed: - An admitted [DATE]; - Diagnoses of hypertensive heart disease (changes in the heart due to chronic elevated blood pressure) with heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), atrial fibrillation (abnormal heart rhythm), atherosclerotic heart disease (the buildup of cholesterol, fats and other substances in and on the artery walls), chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), pulmonary hypertension (a condition that affects the blood vessels in the lungs), diabetes mellitus (DM) (a condition that affects the way the body processes blood sugar), hypertension (high blood pressure), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), mood disturbance, anxiety (persistent worry and fear about everyday situations), and pressure ulcer (damage to the skin and/or underlying tissue as a result of pressure). Review of the resident's significant change MDS, dated [DATE], showed: - Cognitive status mildly impaired; - Total dependence of two staff for lower body dressing, chair/bed to chair transfer, toilet transfer, and tub/shower transfer; - Unhealed Stage 3 (full thickness tissue loss and subcutaneous fat may be visible but bone, tendon or muscle are not exposed) pressure ulcer; - One Stage 3 pressure ulcer upon admission; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Pressure ulcer care; - Almost constant pain. Review of the resident's Physician's Order Sheet (POS), dated March 2024, showed: - An order to screen for pain every shift, dated 02/12/24; - An order for hydrocodone-acetaminophen (an opioid pain medication) 5-325 milligram (mg) tablet by mouth every four hours as needed for pain, dated 02/21/24; - An order to cleanse the area to the coccyx (tail bone) with wound cleanser, pat dry, cover the area with a foam dressing, change in the morning every other day and as needed, dated 02/26/24; - An order for hydrocodone-acetaminophen 5-325 mg tablet by mouth twice a day at 9 A.M., and 9 P.M., dated 03/28/24. Review of the resident's Medication Administration Record (MAR), dated March 2024, showed: - Hydrocodone-acetaminophen 5-325 mg tablet administered on 03/17/24; - Pain screens completed on 03/26/24 through 03/29/24 showed the resident had a pain score of zero (no pain), six out of eight opportunities and a score of two (mild pain), two out of the eight opportunities. Review of the resident's care plan, revised on 03/27/24, showed: - Resident at risk for pressure ulcer due to moisture and admitted with skin breakdown; - Pad bony prominences with foam wedges, rolled blankets or towels; - Pain/discomfort related to left humerus (the upper arm bone) fracture from 09/25/23; - Administer analgesic (pain medication), anticipate comfort needs, assist with positioning for comfort, observe nonverbal sign/symptom of discomfort, utilize non-medication interventions to relieve pain, and utilize pain scale to assess for pain. Observations of the resident showed: - On 03/26/24 at 10:36 A.M., 12:36 P.M., 1:36 P.M., and 2:46 P.M., the resident lay in bed on his/her back with no wedge; - On 03/27/24 at 8:37 A.M., the resident lay in bed on his/her back with no wedge; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- On 03/27/24 at 1:17 P.M., the resident lay in bed on his/her back with no wedge. The resident's call light was on. Registered Nurse (RN) C entered the resident's room and turned the call light off. The resident asked RN C to please get him/her up. RN C told the resident he/she would be okay and would be back to complete his/her dressing change. RN C did not assess the resident's pain, offer any pain medication, nor offer any non-pharmalogical interventions to the resident; - On 03/27/24 at 2:14 P.M., Certified Nursing Assistant (CNA) J and RN C provided incontinent and wound care for the resident. RN C began the wound dressing change. During the dressing change, the resident moaned six times in pain and said, You're hurting me. I can't take this anymore. The resident was tearful during the dressing change and became nauseated. RN C did not assess the resident for pain nor was any pain medication offered prior to the dressing change. CNA J and RN C told the resident he/she was going to be okay and they were almost done with the treatment. RN C did not assess the resident's pain, offer any pain medication, nor offer any non-pharmalogical interventions to the resident after the wound treatment was completed; - On 03/27/24 at 4:50 P.M., the resident lay in bed on his/her back and complained he/she might throw up. CNA A went to get a bedpan. The resident was not assessed for pain, offered pain medication, nor provided with any non-pharmalogical interventions; - On 03/28/24 at 9:33 A.M., the resident asked staff to turn him/her, refused to eat breakfast, asked for his/her spouse, and said he/she was in pain and wanted to be turned. The resident lay on his/her back with no wedge and his/her feet hung off the side of the bed. The resident was not assessed for pain, offered pain medication, nor provided with any non-pharmalogical interventions; - On 03/28/24 at 1:40 P.M., the resident lay in bed on his/her back with a wedge under the left thigh area. CNA J assisted the resident with getting dressed. The resident said he/she was in pain and needed CNA J to help him/her. CNA J assisted the resident to get out of bed. The resident was not assessed for pain, offered pain medication, nor provided with any non-pharmalogical interventions. During an interview on 03/26/24 at 10:47 A.M., and 12:59 P.M., Resident #26 said he/she had a hole in his/her butt and it hurt. The wound had been there about a month and staff did not turn him/her most of the time during the day. Staff turned him/her maybe one time a day if he/she was lucky. The resident would like to get out of bed more often. During an interview on 03/27/24 at 3:57 P.M., Physical Therapist (PT) O said Resident #26 had been discharged from therapy on 03/26/24, due to noncompliance and not cooperating. The resident did not want to participate with PT, and was now on restorative therapy. The resident had always been noncompliant even before his/her wound developed. He/She did not know if the resident's pain contributed to his/her noncompliance. The resident often did not want to be in a wheelchair because of his/her pain. Observation on 03/28/24 at 2:10 P.M. - 3:10 P.M., showed the resident screaming, Please someone help me. Please I am hurting. Please come see me CNA J. CNA J told the resident he/she would be there in a minute but went to three other residents' rooms first. The resident was not assessed for pain, offered pain medication, nor provided with any non-pharmalogical interventions. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/28/24 at 4:33 P.M., CNA J said when a resident was in pain, he/she should notify the charge nurse and give the information about the resident's pain. Signs and symptoms of pain could be abnormal vital signs and grunting/moaning with movement. Non-pharmalogical things that could be done to help with pain was massage, apply lotion, rotate the resident in bed and keep the resident clean. During an interview on 03/28/24 at 4:48 P.M., Certified Medication Technician (CMT) N said he/she would consider giving a resident pain medication when they were screaming, acting anxious, fidgety, and grimacing. If the pain medication did not work, he/she would go to the main nurse to see if there was something else to give the resident. If the resident refused the pain medication, he/she would give them some time and try again. He/She would let the nurse know if they refused three times. Resident #26 didn't refuse pain medication. During an interview on 03/28/24 at 5:06 P.M., the Assistant Director of Nursing (ADON) said pain associated with pressure ulcers was assessed before a dressing change, prior to administering pain medication, and daily. Grimacing and verbal cues were all indicators of pain. The pain management regimen was reviewed as needed and by what the resident said or conveyed. If the pain management wasn't working, then staff faxed communication to the doctor. If a resident wasn't verbal about their pain, the staff looked for nonverbal signs. The CMT gave most pain medications to the residents. During an observation and interview on 03/29/24 at 10:41 A.M., Resident #26 was awake and alert. He/She lay in bed on his/her back and said he/she was in severe pain and hadn't received any pain medication. The resident wasn't sure what pain medication he/she had ordered. During an interview on 03/29/24 at 10:45 A.M., CMT N said Resident #26 said he/she was in pain. CMT N administered a pain pill on 03/29/24 at 9:00 A.M., to the resident. There was now a new order for the pain pill to be scheduled twice a day at 9:00 A.M., and 9:00 P.M. Due to miscommunication, the staff had been unaware of the resident's pain the last few days. During an interview on 03/29/24 at 1:49 P.M., RN C said the resident should be administered a pain pill when he/she reported or showed signs of pain. If there were observable signs of pain, staff should asses the resident's pain level, have the resident rate their pain, check the resident's physician orders, and give the resident the pain medication as ordered. He/She would not routinely assess or administer pain medication before a wound dressing, but it would depend on the wound.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 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 two residents (Resident #23 and #27) out of two sampled residents. The facility census was 62. Review of the facility's policy titled, Care of a Resident Who Receives Hemodialysis, undated, showed: - Obtain a physician order, may include dialysis schedule, number of treatments per week, and fluid restrictions; - If needed, weights to be obtained if in addition to routine weights; - Pre and post dialysis weight may be obtained at the dialysis center or at the facility; - This should be communicated between the dialysis clinic and facility; - Nurse should assess/monitor and document the shunt (a surgically created connection between a vein and artery used for dialysis) site for bleeding and infection, fluid volume and restrictions if ordered by the physician, weights as ordered, edema, shortness of breath, elevated heart rate, and abnormal breath sounds. 1. Review of Resident #23's Physician's Order Sheet (POS) dated March 2024, showed: - admitted [DATE]; - An order for dialysis on Monday, Wednesday and Friday, dated 01/24/23; - An order for daily weights, call if gains more than two pounds in one day or five pounds in one week, start date 12/31/22, with no stop date; - An order to palpate (examine a part of the body by touch) for the thrill (a palpable murmur that feels like a ringing phone or fly trapped in one's hand) and auscultate (examine a patient by listening to sounds from the heart, lungs or other organs) for the bruit (a sound, especially an abnormal one, heard through a stethoscope) every shift, dated, 01/24/23. Review of the resident's care plan, reviewed on 02/26/24, did not address renal dialysis and the assessment/monitoring of the resident. Review of the resident's medical record showed: - Diagnoses of end stage renal disease (ESRD) (when the kidneys are no longer able to work at a level needed for day-to-day life), diabetes mellitus (DM) (a condition that affects the way the body processes blood sugar), left lower below the knee amputation, and unsteadiness on feet; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Documentation of the communication report from the facility to the dialysis center, dated 2/26/24 - 3/28/24, with six out of twelve opportunities missed; - No documentation of daily weights for 01/16/24, 01/18/24, 01/19/24, 10/21/24, 01/23/24, 01/25/24, and 01/27/24, with seven missed out of 31 opportunities; - No documentation of daily weights for 02/06/24, 02/07/24, 02/15/24, 02/16/24, 02/20/24, 02/25/24, and 02/26/24, with seven missed out of 29 opportunities; - No documentation of daily weights for 03/06/24, 03/10/24, and 03/24/24, with three missed out of 28 opportunities ; - The facility failed to provide and obtain consistent pre and post dialysis communication with the dialysis center; - The facility failed to consistently monitor daily weights. 2. Review of Resident #27's POS, dated March 2024, showed: - admitted [DATE]; - An order for dialysis on Monday, Wednesday and Friday, dated 01/24/24; - An order for daily weights, call if gains more then two pounds in one day or five pounds in one week, start date 01/11/24, with no stop date. Review of the resident's medical record showed: - Diagnoses of ESRD, dyspnea (shortness of breath), DM, right and left lower below the knee amputation, and impaired mobility; - Documentation of the communication report from the facility to the dialysis center, dated 2/26/24 - 3/28/24, with four out of nine opportunities missed; - No documentation of the communication report from the dialysis center, dated 2/26/24 - 3/28/24, to the facility with nine out of nine opportunities missed; - No documentation of daily weights for 01/12/24, 01/15/24, 01/16/24, 01/17/24, 01/19/24, 01/21/24, 1/23/24, 01/25/24, 01/26/24, 01/27/24, and 01/29/24, with 11 missed out of 31 opportunities; - No documentation of daily weights for 02/03/24, 02/06/24, 02/09/24, 02/11/24, 02/20/24, 02/24/24, 02/25/24, and 02/29/24, with eight missed out of 29 opportunities; - No documentation of daily weights for 03/04/24, 03/10/24, 03/13/24, 03/15/24, and 03/23/24, with five missed out of 28 opportunities; - The facility failed to provide and obtain consistent pre and post dialysis communication with the dialysis center; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility failed to consistently monitor daily weights. During an interview on 03/29/24 at 10:25 A.M., the Assistant Director of Nursing (ADON) said the dialysis center would not complete their portion of the communication form. During an interview on 03/29/24 at 1:15 P.M., the Administrator said the dialysis center refused to fill out the paperwork and send it back. During an interview on 03/29/24 at 1:46 P.M., the ADON said she would expect daily weights to be completed as ordered and documented. If the weight was inaccurate, she would expect the resident to be reweighed and the physician to be notified if needed. During an interview on 03/29/24 at 2:20 P.M., Registered Nurse (RN) D said he/she did not usually send any paperwork as the residents were already established with the dialysis center. The residents did not normally return with any. Daily weights were done and the physician should be notified per the orders of certain changes. Surveyor: Carpenter, [NAME] 46521

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on observation, interview, and record review, the facility failed to identify, assess and provide supportive interventions for two residents (Resident #27 and #44) with a diagnosis of Post-Traumatic Stress Disorder (PTSD) (a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of five sampled residents. The facility's census was 62. Review of the facility's policy titled, Trauma-Informed Care, undated, showed: - Use the attached abbreviated Trauma Screen; - Use the two item version of the Trauma screen at the time of admission to determine the need for further investigation; - This should be done within seventy-two hours of admission and with the patient if at all possible; - Review patient diagnoses of PTSD also within seventy-two hours of admission; - If positive screen results from the two-item Trauma Screening questions or diagnosis of PTSD, then we complete the six item version of the Trauma Screen for the five day assessment and put interventions in place and care plan accordingly; - For current patients, review diagnosis list for PTSD and complete six item version of the Trauma Screen and if positive, ensure appropriate interventions and care plans are in place; - As patient's quarterly and annual assessments occur, complete the six item version of the Trauma Screen and if positive, ensure appropriate interventions and care plans are in place. 1. Review of Resident #27's medical record showed: - admitted on [DATE]; - discharged on [DATE], and readmitted on [DATE]; - Diagnoses of PTSD, insomnia (a common sleep disorder) and depression (a mental disorder that involves a depressed mood or loss of interest in activities); - No documentation of a PTSD assessment. Review of the resident's Physician's Order Sheet (POS), dated March 2024, showed: - An order for sertraline (an antidepressant medication) 25 milligram (mg) once a day, for depression, dated 03/28/24. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for temazepam (a sedative medication) 7.5 mg at bedtime to treat insomnia, dated 03/28/24. Review of the resident's care plan, reviewed 03/27/24, showed: - PTSD not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. 2. Review of Resident #44's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD and depression; - No documentation of a PTSD assessment. Review of the resident's POS, dated March 2024, showed an order for duloxetine (an antidepressant medication) 60 mg once a day for pain/depression, dated 02/28/24. Review of the resident's care plan, reviewed 02/19/24, showed no documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 03/28/24 at 2:58 P.M., the Social Service Director (SSD) said he/she usually completed the PTSD screening and it was not completed for Resident #27 and #44. During an interview on 03/29/24 at 4:15 P.M., the Minimum Data Set (MDS) (a federally mandated assessment instrument completed by the facility staff) Coordinator said residents with a PTSD diagnoses should have a care plan that addressed the triggers with individualized interventions. Surveyor: Carpenter, [NAME] 46521

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47445 Based on interview and record review, the facility failed to ensure a resident diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care to ensure services to promote the resident's highest level of functioning and psychosocial needs for two residents (Residents #10 and #50) out of three sampled residents. The facility census was 62. Review of the facility's policy titled, Dementia - Clinical Protocol, revised March 2015, showed: - For the individual with confirmed dementia, the interdisciplinary team (IDT) will identify a resident-centered care plan to maximize remaining function and quality of life; - The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise; - Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses notes and documentation tools); - The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of the dementia, development of new acute medical conditions or complications, and changes in the resident's or family's wishes, etc. 1. Review of Resident #10's medical record showed: - An admitted [DATE]; - Diagnoses of age-related dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and cognitive loss. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 02/16/24, showed moderate cognitive impairment. Review of the resident's care plan, last reviewed 03/13/24, showed: - Did not address dementia; - Did not address specific problems, interventions, or goals for dementia care; - Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. 2. Review of Resident #50's medical record showed: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An admitted [DATE]; - Diagnoses of dementia, unspecified severity, with mood disturbance, anxiety (persistent worry and fear about everyday situations), cognitive communication deficit, and Down's Syndrome (a genetic disorder causing developmental and intellectual delays). Review of the resident's admission MDS, dated [DATE], showed: - Diagnosis of dementia; - Severe cognitive impairment. Review of the resident's care plan, last reviewed 03/26/24, showed: - Did not address dementia; - Did not address specific problems, interventions, or goals for dementia care; - Did not address specific problems, interventions, or goals for activities for a resident diagnosed with dementia. During an interview on 03/29/24 at 1:39 P.M., the MDS Coordinator said dementia should be addressed on a resident's care plan and include personalized interventions such as medications, activities of daily living, care, wandering and behaviors. During an interview on 03/29/24 at 1:45 P.M., the Assistant Director of Nursing (ADON) said she would expect dementia to be addressed on a resident's care plan and include personalized interventions. She would expect the care plan to be person-centered and reflect a resident's current diagnoses.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Desloge	801 Brim Street, Desloge, MO 63601

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45693 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during incontinent care for three residents (Resident #10, #16, and #19) out of five sampled residents, Foley catheter (a tube inserted into the bladder to drain urine) care for one resident (Resident #10) out of five sampled residents and one resident (Resident #43) outside the sample, and wound care for one resident (Resident #307) out of two sampled residents. The facility failed to maintain proper infection control practices during medication administration for one resident (Resident #46) out of six sampled residents when staff touched a pill with his/her bare hand. The facility census was 62. Review of the facility's policy titled, Hand Hygiene, last revised May 2023, showed: - Hand hygiene is a generic term that applies to either hand washing, antiseptic handwashing, antiseptic hand rub, or surgical hand antisepsis; - There are two methods for hand hygiene: Alcohol-based hand sanitizer (60-95 percent (%) alcohol) and washing the hands with soap and water; - Use alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal; - Wash hands with soap and water when hands are visibly soiled, after caring for a person with known or suspected infection, and after known or suspected exposure. Review of the facility's policy titled, Perineal Care, undated, showed: - Gather supplies, wash hands, and put on gloves; - For females, wash inner legs, outer peri area along the outside of the labia (the folds of skin around the vaginal opening), use clean wash cloth/wipe for each wipe of peri area, and wash front to back; - For males, wash the penis from the tip downward and dry, wash the scrotum, wash and dry the skin between the legs, and wash and dry the anal area; - Remove soiled gloves, dispose, and finish the bed change, put on clean gloves and apply barrier cream; - Remove soiled gloves and dispose; - Remove bagged linen and trash. 1. Observation on 03/27/24 at 9:30 A.M., of incontinent care for Resident #19 showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Certified Nursing Assistant (CNA) A and CNA J performed hand hygiene and put on gloves; - CNA A and CNA J removed the resident's pants and unfastened the brief; - CNA J performed peri care; - CNA J changed gloves and did not perform hand hygiene; - CNA J performed incontinent care, wiping from the back to the front peri areas when cleansing between the buttocks; - CNA J changed gloves and did not perform hand hygiene, touched the resident's pants and blanket, removed the gloves and did not perform hand hygiene. 2. Observation on 03/27/24 at 9:40 A.M., of incontinent care for Resident #16 showed: - CNA A and CNA J did not perform hand hygiene after care of Resident #19; - CNA A and CNA J put on gloves and did not perform hand hygiene; - CNA A and CNA J transferred the resident from the wheelchair to the bed with a gait belt; - CNA A and CNA J removed the gloves, performed hand hygiene, and put on gloves; - CNA A and CNA J removed the resident's pants and unfastened the brief; - CNA J cleaned the resident's genitals with the same area of the wipe; - CNA A and CNA J did not perform hand hygiene and change gloves; - CNA J cleaned the resident's buttocks; - CNA J removed the gloves, did not perform hand hygiene, and touched the resident's lollipops, a blanket, a drink, and exited the room with the trash; - CNA J entered another resident's room and exited without performing hand hygiene, walked to the medication cart and touched the water picture to obtain water; - CNA J entered another resident's room and closed the door. During an interview on 03/28/24 at 4:32 P.M., CNA J said hands should be sanitized between glove changes and gloves changed when going from dirty to clean care. For incontinent care, a different wipe or a different area of the wipe should be used for each stroke. Should clean front to back during incontinent care. Review of the facility's policy titled, Urinary Cath Care, undated, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Catheter care is performed appropriately to prevent complications caused by the presence of an indwelling urethral catheter; - Wash hands or hand sanitize before any manipulation of the catheter site and/or apparatus; - The only place in the closed system intended to be open is the empty spout at the bottom of the drainage bag; - Drainage bag should be kept below the level of the bladder. 3. Observation of incontinent care for Resident #43 on 03/26/24 at 01:21 P.M. showed: - The resident sat in a wheelchair in his/her room and the catheter drainage bag hung underneath the wheelchair; - CNA A and CNA M transferred the resident from the wheelchair to the bed via mechanical lift (a device designed to lift and transfer residents from one surface to another); - CNA A and CNA M performed hand hygiene and put on gloves; - CNA A placed the catheter drainage bag on the bed, beside the resident's left thigh. As the resident was turned to get his/her pants down, the catheter drainage bag fell to the floor; - CNA A did not perform hand hygiene or change gloves, and provided catheter care; - CNA M rolled the resident to the right; - CNA A did not perform hand hygiene or change gloves, cleaned the resident's left buttock and thigh, picked up the catheter drainage bag and placed it back on the bed, and did not perform hand hygiene or change gloves; - CNA M rolled the resident to the left, the catheter drainage bag fell back to the floor, touching the toe of CNA A's shoe; - CNA A cleaned the resident's right buttock and thigh, did not perform hand hygiene or change gloves, reached over to the bedside cabinet, and opened two drawers to get barrier cream; - CNA M changed gloves but did not perform hand hygiene, and applied barrier cream to the resident's buttocks; - CNA A placed the catheter drainage bag back onto the bed; - Registered Nurse (RN) I entered the room and assisted in replacing the catheter statlock (a strap free stabilization device) and the handle on the catheter drainage bag was broken; - RN I changed out the catheter drainage bag and left the room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A and CNA M pulled up the resident's pants and the tubing from the drainage bag to the Foley catheter came apart and moved down the pant leg. CNA A, wearing the same gloves, pushed the drainage tubing up the left pant leg, reconnected it to the Foley catheter tubing, and failed to clean the tip of the drainage bag tubing. During an interview on 03/28/24 at 4:36 P.M., CNA A said the catheter drainage bag should be below the bladder, it should not be in the floor and he/she probably should've got the nurse back in to reconnect the tubing. During an interview on 03/28/24 at 430 P.M., RN I said hands should be sanitized between glove changes, gloves should be changed going from dirty to clean care. A different area of a wipe should be used when cleaning during incontinent care. 4. Observation on 03/28/24 at 2:14 P.M., of incontinent care for Resident #10 showed: - CNA L and CNA H did not perform hand hygiene, put on gloves, and transferred the resident from the wheelchair to the bedside with a gait belt (an assistive devices used to help safely transfer a person); - CNA L and CNA H removed the resident's pants while his/her catheter drainage bag lay in the floor, and assisted the resident to lay down on the bed; - CNA L removed his/her gloves, did not perform hand hygiene, put on gloves, and unfastened the brief; - CNA L performed peri care to the front peri area and the groin; - CNA H assisted the resident to turn and handed a wipe to CNA L; - CNA L performed peri care to the buttock area, rolled the brief under the resident, removed the gloves, did not perform hand hygiene, and put on gloves; - CNA L applied barrier cream to the resident's coccyx (tail bone) and between the buttocks, removed gloves, did not perform hand hygiene, and put on gloves; - CNA L performed catheter care with a wipe, removed gloves, did not perform hand hygiene, and put on gloves; - CNA L positioned a clean brief under the resident and touched the clean sheet and the blanket; - CNA H touched the bed controls to lower the bed; - CNA H and CNA L removed the gloves, performed hand hygiene, and left the room; - The catheter drainage bag hung on the bed frame and the bottom of the drainage bag lay on the floor with no privacy bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/24 at 2:30 P.M., CNA L said hand hygiene should be completed before and after care, gloves should be changed when moving from the front to the back sides, before and after cleaning a catheter, and sanitize hands each time gloves were changed. He/She said the drainage bag should not touch the floor and should be in a privacy bag. During an interview on 03/28/24 at 2:40 P.M., CNA H said to sanitize hands and put on gloves when entering a room. Peri care was done front to back using wipes, moving top to bottom, clean to dirty, roll the resident, and change gloves. Should clean the middle from front to back, use a new wipe to clean the buttocks, change gloves, roll the resident, and provide catheter care down and away from the insertion site 9-12 inches. Should change gloves, re-brief and apply cream, cover the resident and place the call light in reach, hang the catheter drainage bag on the side of the bed frame, the drainage bag had to be up off the floor, and in a dignity bag. Review of the facility's policy titled, How to Perform a Dressing Change, undated, showed: - Review the order; - Prepare ointments in a medicine cup, ointments in jars are removed with a tongue blade, or cotton swab and applied to the dressing or wound bed using a tongue blade or cotton swab; - Wash hands; - Clean the bedside table, set up the clean field; - Open all dressings and trays before beginning procedure; - If scissors are needed, clean with bleach wipes and place on the clean field; - Position patient and expose the area to be treated; - Wash hands, put on gloves; - Remove soiled dressing; - Place soiled dressing in a plastic bag; - Remove gloves, wash hands or sanitize hands, put on clean gloves; - Clean wound from the center out; - Remove gloves, wash hands or sanitize, put on clean gloves; - Apply ordered dressing and secure. 5. Review of Resident #307's medical record showed an order to cleanse the open areas to the bilateral lower extremities with wound cleanser, apply Xeroform (a wound dressing) to the open wounds and wrap with kling (absorbent gauze roll, which stretches and conforms to the body shape and clings to itself as it is wrapped) daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of wound care for Resident #307 on 03/27/24 at 1:30 P.M., showed: - RN C put on gloves, cleaned the table, put the wound care supplies on the table, changed gloves, and did not perform hand hygiene; - RN C used personal scissors to cut the dressing to the left lower leg, changed gloves without performing hand hygiene, and failed to clean the scissors after cutting the old dressing; - RN C left the room to get a CNA, returned, changed gloves and did not perform hand hygiene; - CNA A put on gloves and held the lower leg up; - RN C's gait belt touched the open wound; - RN C cleaned the wounds with wet gauze and dried the wounds with dry gauze; - RN C, wearing the same gloves and using the same scissors, cut the Xeroform and applied it on the wounds, and did not clean the scissors; - RN C, wearing the same gloves, applied clobetasol (an anti-inflammatory medication) cream with a gloved finger around the wound; - RN C changed gloves and did not perform hand hygiene; - RN C wrapped the left lower leg with kling wrap; - RN C moved to the resident's right lower leg without changing gloves or performing hand hygiene, and used the same scissors to cut the old dressing from the right lower leg; - RN C removed the dressing and changed gloves without performing hand hygiene; - RN C cleaned the area with wet gauze and dried with dry gauze; - RN C, wearing the same gloves, applied clobetasol cream with a gloved finger around the wounds; - RN C changed gloves without performing hand hygiene; - RN C applied Xeroform gauze to the wounds, dropped the package of kling wrap onto the floor, and picked up the package; - RN C, wearing the same gloves, opened the kling wrap, and wrapped the right leg wounds; - RN C removed the gloves and performed hand hygiene. During an interview on 03/28/24 at 4:36 P.M., RN C said hands should be sanitized between glove changes and that he/she didn't know that until now. He/She knew it should be done at the start and end of care, and for incontinent care, should clean from the front to back. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy regarding medication administration. 6. Observation on 03/28/24 at 9:30 A.M., of medication administration preparation for Resident #46 showed: - Licensed Practical Nurse (LPN) K opened a package of sertraline (an antidepressant) 25 milligram three tablets; - LPN K dropped one sertraline tablet onto the top of the medication cart; - LPN K picked up the pill with his/her bare hand and added to the medication cup with the other tablets; - LPN K crushed the pills and administered the medication through a feeding tube. During an interview on 03/28/24 at 2:45 P.M., the Assistant Director of Nursing (ADON) said the catheter drainage bag should not touch the floor and should be in a dignity bag. Staff should wash hands and put on gloves before care, change anytime going clean to dirty care, sanitize hands with every glove change, after care, and should wash hands. 47445 50260